INSURANCE

CHAPTER 232

HOUSE BILL NO. 1399

(Representatives Devlin, Delzer, Nelson, Price)
(Senators Fischer, J. Lee)

PRESCRIPTION DRUG ASSISTANCE

AN ACT to create a pharmaceutical manufacturers drug access program within the office of insurance commissioner for low-income individuals; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Prescription drug assistance. The insurance commissioner shall create and implement a program to assist individuals of low income to gain access to prescription medications through prescription drug assistance programs offered by pharmaceutical manufacturers, including free discount and coverage programs. The commissioner shall use available computer software programs that link an eligible individual with the appropriate pharmaceutical company patient assistance program relating to the individual's medically necessary drugs. The commissioner shall provide education to individuals and providers to promote the program and to expand enrollment and access to necessary medications for low-income individuals qualifying for the programs.

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $100,000, or so much of the sum as may be necessary, to the insurance commissioner for the purpose of implementing the pharmaceutical manufacturers drug access program, for the biennium beginning July 1, 2003, and ending June 30, 2005.

Approved April 7, 2003
Filed April 7, 2003

CHAPTER 233

HOUSE BILL NO. 1137

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

INSURANCE COMPANY REPORTS

AN ACT to amend and reenact section 26.1-02-03 of the North Dakota Century Code, relating to requirements for an insurance company to do business in this state; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-02-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-02-03. Inquiry into condition of company - Information supplied to commissioner - Penalty. The commissioner may address to any insurance company doing or applying for permission to do business in this state any inquiries in relation to ~~its~~ the company's activities, condition, or any other matter connected with ~~its~~ the company's transactions. The company shall reply ~~to the inquiries promptly and~~ in writing to such an inquiry within twenty days of receipt of the inquiry unless within that twenty days the company requests and the commissioner grants an extension of time. It is a violation of this title for a person to knowingly supply the commissioner with false, misleading, or incomplete information.

Approved March 13, 2003
Filed March 13, 2003

CHAPTER 234

HOUSE BILL NO. 1179

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

DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION

AN ACT to amend and reenact section 26.1-02-27 of the North Dakota Century Code, relating to disclosing nonpublic personal information.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-02-27 of the North Dakota Century Code is amended and reenacted as follows:

26.1-02-27. Disclosing nonpublic personal information.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not disclose to a nonaffiliated third party a customer's nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley Act [Pub. L. 106-102; 113 Stat. 1436] or contrary to the rules adopted by the commissioner under this section.

2. a. The commissioner ~~may~~ shall adopt rules ~~as may be~~ necessary to carry out this section.

   b. The rules must be consistent with and not more restrictive than the model regulation adopted by the national association of insurance commissioners entitled "Privacy of Consumer Financial and Health Information Regulation".

   c. Notwithstanding subdivision b and subject to the exceptions, including the affiliate sharing exception provided for in the national association of insurance commissioner's model regulation, the rules may prohibit the disclosure of nonpublic personal health and financial information concerning an individual unless an authorization is obtained from the individual whose nonpublic personal health and financial information is sought to be disclosed.

3. This section does not create a private right of action.

Approved April 23, 2003
Filed April 23, 2003

CHAPTER 235

HOUSE BILL NO. 1231

(Representatives Keiser, Carlson, Dosch)
(Senators Espegard, Grindberg, Klein)

INSURANCE FRAUD PREVENTION

AN ACT to create and enact sections 26.1-02.1-02.1, 26.1-02.1-06, 26.1-02.1-07, 26.1-02.1-08, 26.1-02.1-09, 26.1-02.1-10, and 26.1-02.1-11 of the North Dakota Century Code, relating to insurance fraud; to amend and reenact sections 26.1-02.1-01, 26.1-02.1-04, and 26.1-02.1-05 of the North Dakota Century Code, relating to insurance fraud; to repeal sections 26.1-02.1-02 and 26.1-02.1-03 of the North Dakota Century Code, relating to insurance fraud; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-02.1-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-02.1-01. Definitions. As used in this chapter:

1. ~~"Authorized agency" means any duly constituted criminal investigative department or agency of the United States or this state; the prosecuting attorney of any city, county, state, or of the United States or any subdivision thereof; or the insurance commissioner.~~ "Business of insurance" means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or who are officers, directors, agents, or employees of insurers, or who are other persons authorized to act on their behalf. The term does not include the activities of the North Dakota life and health insurance guaranty association or the North Dakota insurance guaranty association.

2. "Financial loss" includes loss of earnings, out-of-pocket and other expenses, repair and replacement costs, and claims payments.

3. "Fraudulent insurance act" includes the following acts or omissions committed by a person knowingly and with intent to defraud:

   a. Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by an insurer, reinsurer, insurance producer, or any agent thereof, false or misleading information as part of, in support of, or concerning a fact material to one or more of the following:

      (1) An application for the issuance or renewal of an insurance policy or reinsurance contract;

      (2) The rating of an insurance policy or reinsurance contract;

      (3) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract;

(4) Premiums paid on an insurance policy or reinsurance contract;

(5) Payments made in accordance with the terms of an insurance policy or reinsurance contract;

(6) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;

(7) The financial condition of an insurer or reinsurer;

(8) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer;

(9) The issuance of written evidence of insurance;

(10) The reinstatement of an insurance policy; or

(11) The formation of an agency, brokerage, or insurance producer contract.

b. Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

c. Removal, concealment, alteration, or destruction of the assets or records of an insurer, reinsurer, or other person engaged in the business of insurance.

d. Theft by deception or otherwise, or embezzlement, abstracting, purloining, or conversion of moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person engaged in the business of insurance.

e. Attempting to commit, aiding or abetting in the commission of, or conspiring to commit the acts or omissions specified in this section.

4. "Insurance" means a contract or arrangement in which one undertakes to pay or indemnify another as to loss from certain contingencies called "risks", including through reinsurance; pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies; pay an annuity to another; or act as surety. The term does not include a debt cancellation contract between a bank and debtor, between a credit union and debtor, or between a savings association and debtor and does not include a debt suspension contract between a bank and debtor, between a credit union and debtor, or between a savings association and debtor.

~~3.~~ 5. "Insurer" ~~includes an authorized insurer, self-insurer, reinsurer, broker, insurance producer, or any agent thereof~~ means a person entering into arrangements or contracts of insurance or reinsurance and who agrees to perform any of the acts set forth in subsection 4, whether the person

has or is required to have a certificate of authority or denies being an insurer. The term does not include the North Dakota life and health insurance guaranty association, the risk management fund, a bank, credit union, or savings association as a party to a debt cancellation contract or debt suspension contract, or the North Dakota insurance guaranty association.

~~4.~~ 6. "Person" means ~~a natural person, company,~~ an individual, corporation, ~~unincorporated association,~~ partnership, ~~professional corporation, and any other legal~~ association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing.

7. "Policy" means an individual or group policy, group certificate, contract, or arrangement of insurance or reinsurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

~~5.~~ 8. "Practitioner" means a licensee of this state authorized to practice medicine and surgery, psychology, chiropractic, or law or any other licensee of the state whose services are compensated, directly or indirectly, by insurance proceeds, or a licensee similarly licensed in other states and nations or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

~~6. "Statement" includes any notice statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bills for services, diagnosis, prescription, hospital or doctor records, x-rays, test result, or other evidence of loss, injury, or expense.~~

9. "Reinsurance" means a contract, binder of coverage including placement slip, or arrangement under which an insurer procures insurance for itself in another insurer as to all or part of an insurance risk of the originating insurer.

SECTION 2. Section 26.1-02.1-02.1 of the North Dakota Century Code is created and enacted as follows:

26.1-02.1-02.1. Fraudulent insurance acts, interference, and participation of convicted felons prohibited.

1. A person may not commit a fraudulent insurance act.

2. A person may not knowingly or intentionally interfere with the enforcement of the provisions of this chapter or investigations of suspected or actual violations of this chapter.

3. a. A person convicted of a felony involving dishonesty or breach of trust may not participate in the business of insurance.

b. A person in the business of insurance may not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance.

SECTION 3. AMENDMENT. Section 26.1-02.1-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-02.1-04. Immunity.

1. A person when acting without malice is not subject to liability by virtue of filing reports, or furnishing orally or in writing other information concerning any suspected, anticipated, or completed fraudulent insurance act, when the reports or information are provided to or received from ~~any authorized agency,~~ the commissioner; federal, state, or local law enforcement or regulatory officials; the national association of insurance commissioners~~,~~; or any other not-for-profit organization established to detect and prevent insurance fraud~~,~~ and ~~their agents, employees,~~ any employee or ~~designees~~ agent of any of these entities.

2. Except in prosecution for perjury or insurance fraud, and in the absence of malice, an insurer, or any officer, employee, or agent thereof, or any licensed insurance producer or private person who cooperates with, furnishes evidence, or provides or receives information regarding any suspected fraudulent insurance act to or from ~~an authorized agency,~~ the commissioner; federal, state, or local law enforcement or regulatory officials; the national association of insurance commissioners~~,~~; or any not-for-profit organization established to detect and prevent fraudulent insurance acts ~~or~~ and any employee or agent of any these entities who complies with an order issued by a court of competent jurisdiction acting in response to a request by any of these entities to provide evidence or testimony is not subject to a criminal proceeding or to a civil penalty with respect to any act concerning which the person testifies to or produces relevant matter.

3. In the absence of malice, an insurer, or any officer, employee, or agent thereof, or any licensed insurance producer or private person who cooperates with, furnishes evidence, or provides information regarding any suspected fraudulent insurance act to ~~an authorized agency,~~ the commissioner; federal, state, or local law enforcement or regulatory officials; the national association of insurance commissioners~~,~~; or any not-for-profit organization established to detect and prevent fraudulent insurance acts ~~or~~ and any employee or agent of any of these entities who complies with an order issued by a court of competent jurisdiction acting in response to a request by any of these entities to furnish evidence or provide testimony, is not subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature exists against the person, for filing reports, providing information, or otherwise cooperating with an investigation or examination of any of these entities.

4. The ~~authorized agency,~~ commissioner; federal, state, or local law enforcement or regulatory officials; the national association of insurance commissioners~~,~~; or any not-for-profit organization established to detect and prevent fraudulent insurance acts and any employee or agent of any of these entities, when acting without malice is not subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature will lie against the person by virtue of the execution of official activities or duties of the entity by virtue of the publication of any report or bulletin related to the official activities or duties of the entity.

5. This section does not abrogate or modify in any way common law or statutory privilege or immunity heretofore enjoyed by any person or entity.

SECTION 4. AMENDMENT. Section 26.1-02.1-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-02.1-05. Penalties - ~~Probation~~ - Restitution.

1. A violation of section ~~26.1-02.1-02~~ 26.1-02.1-02.1 is a class C felony if the value of any property or services retained exceeds five thousand dollars and a class A misdemeanor in all other cases. For purposes of this section, the value of any property and services must be determined in accordance with subsection 6 of section 12.1-23-05.

2. In the event that a practitioner is adjudicated guilty of a violation of section ~~26.1-02.1-02~~ 26.1-02.1-02.1, the court shall notify the appropriate licensing authority of this state of the adjudication. The appropriate licensing authority shall hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against the practitioner.

3. ~~Probation may not be granted to, nor may the imposition of a sentence be suspended, after the first adult conviction for a violation under section 26.1-02.1-02 and any subsequent conviction of the same.~~

~~4. The existence of any fact that would make a person ineligible for probation under this section must be alleged in the information or indictment, and:~~

~~a. Admitted by the defendant in open court;~~

~~b. Determined to be true at trial by a jury or the court; or~~

~~c. By plea of guilty or nolo contendere.~~

~~5.~~ In addition to any other punishment, a person who violates section ~~26.1-02.1-02~~ 26.1-02.1-02.1 must be ordered to make restitution to the insurer or to any other person for any financial loss sustained as a result of the violation of section ~~26.1-02.1-02~~ 26.1-02.1-02.1. The court shall determine the extent and method of restitution.

SECTION 5. Section 26.1-02.1-06 of the North Dakota Century Code is created and enacted as follows:

26.1-02.1-06. Mandatory reporting of fraudulent insurance acts.

1. A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed shall provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

2. Any other person having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

3. A person who provides nonpublic personal information to the commissioner pursuant to this section does not violate the insurance privacy law under section 26.1-02-27.

SECTION 6. Section 26.1-02.1-07 of the North Dakota Century Code is created and enacted as follows:

26.1-02.1-07. Confidentiality.

1. Any documents, materials, or other information in the possession or control of the commissioner which are provided pursuant to section 26.1-02.1-06 or obtained by the commissioner in an investigation of suspected or actual fraudulent insurance acts are confidential by law and privileged, not subject to subpoena, and not subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

2. Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner may be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection 1.

3. In order to assist in the performance of the commissioner's duties, the commissioner may:

   a. Share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection 1 with other state, federal, and international regulatory agencies, with the national association of insurance commissioners and its affiliates and subsidiaries, and with local, state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

   b. Receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from the national association of insurance commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

   c. Enter into agreements governing sharing and use of information consistent with this subsection.

4. A privilege or claim of confidentiality in the documents, materials, or information is not waived as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection 3.

5. Any investigative information gathered under section 26.1-02.1-06 or 26.1-02.1-08 is criminal investigative information and may not be disclosed except as provided under section 44-04-18.7.

SECTION 7. Section 26.1-02.1-08 of the North Dakota Century Code is created and enacted as follows:

26.1-02.1-08. Creation and purpose of the insurance fraud unit.

1. The North Dakota insurance fraud unit is established within the insurance department. The commissioner may appoint the full-time supervisory and investigative personnel of the insurance fraud unit, who must be qualified by training and experience to perform the duties of their positions. The commissioner may also appoint clerical and other staff necessary for the insurance fraud unit to carry out its duties and responsibilities under this chapter.

2. The insurance fraud unit shall:

   a. Initiate independent inquiries and conduct independent investigations when the insurance fraud unit has cause to believe that a fraudulent insurance act may be, is being, or has been committed;

   b. Review reports or complaints of alleged fraudulent insurance activities from federal, state, and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations; and

   c. Conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.

3. The insurance fraud unit may:

   a. Inspect, copy, or collect records and evidence;

   b. Serve subpoenas;

   c. Administer oaths and affirmations;

   d. Share records and evidence with federal, state, or local law enforcement or regulatory agencies;

   e. Execute search warrants and arrest warrants for criminal violations of this chapter;

   f. Arrest upon probable cause without warrant a person found in the act of violating or attempting to violate a provision of this chapter;

   g. Make criminal referrals to prosecuting authorities; and

   h. Conduct investigations outside of this state. If the information the insurance fraud unit seeks to obtain is located outside this state, the person from whom the information is sought may make the

information available to the insurance fraud unit to examine at the place where the information is located. The insurance fraud unit may designate a representative, including an official of the state in which the matter is located, to inspect the information on behalf of the insurance fraud unit, and the insurance fraud unit may respond to a similar request from an official of another state.

SECTION 8. Section 26.1-02.1-09 of the North Dakota Century Code is created and enacted as follows:

26.1-02.1-09. Peace officer status. A fraud unit investigator has all the powers conferred by law upon any peace officer of this state when making arrests for criminal violations established as a result of an investigation pursuant to this chapter. The general laws applicable to arrests by a peace officer of the state also apply to a fraud unit investigator. A fraud unit investigator may execute an arrest warrant and search warrant for the same criminal violation; serve subpoenas issued for the examination, investigation, and trial of all offenses identified through an investigation; and arrest upon probable cause without warrant a person found in the act of committing a violation of the provisions of this chapter.

SECTION 9. Section 26.1-02.1-10 of the North Dakota Century Code is created and enacted as follows:

26.1-02.1-10. Other law enforcement or regulatory authority. This chapter does not:

1. Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

2. Prevent or prohibit a person from disclosing voluntarily information concerning insurance fraud to a law enforcement or regulatory agency other than the insurance fraud unit; or

3. Limit the powers granted elsewhere by the laws of this state to the commissioner or the insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

SECTION 10. Section 26.1-02.1-11 of the North Dakota Century Code is created and enacted as follows:

26.1-02.1-11. Rules. The commissioner may adopt rules determined necessary by the commissioner for the administration of this chapter.

SECTION 11. REPEAL. Sections 26.1-02.1-02 and 26.1-02.1-03 of the North Dakota Century Code are repealed.

Approved April 11, 2003
Filed April 11, 2003

CHAPTER 236

SENATE BILL NO. 2121

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

INSURANCE COMPANY ANNUAL STATEMENT FILINGS

AN ACT to amend and reenact section 26.1-03-07 of the North Dakota Century Code, relating to annual statement filings by insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-07. Annual statement to be filed. Every insurance company doing business in this state shall transmit to the commissioner, not later than March first of each year, a statement of its condition and business for the year ending on the preceding December thirty-first. If March first falls on a Saturday or legal holiday, the statement is due on the next succeeding business day. A company organized under the law of any foreign country or province shall include in the statement only business transacted within the United States, and shall file a supplemental statement of business transacted without the United States not later than December first. The commissioner shall stamp the date of receipt on every statement. The commissioner may not accept the annual statement from any company if the statement was transmitted after the date designated in this section unless the statement is accompanied by the penalty prescribed by section 26.1-03-16. The commissioner may designate the national association of insurance commissioners as the repository for the filing.

Approved March 14, 2003
Filed March 17, 2003

CHAPTER 237

SENATE BILL NO. 2205

(Senators Klein, Espegard)
(Representatives Dosch, Wald)

INSURANCE COMPANY FILING EXTENSIONS

AN ACT to amend and reenact section 26.1-03-16 of the North Dakota Century Code, relating to extension of the time for an insurance company to file a statement with the insurance commissioner.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-16 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-16. Penalty for not making statement. Any insurance company doing business in this state which neglects to make and file any statement in the manner and within the time prescribed in this chapter forfeits one hundred dollars for each day's neglect, and upon notice by the commissioner to that effect, its authority to do new business ceases during the default. Any new business done by an insurance company after it has neglected to make a required statement is in violation of law. The commissioner may grant an insurance company an extension beyond the date designated in this section and may waive or reduce any penalty during the extension, upon a showing of good cause by the insurance company.

Approved March 14, 2003
Filed March 17, 2003

CHAPTER 238

HOUSE BILL NO. 1140

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

INSURANCE COMPANY REPORTS, EXISTENCE, AND INCORPORATION

AN ACT to amend and reenact subsection 3 of section 26.1-03-19.2, subsection 5 of section 26.1-12-03, and sections 26.1-12-04 and 26.1-18.1-08 of the North Dakota Century Code, relating to examination reports of foreign companies, term of existence of a mutual insurance company, articles of incorporation of a mutual insurance company, and annual reports of health maintenance organizations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26.1-03-19.2 of the North Dakota Century Code is amended and reenacted as follows:

3. In lieu of an examination under this chapter of any foreign insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, the reports may only be accepted if the insurance department was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program, or the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department, or the commissioner finds that the examination was performed by the insurance department of a state that was previously accredited under the national association of insurance commissioners but has lost its accreditation, provided that state's consumer protection laws are no less protective than those present under North Dakota law.

SECTION 2. AMENDMENT. Subsection 5 of section 26.1-12-03 of the North Dakota Century Code is amended and reenacted as follows:

5. The term of existence of the company, which may ~~not exceed thirty years~~ be perpetual.

SECTION 3. AMENDMENT. Section 26.1-12-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-12-04. Articles of incorporation - Filing - Issuance of certificate. The articles of incorporation or amendments thereto of a mutual insurance company organized under this chapter must be submitted to the commissioner ~~and to the~~

~~attorney general~~. If the commissioner ~~and the attorney general determine~~ determines the articles or amendments comply with this chapter, the commissioner shall approve the same. The articles or amendments must be filed in the office of the secretary of state and a certified copy must be filed with the commissioner. The commissioner shall deliver a certificate to the company indicating that it has complied with this chapter.

SECTION 4. AMENDMENT. Section 26.1-18.1-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18.1-08. Annual report.

1. Every domestic health maintenance organization shall annually, on or before March first, and every foreign health maintenance organization shall annually, on or before the date that its annual report is due in its domestic state, file a report verified by at least two principal officers with the commissioner, covering the preceding calendar year. The report must be on forms prescribed by the commissioner. In addition, the domestic health maintenance organization shall file by March first, and every foreign health maintenance organization shall file annually, on or before the date that its annual report is due in its domestic state, unless otherwise stated:

   a. Audited financial statements on or before June first.

   b. A list of the providers who have executed a contract that complies with subdivision a of subsection 4 of section 26.1-18.1-12.

   c. (1) A description of the grievance procedures.

      (2) The total number of grievances handled through the procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

2. The commissioner may require additional reports as are deemed necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this chapter. The commissioner may waive the filing of the annual report and other information for a health maintenance organization that has discontinued its operation in this state.

Approved March 13, 2003
Filed March 13, 2003

CHAPTER 239

SENATE BILL NO. 2195

(Senator J. Lee)
(Representative Price)

COMPREHENSIVE HEALTH ASSOCIATION REVISIONS

AN ACT to create and enact a new subsection to section 26.1-04-03 and four new sections to chapter 26.1-08 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota; to amend and reenact subsection 2 of section 26.1-03-17 and sections 26.1-08-01, 26.1-08-06, 26.1-08-06.1, 26.1-08-07, 26.1-08-08, 26.1-08-09, 26.1-08-10, 26.1-08-11, 26.1-08-12, 26.1-08-13, and 57-38-30.4 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota; and to repeal sections 26.1-08-02, 26.1-08-03, and 26.1-08-04 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

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~~ 3 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 26.1-18.1-18, 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.

[117] **SECTION 2.** A new subsection to section 26.1-04-03 of the North Dakota Century Code is created and enacted as follows:

Unfair referral. An insurer, insurance producer, or third-party administrator referring an individual employee to the association, or arranging for an individual employee to apply to the association for the

[117] Section 26.1-04-03 was also amended by section 17 of House Bill No. 1438, chapter 211.

purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

[118] **SECTION 3. AMENDMENT.** Section 26.1-08-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Association" means the comprehensive health association ~~created by section 26.1-08-03~~ of North Dakota.

2. "~~Association~~ Benefit plan" means insurance policy coverage offered by the association through the lead carrier.

3. "~~Association~~ Benefit plan premium" means the charge for ~~membership in~~ the ~~association~~ benefit plan based on the benefits provided in section 26.1-08-06 and determined pursuant to section 26.1-08-08.

4. "Board" means the association board of directors.

5. "Credible coverage" means, with respect to an individual, coverage of the individual provided under:

   a. A group health plan;

   b. Health insurance;

   c. Part A or part B of title XVIII of the federal Social Security Act [42 U.S.C. 1395 et seq.], relating to health insurance for the aged and disabled;

   d. Title XIX of the federal Social Security Act [42 U.S.C. 1396 et seq.], relating to grants to states for medical assistance programs, with the exception of coverage consisting solely of benefits under section 1928 of the federal Social Security Act [Pub. L. 103-66; 107-637; 42 U.S.C. 1396s], relating to the program for distribution of pediatric vaccines;

   e. Chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.], relating to armed forces medical and dental care;

   f. A medical care program of the Indian health service or of a tribal organization;

   g. A state health benefits risk pool;

   h. A public health plan as defined in federal regulations;

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[118] Section 26.1-08-01 was also amended by section 1 of Senate Bill No. 2029, chapter 240.

i. A health plan offered under chapter 89 of United States Code title 5 [5 U.S.C. 8901 et seq.], relating to government employee health insurance; or

j. A benefit plan under section 5(e) of the federal Peace Corps Act [Pub. L. 87-293; 75 Stat. 613; 22 U.S.C. 2504(e)].

6. "Eligible ~~person~~ individual" means ~~either:~~

~~a.~~ ~~An~~ an individual ~~who has been a resident of this state for a period of six months and meets the enrollment requirements of~~ eligible for association benefit plan coverage as specified under section 26.1-08-12~~; or~~

~~b. An individual who:~~

~~(1) Is currently a resident of this state;~~

~~(2) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01, the most recent of which is coverage under a group health benefit plan, governmental plan, or church plan, as those terms are defined in section 26.1-36.3-01;~~

~~(3) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;~~

~~(4) Is not eligible for coverage under a group health benefit plan as that term is defined in section 26.1-36.3-01, medicare, or medicaid;~~

~~(5) Does not have any other health insurance coverage;~~

~~(6) Has not had the most recent qualifying previous coverage described in paragraph 2 terminated for nonpayment of premiums or fraud; and~~

~~(7) If offered the option, has elected continuation coverage under the Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage was exhausted~~.

7. "Governmental plan" has the same meaning as provided under section 3(32) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] and as may be provided under any federal governmental plan.

8. "Group health plan" has the same meaning as employee welfare benefit plan as provided under section 3(1) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] to the extent that the plan provides medical care, and including items and service paid for as medical care to employees or the employees' dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

~~5.~~ 9. "Health ~~benefits~~ insurance coverage" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits ~~offered on an indemnity or prepaid basis which~~ that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible ~~person~~ individual, chiropractic care. The term does not include:

a. Coverage only for accident, disability income insurance, or any combination of the two;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for onsite medical clinics; or

h. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

~~6.~~ 10. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, ~~or~~ health maintenance organization ~~selling group or individual hospital, medical, surgical, or major medical coverage~~, and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

~~7.~~ 11. "Lead carrier" means the insurance company selected by the ~~association~~ board to administer the association ~~plan~~ benefit plans.

12. "Medicare" means coverage under both parts A and B of title XVIII of the federal Social Security Act [Pub. L. 89-97; 79 Stat. 291; 42 U.S.C. 1395 et seq.].

13. "Participating member" means any insurance company that is licensed or authorized to do business in this state which has an annual premium volume of accident and health insurance contracts derived from or on behalf of residents in the previous calendar year of at least one hundred thousand dollars.

~~8.~~ 14. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of individual policies or coverage under a nonprofit health service plan.

~~9.~~ 15. "Policy" means insurance, health care plan, health benefit plan as defined in section 26.1-36.3-01, or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage ~~which~~ that is:

a. Limited to disability or income protection coverage;

b. Automobile medical payment coverage;

c. Supplemental to liability insurance;

d. Designed solely to provide payment on a per diem basis, daily indemnity, or non-expense-incurred basis; or

e. Credit accident and health insurance.

~~10.~~ 16. "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by section 26.1-08-06 for a qualified comprehensive plan, or section 26.1-08-06.1 for ~~a qualified medicare supplement plan~~ the age sixty-five and over and disabled supplements, or other plan developed by the board and certified by the commissioner as complying with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

17. "Resident" means an individual who has been a legal resident of this state for a minimum of one hundred eighty-three days. However, for a federally defined eligible individual, there is no minimum length of residency requirement.

18. "Significant break in coverage" means a period of sixty-three or more consecutive days during all of which the individual does not have any credible coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

SECTION 4. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Board of directors.

1. The board consists of the commissioner; the state health officer; the director of the office of management and budget; one senator appointed by the majority leader of the senate of the legislative assembly; one representative appointed by the speaker of the house of representatives of the legislative assembly; and one individual from each of the three participating member insurance companies of the association with the highest annual premium volumes of accident and health insurance contracts as provided by the commissioner, verified by the lead carrier, and approved by the board.

2. Members of the board may be reimbursed from the moneys of the association for expenses incurred by the members due to their service as board members, but may not otherwise be compensated by the association for board services.

3. The costs of conducting the meetings of the association and the board is borne by the association.

4. The commissioner shall fill vacancies and, for cause, may remove any board member representing one of the three participating member insurance companies.

SECTION 5. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Powers and duties of commissioner and board - Fees.

1. The lead carrier shall operate the association subject to the supervision and control of the board.

2. The board shall:

   a. Formulate general policies to advance the purposes of this chapter;

   b. Approve the association's contract with the lead carrier;

   c. Approve the benefit plans;

   d. Approve the benefit plan premiums;

   e. Establish and modify from time to time, as appropriate, agents' referral fees;

   f. Approve the annual operating budget and any assessments to the participating members;

   g. Approve independent annual audits to assure the general accuracy of the financial date submitted by the lead carrier for the association;

   h. Develop and implement a program to publicize the existence of the association, the eligibility requirement, and procedures for enrollment and to maintain public awareness of the association;

   i. Approve bylaws and operating rules;

   j. Exempt, by a two-thirds majority vote, an applicant from the preexisting condition provisions of subsection 10 of section 26.1-08-12 when required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life; and

   k. Provide for other matters as may be necessary and proper for the execution of the commissioner's and board's powers, duties, and obligations.

3. The commissioner, board, and lead carrier employees are not liable for any obligations of the association.

4. The commissioner may establish additional powers and duties of the board and may adopt rules necessary and proper for the association and to implement this chapter.

SECTION 6. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Operation of the association. The association may:

1. Exercise the powers granted to insurance companies under the laws of this state.

2. Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessment due the association.

3. Take such legal action as necessary:

   a. To avoid the payment of improper claims against the association or the coverage provided by or through the association;

   b. To recover any amounts erroneously or improperly paid by the association;

   c. To recover any amounts paid by the association as a result of mistake of fact or law; or

   d. To recover other amounts due the association.

4. Enter contracts with the insurance companies, similar associations in other states, or other persons for the performance of administrative functions.

5. Establish administrative and accounting procedures for the operation of the association.

6. Provide for the reinsuring of risks incurred as a result of issuing the coverages required by individuals covered by the association benefit plans.

7. Provide for the administration by the association of policies, which are reinsured pursuant to subsection 6.

8. Issue benefit plans for coverage in accordance with the requirements of sections 26.1-08-06 and 26.1-08-06.1.

9. Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

SECTION 7. AMENDMENT. Section 26.1-08-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06. ~~Minimum benefits of a qualified comprehensive~~ Comprehensive benefit plan.

1. A plan of health coverage is a qualified comprehensive plan if it otherwise meets the requirements established by chapters 26.1-36 and 26.1-36.4 and the other laws of the state~~, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:~~

a. The minimum benefits for covered individuals must, subject to subsection 2, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which must not be less than five hundred dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than one million dollars.

b. Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services.

(2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

(3) Drugs requiring a physician's prescription.

(4) Services of a nursing home for not more than one hundred twenty days in a year if the services commence within fourteen days following confinement of at least three days in a hospital for the same condition.

(5) Service of a home health agency up to a maximum of two hundred seventy visits per year.

(6) Use of radium or other radioactive materials.

(7) Oxygen.

(8) Anesthetics.

(9) Prostheses.

(10) Rental or purchase, as appropriate, of durable medical equipment.

(11) Diagnostic x-rays and laboratory tests.

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(13) Services of a physical therapist.

(14) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

(15) Substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.

~~c. Covered expenses must include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.~~

~~d. Covered expenses for the services or articles specified in this subsection do not include:~~

~~(1) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another accident and health insurance policy or medicare.~~

~~(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.~~

~~(3) Any charge for travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.~~

~~(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.~~

~~(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel, which exceeds the prevailing charge in the locality where the service is provided.~~

~~(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.~~

~~(7) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.~~

~~(8) Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association~~.

2. ~~A qualified comprehensive plan also must offer the eligible person the choice of an annual deductible of not less than one thousand dollars per person instead of that provided in subdivision a of subsection 1.~~ The benefit plan must offer comprehensive health care coverage to every eligible individual. The coverage to be issued by the association, its schedule of benefits, exclusions, and other limitations must be established by the lead carrier and subject to the approval of the board.

3. In establishing the benefit plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate.

Benefit levels, deductibles, coinsurance factors, copayments, exclusions, and limitations may be applied as determined to be generally reflective of health insurance coverage provided in the state.

4. The coverage may include deductibles of not less than five hundred dollars per individual per benefit period.

5. The coverage must include a limitation of not less than three thousand dollars per individual on the total annual out-of-pocket expenses for services covered under this subsection.

6. Any coverage or combination of coverages through the association may not exceed a lifetime maximum benefit of one million dollars for an individual.

7. The coverage may include cost-containment measures and requirements, including preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost-effective.

8. The coverage may include preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

9. Coverage must include oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

10. Coverage must include substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.

11. Covered expenses must include, at the option of the eligible individual, professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

12. The coverage must include organ transplants as approved by the board.

13. The association must be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under an association benefit plan must be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or no fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. The association must have a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this subsection.

SECTION 8. AMENDMENT. Section 26.1-08-06.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06.1. ~~Qualified medicare~~ Age sixty-five and over and disabled supplement ~~plan~~ plans. A ~~qualified medicare~~ basic supplement plan ~~includes medicare supplement plans A and F. These plans are available to~~ and standard supplemental plan must be offered to individuals who are eligible for medicare by reason of age or disability. Supplemental plans issued by the association must be developed by the lead carrier and approved by the board. Any coverage or combination of coverages through the association may not exceed a maximum benefit of one million dollars for an individual.

SECTION 9. AMENDMENT. Section 26.1-08-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-07. Approval and filing of benefit plans. The ~~association or the~~ lead carrier shall file with the commissioner, following approval from the board, all benefit plans, brochures, and other materials required to be approved to be offered under this chapter. The commissioner shall approve or disapprove any form within sixty days of receipt.

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

26.1-08-08. ~~Association~~ Benefit plan premium. The schedule of premiums to be charged eligible ~~persons~~ individuals for ~~membership in the association~~ a benefit plan must be established by the ~~association~~ lead carrier and approved by the board, but may not exceed one hundred thirty-five percent of the ~~average~~ individual premium rates charged ~~by the five largest insurers with the largest individual qualified plan of insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided by all insurers annually at the request of the commissioner. The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer and the rates charged by the insurer for each type of plan offered by the insurer and any other information the commissioner considers as necessary. The commissioner shall utilize generally acceptable actuarial principles and structurally compatible rates~~ for similar coverage throughout the state. If similar coverage is not offered by other insurance carriers, premium rates for actuarial equivalent benefit plans offered by other insurers in the state must be provided by the commissioner and utilized by the lead carrier to determine association rates for the benefit plans.

SECTION 11. AMENDMENT. Section 26.1-08-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-09. ~~Operation of association plan~~ Participating members.

1. ~~Upon certification as an eligible person in the manner provided by section 26.1-08-12, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.~~ There is established a comprehensive health association with participating membership consisting of those insurance companies, licensed or authorized to do business in this state, with an annual premium volume of accident and health insurance contracts, derived from or on behalf of residents in the previous calendar year, of at least one hundred thousand dollars, as determined by the commissioner.

2. ~~Not less than eighty-seven and one-half percent of the association plan premium paid to the lead carrier may be used to pay claims and not more than twelve and one-half percent may be used for payment of the lead carrier's direct and indirect expenses as specified in section 26.1-08-10.~~ All participating members shall maintain their membership in the association, as a condition for writing policies in this state.

3. ~~Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.~~

~~4.~~ Each participating member of the association which is liable for state income tax or state premium tax shall share the losses due to claims and administrative expenses ~~and meeting expenses under subsection 2 of section 26.1-08-03~~ of the association ~~plan~~. The difference between the total claims expense of the association ~~plan~~ and the ~~premium payments allocated to the payment of benefits~~ benefit plan premiums received is the liability of ~~those association~~ the participating members ~~that are liable for state income tax or state premium tax~~. Such ~~association~~ participating members shall share in the excess costs of the association ~~plan~~ in an amount equal to the ratio of a participating member's total annual premium volume for accident and health insurance ~~charges,~~ received from or on behalf of state residents, to the total accident and health insurance premium ~~contract charges~~ volume received by ~~association~~ all of the participating members ~~that are liable for state income taxes or state premium taxes from or on behalf of state residents,~~ as determined by the ~~commissioner~~ lead carrier and approved by the board.

4. Each member's liability may be determined retroactively and payment of the assessment is due within thirty days after notice of the assessment is given. Failure by a member to tender to the lead carrier on behalf of the association the full amount assessed within thirty days of notification by the ~~association~~ lead carrier is grounds for termination of membership.

SECTION 12. AMENDMENT. Section 26.1-08-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-10. Administration of the association ~~plan~~.

1. ~~Any participating member of the association shall submit to the commissioner the policies which are being proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.~~ Not less than eighty-seven and one-half percent of the association plan premium paid to the lead carrier may be used to pay claims.

2. ~~The association shall select policies and contracts by a member or members of the association to be the association plan. The association shall select one lead carrier to issue the qualified plans. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from the members of the association for the purpose of selecting the lead carrier. The selection of the lead~~

~~carrier must be based upon criteria established by the board.~~ Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association or be allocated to reduce benefit plan premiums.

3. ~~The lead carrier shall perform all administrative and claims payment functions required by this section.~~ The lead carrier ~~shall provide these services~~ agreement must continue for a period of at least three years, unless a request to terminate is approved by the ~~association and the commissioner~~ board. The ~~association and the commissioner~~ board shall approve or deny a request to terminate within ninety days of its receipt. A failure to make a final decision on a request to terminate within the specified period is deemed an approval. ~~The association shall invite submissions of policy forms from members of the association, including the lead carrier, six months prior to the expiration of each three-year period. The association shall follow subsection 2 in selecting a lead carrier for the subsequent three-year period, or if a request to terminate is approved on or before the end of the three-year period.~~ The agreement will be automatically renewed until either party terminates the agreement.

4. ~~The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.~~

~~5. The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association shall determine the specific information to be contained in the report prior to the effective date of the association plan.~~

~~6. The lead carrier shall pay all claims pursuant to this chapter and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.~~

~~7.~~ The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses which are assignable to the maintenance and administration of the association ~~plan~~. ~~The association shall approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles.~~ Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~8.~~ 5. The lead carrier is, when carrying out its duties under this chapter, an agent of the association and the ~~commissioner~~ board, and is civilly liable for its actions, subject to the laws of this state.

6. The lead carrier shall:

a. Perform all administrative and claims payment functions required under this chapter.

b. Determine eligibility of individuals requesting coverage through the association.

c. Provide all eligible individuals involved in the association an individual certificate setting forth a statement as to the insurance protection to which the individual is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

d. Pay all claims under this chapter and indicate that the association paid the claims. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

e. Establish a premium billing procedure for collection of premium from individuals covered by the association.

f. Obtain approval from the board for all benefit plans issued.

g. Submit regular reports to the board regarding the operation of the association.

h. Submit to the participating companies and board, on a semiannual basis, a report of the operation of the association.

i. Verify premium volumes of all accident and health insurers in the state.

j. Determine and collect assessments.

k. Perform such functions relating to the association as may be assigned to it.

SECTION 13. AMENDMENT. Section 26.1-08-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-11. Solicitation of eligible ~~persons~~ individuals.

1. The association, pursuant to a plan approved by the ~~commissioner~~ board, shall disseminate appropriate information to the residents of this state regarding the existence of the association ~~plan~~, the benefit plans, and the means of enrollment. Means of communication may include use of the press, radio, electronic mail, internet, and television, as well as publication in appropriate state offices and publications.

2. The association and board shall devise and implement means of maintaining public awareness of ~~this chapter~~ the association and shall administer this chapter in a manner ~~which~~ that facilitates public participation ~~in the association plan~~.

3. All licensed accident and health insurance producers may engage in the selling or marketing of qualified association benefit plans. The lead carrier shall pay an insurance producer's referral fee ~~of twenty-five~~

~~dollars~~ to each licensed accident and health insurance insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid to the lead carrier from moneys received as premiums for the association benefit plan.

4. Every insurance company ~~which~~ that rejects or applies underwriting restrictions to an applicant for accident and health insurance shall notify the applicant of the existence of the association ~~plan~~, requirements for being accepted in it, and the procedure for applying to it.

[119] **SECTION 14. AMENDMENT.** Section 26.1-08-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-12. ~~Enrollment by eligible person~~ Eligibility.

1. The association ~~plan~~ must be open for enrollment by eligible ~~persons~~ individuals. ~~A person is eligible and may enroll in the plan by submission of an application to the lead carrier.~~ Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must ~~provide~~:

   a. ~~The~~ Provide the name, address, and age of the applicant~~, and~~.

   b. Provide the length of applicant's residence in this state.

   ~~b.~~ c. ~~The~~ Provide the name, address, and age of spouse and children, if any~~, if they are to be insured~~.

   ~~c. For an "eligible person" under subdivision a of subsection 4 of section 26.1-08-01, written evidence that the applicant has been rejected for accident and health insurance, or that restrictive riders or a preexisting conditions limitation, the effect of which is to reduce substantially coverage from that received by a person considered a standard risk, was required, by at least one insurance company within six months of the date of the application.~~

   d. ~~A~~ Provide a designation of coverage desired.

   e. Be accompanied by premium and evidence to prove eligibility.

2. Within thirty days of receipt of the application, the lead carrier shall either reject the application for failing to comply with the requirements of ~~subsection 1~~ this section or forward the eligible ~~person~~ individual a notice of acceptance and billing information. Insurance is effective ~~immediately upon receipt of the first month's association plan premium, and is~~ retroactive to the date of the application or the day following the date shown on the written rejection or refusal, if the applicant otherwise complies with this chapter.

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[119] Section 26.1-08-12 was also amended by section 2 of Senate Bill No. 2029, chapter 240, section 3 of Senate Bill No. 2029, chapter 240, section 4 of Senate Bill No. 2029, chapter 240, and section 5 of Senate Bill No. 2029, chapter 240.

3. An eligible ~~person~~ individual may not purchase more than one policy from the association ~~plan~~.

4. ~~A person who obtains coverage pursuant to this section may not be covered for maternity during the first two hundred seventy days or any other preexisting condition during the first one hundred eighty days of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the date of the application. Any person with coverage through the association plan due to a catastrophic condition or major illness who is also pregnant at the time of application is eligible for maternity benefits after the first one hundred eight days of coverage. This subsection does not apply to a person receiving nonelective procedures who has lost dependent status under a parent's or guardian's policy that has been in effect for the twelve-month period immediately preceding the filing of an application or to a person who is treated by nonelective procedures for a congenital or genetic disease. No preexisting condition exclusion or waiting period may be imposed under this subsection, or in the terms of the coverage obtained under this chapter, on an "eligible person" under subdivision b of subsection 4 of section 26.1-08-01. For an "eligible person" under subdivision a of subsection 4 of section 26.1-08-01, any preexisting condition exclusion must be reduced by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06.~~ An individual may qualify to enroll in the association for benefit plan coverage as:

   a. A standard applicant:

      (1) An individual who has been a resident of this state for one hundred eighty-three days and continues to be a resident of the state who has received from at least one insurance carrier within one hundred eighty-three days of the date of application, one of the following:

         (a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

         (b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

         (c) Refusal by an insurer to issue insurance except at the rate exceeding the association benefit rate.

      (2) Is not eligible for the state's medical assistance program.

   b. A Health Insurance Portability and Accountability Act of 1996 applicant:

      (1) An individual who meets the federally defined eligibility guidelines as follows:

(a) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01, the most recent of which is covered under a group health plan, governmental plan, or church plan;

(b) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;

(c) Is not eligible for coverage under a group health benefit plan as the term is defined in section 26.1-36.3-01, medicare, or medicaid;

(d) Does not have any other health insurance coverage;

(e) Has not had the most recent qualifying previous coverage described in subparagraph a terminated for nonpayment of premiums or fraud; and

(f) If offered under the option, has elected continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage has exhausted.

(2) Is and continues to be a resident of the state.

(3) Is not eligible for the state's medical assistance program.

c. An applicant age sixty-five and over or disabled:

(1) An individual who is eligible for medicare by reason of age or disability and has been a resident of this state for one hundred eighty-three days and continues to be a resident of this state who has received from at least one insurance carrier within one hundred eighty-three days of the date of application, one of the following:

(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

(c) Refusal by an insurer to issue insurance except at the rate exceeding the association benefit rate.

(2) Is not eligible for the state's medical assistance program.

5. The board and lead carrier shall develop a list of medical or health conditions for which an individual must be eligible for association coverage without applying for health insurance coverage under

subdivisions a and c of subsection 4. Individuals with written evidence of the existence or history of any medical or health conditions on the approved list may not be required to provide written evidence of rejection, refusal, or substantially reduced coverage.

6. A rejection or refusal by an insurer offering only stop loss, excess of loss, or reinsurance coverage with respect to an applicant under subdivisions a and c of subsection 4 is not sufficient evidence to qualify.

7. An eligible individual may have insurance coverage, other than the state's medical assistance program, with an additional commercial insurer; however, the association will reimburse eligible claim costs as payer of last resort.

8. Each resident dependent of an individual who is eligible for association coverage is also eligible for association coverage.

9. Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition is also eligible for association coverage.

10. Preexisting conditions.

    a. Association coverage must exclude charges or expenses incurred during the first one hundred eighty days following the effective date of coverage for any condition for which medical advice, diagnosis, care, or treatment was recommended or received during the ninety days immediately preceding the date of the application.

    b. Association coverage must exclude charges or expenses incurred for maternity during the first two hundred seventy days following the effective date of coverage.

    c. Any individual with coverage through the association due to a catastrophic condition or major illness who is also pregnant at the time of application is eligible for maternity benefits after the first one hundred eighty days of coverage.

11. Waiting periods do not apply to an individual who:

    a. Is receiving nonelective treatment or procedures for a congenital or genetic disease.

    b. Is receiving nonelective treatment or procedures and has lost dependent status under a parent's or guardian's policy that has been in effect for the twelve-month period immediately preceding the date of the application.

    c. Has obtained coverage as a federally eligible individual as defined in subdivision b of subsection 4.

    d. Has obtained coverage as an eligible person under subdivision a of subsection 4, allowing for a reduction in waiting period days by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06 and

provided the association application is made within sixty-three days of termination of the qualifying previous coverage.

12. An individual is not eligible for coverage through the association if:

a. The individual is determined to be eligible for health care benefits under the state's medical assistance program.

b. The individual has previously terminated association coverage unless twelve months have lapsed since such termination. This limitation does not apply to an applicant who is a federally defined eligible individual.

c. The association has paid out one million dollars in benefits on behalf of the individual.

d. The individual is an inmate or resident of a public institution. This limitation does not apply to an applicant who is a federally defined eligible individual.

e. The individual's premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or the individual's employer.

13. A period of credible coverage is not counted with respect to the enrollment of an individual who seeks coverage under this chapter if after such period and before the enrollment date, the individual experiences a significant break in coverage which is more than sixty-three days.

SECTION 15. AMENDMENT. Section 26.1-08-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-13. Termination of coverage. Coverage under this chapter terminates:

1. Upon request of the covered person.

2. For failure to pay the required premium subject to a thirty-one-day grace period.

3. When the one million dollar lifetime maximum benefit amount has been reached ~~under subdivision a of subsection 1 of section 26.1-08-06~~.

4. If the covered person qualifies for health benefits under ~~other plans or policies~~ the state's medical assistance program.

5. If the covered individual physically resides outside this state for more than one hundred eighty-two days of each ~~plan~~ calendar year, except for an ~~association participant~~ individual who is absent from the state for a verifiable medical reason as determined by the ~~association~~ board.

SECTION 16. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Exempt from premium tax. The association is exempt from the insurance premium tax imposed under section 26.1-03-17.

SECTION 17. AMENDMENT. Section 57-38-30.4 of the North Dakota Century Code is amended and reenacted as follows:

57-38-30.4. Income tax credit for comprehensive health association assessments. The amount of any assessment paid by any member of the comprehensive health association under subsection ~~4~~ 3 of section 26.1-08-09 is a credit against the state income tax for which a member may be liable for the year which the assessment was paid.

SECTION 18. REPEAL. Sections 26.1-08-02, 26.1-08-03, and 26.1-08-04 of the North Dakota Century Code are repealed.

Approved March 26, 2003
Filed March 26, 2003

CHAPTER 240

SENATE BILL NO. 2029

(Legislative Council)
(Budget Committee on Health Care)

HEALTH INSURANCE MANDATE REVIEW

AN ACT to create and enact a new subsection to section 26.1-08-01, a new subdivision to subsection 4 of section 26.1-08-12, a new subdivision to subsection 10 of section 26.1-08-12, and a new subdivision to subsection 11 of section 26.1-08-12 of the North Dakota Century Code, relating to health insurance coverage through the comprehensive health association of North Dakota; and to amend and reenact subdivision e of subsection 12 of section 26.1-08-12 and section 54-03-28 of the North Dakota Century Code, relating to health insurance coverage through the comprehensive health association of North Dakota and legislative measures mandating health insurance coverage of services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[120] **SECTION 1.** A new subsection to section 26.1-08-01 of the North Dakota Century Code is created and enacted as follows:

"Trade adjustment assistance, pension benefit guarantee corporation individual" means an individual who is certified as eligible for federal trade adjustment assistance or federal pension benefit guarantee corporation assistance as provided by the federal Trade Adjustment Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933], the spouse of such an individual, or a dependent of such an individual as provided under the federal Internal Revenue Code.

[121] **SECTION 2.** A new subdivision to subsection 4 of section 26.1-08-12 of the North Dakota Century Code as amended in section 14 of Senate Bill No. 2195, as approved by the fifty-eighth legislative assembly, is created and enacted as follows:

A Trade Adjustment Assistance Reform Act of 2002 applicant:

(1) A trade adjustment assistance, pension benefit guarantee corporation individual applicant who:

(a) Has three or more months of previous health insurance coverage at the time of application;

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[120] Section 26.1-08-01 was also amended by section 3 of Senate Bill No. 2195, chapter 239.

[121] Section 26.1-08-12 was also amended by section 3 of Senate Bill No. 2029, chapter 240, section 4 of Senate Bill No. 2029, chapter 240, section 5 of Senate Bill No. 2029, chapter 240, and section 14 of Senate Bill No. 2195, chapter 239.

(b) Has applied for coverage within sixty-three days of the termination of the individual's previous health insurance coverage;

(c) Is and continues to be a resident of the state;

(d) Is not enrolled in the state's medical assistance program;

(e) Is not an inmate or a resident of a public institution; and

(f) Does not have health insurance coverage through:

[1] The spouse's employer if the coverage provides for employer contribution of fifty percent or more of the cost of coverage of the spouse, the eligible individual, and the dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan.

[2] A state's children's health insurance program, as defined under section 50-29-01.

[3] A government plan.

[4] Chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care.

[5] Part A or part B of title XVIII of the federal Social Security Act [42 U.S.C. 1395 et seq.] relating to health insurance for the aged and disabled.

(2) Coverage under this subdivision may be provided to an individual who is eligible for health insurance coverage through the federal Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272; 100 Stat. 82]; a spouse's employer plan in which the employer contribution is less than fifty percent; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain coverage under this subdivision.

[122] **SECTION 3.** A new subdivision to subsection 10 of section 26.1-08-12 of the North Dakota Century Code as amended in section 14 of Senate Bill No. 2195, as approved by the fifty-eighth legislative assembly, is created and enacted as follows:

A preexisting condition may not be imposed on an individual who is eligible under section 2 of this Act.

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[122] Section 26.1-08-12 was also amended by section 2 of Senate Bill No. 2029, chapter 240, section 4 of Senate Bill No. 2029, chapter 240, section 5 of Senate Bill No. 2029, chapter 240, and section 14 of Senate Bill No. 2195, chapter 239.

[123] **SECTION 4.** A new subdivision to subsection 11 of section 26.1-08-12 of the North Dakota Century Code as amended in section 14 of Senate Bill No. 2195, as approved by the fifty-eighth legislative assembly, is created and enacted as follows:

Has obtained coverage as an eligible individual under section 2 of this Act.

[124] **SECTION 5. AMENDMENT.** Subdivision e of subsection 12 of section 26.1-08-12 of the North Dakota Century Code as amended in section 14 of Senate Bill No. 2195, as approved by the fifty-eighth legislative assembly, is amended and reenacted as follows:

e. The individual's premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or the individual's employer. However, this subdivision does not apply if the individual's premiums are paid for or reimbursed under a program established under the federal Trade Adjustment Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933].

SECTION 6. AMENDMENT. Section 54-03-28 of the North Dakota Century Code is amended and reenacted as follows:

54-03-28. Health insurance mandated coverage of services - Cost-benefit analysis requirement.

1. A legislative measure mandating health insurance coverage of services or payment for specified providers of services may not be acted on by any committee of the legislative assembly unless the measure is accompanied by a cost-benefit analysis provided by the legislative council. Factors to consider in this analysis include:

   a. The extent to which the proposed mandate would increase or decrease the cost of the service.

   b. The extent to which the proposed mandate would increase the appropriate use of the service.

   c. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds.

   d. The impact of the proposed mandate on the total cost of health care.

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[123] Section 26.1-08-12 was also amended by section 2 of Senate Bill No. 2029, chapter 240, section 3 of Senate Bill No. 2029, chapter 240, section 5 of Senate Bill No. 2029, chapter 240, and section 14 of Senate Bill No. 2195, chapter 239.

[124] Section 26.1-08-12 was also amended by section 2 of Senate Bill No. 2029, chapter 240, section 3 of Senate Bill No. 2029, chapter 240, section 4 of Senate Bill No. 2029, chapter 240, and section 14 of Senate Bill No. 2195, chapter 239.

2. A legislative measure mandating health insurance coverage of services or payment for specified providers of services may not be acted on by any committee of the legislative assembly unless the measure as recommended by the committee provides:

   a. The measure is effective through June thirtieth of the next odd-numbered year following the year in which the legislative assembly enacted the measure, and after that date the measure is ineffective.

   b. The application of the mandate is limited to the public employees health insurance program and the public employee retiree health insurance program. The application of such mandate begins with every contract for health insurance which becomes effective after June thirtieth of the year in which the measure becomes effective.

   c. That for the next legislative assembly, the public employees retirement system shall prepare and request introduction of a bill to repeal the expiration date and to extend the mandated coverage or payment to apply to accident and health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the mandated coverage or payment on the system's health insurance programs. The report must include information on the utilization and costs relating to the mandated coverage or payment and a recommendation on whether the coverage or payment should continue. For purposes of this section, the bill is not a legislative measure mandating health insurance coverage of services or payment for specified providers of services, unless the bill is amended following introduction so as to change the bill's mandate.

3. A majority of the members of the committee, acting through the chairman, has sole authority to determine whether a legislative measure mandates coverage of services under this section.

~~3.~~ 4. Any amendment made during a legislative session to a measure which mandates health insurance coverage of services may not be acted on by a committee of the legislative assembly unless the amendment is accompanied by a cost-benefit analysis provided by the legislative council.

~~4.~~ 5. The legislative council shall contract with a private entity, after receiving one or more recommendations from the insurance commissioner, to provide the cost-benefit analysis required by this section. The insurance commissioner shall pay the cost of the contracted services to the entity providing the services.

Approved April 23, 2003
Filed April 23, 2003

CHAPTER 241

HOUSE BILL NO. 1141

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

REINSURANCE AGREEMENT NOTICES

AN ACT to amend and reenact subsection 1 of section 26.1-10.1-01 and section 26.1-10.1-03 of the North Dakota Century Code, relating to notice to the insurance commissioner of reinsurance agreements.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-10.1-01 of the North Dakota Century Code is amended and reenacted as follows:

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

SECTION 2. AMENDMENT. Section 26.1-10.1-03 of the North Dakota Century Code is amended and reenacted as follows:

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

1. Materiality and scope.

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

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

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

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

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

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

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

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

b. However, filing is not required if:

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

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

2. Information to be reported.

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

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

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

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

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

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

Approved March 13, 2003
Filed March 13, 2003

CHAPTER 242

HOUSE BILL NO. 1233

(Representatives Keiser, N. Johnson)
(Senators Klein, Mutch)

NONPROFIT MUTUAL INSURANCE COMPANY POWERS

AN ACT to amend and reenact subsection 5 of section 26.1-17-33.1 of the North Dakota Century Code, relating to the powers of nonprofit mutual insurance companies; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

5. A nonprofit mutual insurance company may form a ~~stock~~ wholly owned company for the purpose of administering medicare claims and engaging in other business activities that do not accept insurance risk. A company established under this subsection may form a joint venture or subsidiary to conduct one or more of the functions the nonprofit mutual insurance company could conduct directly. An officer, a director, or a management employee of the nonprofit mutual insurance company may not directly or indirectly own an interest in a subsidiary.

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

Approved March 7, 2003
Filed March 7, 2003

CHAPTER 243

HOUSE BILL NO. 1216

(Representatives Drovdal, Kempenich, Nottestad)
(Senators Urlacher, Wardner)

GAME AND FISH LICENSE VENDOR BONDS

AN ACT to amend and reenact section 26.1-21-09.1 of the North Dakota Century Code, relating to bonds for agents distributing hunting and fishing licenses.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-21-09.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-21-09.1. Bonds of agents appointed to distribute hunting and fishing licenses or stamps - Premiums - Determination of eligibility. The annual premium for a bond of an agent appointed by a county auditor to distribute hunting and fishing licenses or stamps pursuant to section 20.1-03-17 is ten dollars for each five thousand dollars of coverage. The premium must be paid to the fund pursuant to rules adopted by the commissioner. The commissioner shall deposit the premiums with the state treasurer to the credit of the fund. The commissioner may reduce or waive the premium if it is determined that funds received pursuant to this section are sufficient to cover potential claims on the bonds of agents appointed to distribute hunting and fishing licenses or stamps. The commissioner shall determine the conditions and qualifications of agents bonded under this section. The amount of coverage afforded under this section is ~~limited to~~ five thousand dollars, ten thousand dollars, or fifteen thousand dollars per agent per year as determined by the county auditor.

Approved March 12, 2003
Filed March 12, 2003

CHAPTER 244

HOUSE BILL NO. 1138

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

REINSURANCE COVERAGE AND BROKER OF RECORD

AN ACT to create and enact section 26.1-22-21.1 of the North Dakota Century Code, relating to insurance broker of record; to amend and reenact sections 26.1-22-05, 26.1-22-10, and 26.1-22-21 of the North Dakota Century Code, relating to buildings insured by the state fire and tornado fund, optional coverage for the state mill and elevator association, and excess loss reinsurance; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-22-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-05. Public, international peace garden, and winter show buildings insurable in fund. The public buildings and fixtures and permanent contents therein belonging to the state, the various state industries except the state mill and elevator association if the association exercises the option provided in section 26.1-22-10, and the political subdivisions must, and the buildings and fixtures and the permanent contents therein belonging to an international peace garden or a winter show may, be insured under this chapter. No officer or agent of the state or of any political subdivision, and no person having charge of any public buildings belonging to the state, any state industry, or any political subdivision, may pay out any public moneys or funds on account of any insurance against loss by fire, lightning, inherent explosion, windstorm, cyclone, tornado and hail, explosion, riot attending a strike, aircraft, smoke, vehicles, or any other risks of direct physical loss, or contract in any manner for, or incur any indebtedness against, the state or any political subdivision on account of any such insurance upon any of the buildings or fixtures and permanent contents therein belonging to the state or any political subdivision, except in the manner provided in this chapter.

SECTION 2. AMENDMENT. Section 26.1-22-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-10. Commissioner to provide insurance on all buildings. Upon application the commissioner shall provide for insurance against loss by fire, lightning, inherent explosion, windstorm, cyclone, tornado and hail, explosions, riot attending a strike, aircraft, smoke, vehicles, or any other risks of direct physical loss, all in the manner and subject to the restrictions of the standard fire insurance policy and standard endorsement, and no other hazards, in the fund, on all buildings owned by the state, state industries, political subdivisions, international peace gardens, and winter shows, and the fixtures and permanent contents in such buildings, to the extent of not to exceed the insurable value of such property, as the value is agreed to between the commissioner and the officer or board having control of such property, or, in case of disagreement, by approval through arbitration.

All buildings and the contents of the buildings owned by the state mill and elevator association, in lieu of coverage under this chapter, may, at the option of the

industrial commission, be insured by private insurance companies licensed to do business in this state, against at least all the types of hazards insured against by the fund. If the industrial commission exercises the option provided in this section, the commission shall seek competitive sealed bids, shall invite the fund to submit a bid, and may reject any or all bids received.

All public buildings owned by a political subdivision, in lieu of coverage provided for in this section, may at the option of the governing body of the political subdivision be insured on the basis of competitive sealed bids, through the fund which must be invited to submit a sealed bid or private insurance companies licensed to do business in this state, against damage resulting from hazards, which include those types of hazards that may be insured against by the fund. The governing body may reject any or all such bids.

All public libraries owned by the state or political subdivisions may, in addition to the coverage provided for in this section, be covered against damage through vandalism. If this coverage cannot be extended to the public libraries situated within this state, the libraries may contract for this coverage with private insurance companies; provided, that this coverage meets the recommendations of the insurance code of the American library association.

SECTION 3. AMENDMENT. Section 26.1-22-21 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-21. Insurance required - Excess loss reinsurance. The commissioner shall procure and shall keep in force ~~an~~ excess loss reinsurance ~~contract~~ naming the fund as the reinsured. The excess loss reinsurance must be in an amount and for a period determined by the commissioner to be sufficient for the fund. The reinsurance contract must ~~meet the following minimum specifications:~~

~~1.~~ ~~Reimburse~~ reimburse the fund for ~~all~~ losses ~~in excess of one million dollars~~ incurred by the fund under policies issued by the fund and arising out of each occurrence of a ~~peril included in the fund policies.~~

~~2.~~ ~~The limit of liability of such reinsurance contract must be no less than one hundred million dollars for each loss occurrence.~~

~~3.~~ ~~A~~ covered cause of loss and include at least a sixty-day cancellation notice.

~~4.~~ ~~The quoted rate must be the guaranteed rate for the two-year bid period.~~

The cost of the excess loss reinsurance must be paid out of the premium income of the fund~~.~~ ~~This excess~~ and must be assessed against the policyholders that benefit from the reinsurance. Excess loss reinsurance ~~must be procured by the commissioner and the fund only through bids as hereinafter provided and~~ must be written only by a company or companies authorized to do business within this state. The contract must be countersigned by a licensed North Dakota resident insurance producer. ~~On or before the third Monday in June of each odd-numbered year, the commissioner shall publish in the official newspaper of Burleigh County a notice that on the last Monday in June of that year the commissioner will accept bids at the commissioner's office in the state capitol. A copy of the notice must be posted at the office of the fund. A copy of the notice must be mailed to each insurance company licensed to write fire insurance in this state.~~ On the last Monday in June ~~of each odd-numbered year~~ prior to the expiration of the contract, the commissioner, with the approval of the industrial commission, shall contract for the excess loss reinsurance

with the company or group of companies submitting the lowest and best bid for the ~~two-year~~ period commencing on the ensuing first day of August. The commissioner, with the approval of the industrial commission, may disregard this section after the commissioner and the commission have studied the available bids for the reinsurance required by this section.

SECTION 4. Section 26.1-22-21.1 of the North Dakota Century Code is created and enacted as follows:

26.1-22-21.1. Insurance broker of record. The fund may contract for insurance broker of record services to assist in procuring excess loss reinsurance by soliciting bids. The fund may award a contract to an insurance broker licensed by, and in good standing with, the state to serve the interests of the fund and its policyholders under this title. The contract must be for the period of a biennium. The fund may renew, renegotiate, or rebid a contract based upon contract performance, cost, and the best interests of the fund and policyholders.

SECTION 5. EMERGENCY. This Act is declared to be an emergency measure.

Approved April 11, 2003
Filed April 11, 2003

CHAPTER 245

HOUSE BILL NO. 1142

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

INSURER WITHDRAWAL, NONRENEWAL, AND REPORTS

AN ACT to create and enact section 26.1-25-04.4 of the North Dakota Century Code, relating to withdrawal of insurance companies; to amend and reenact subsection 1 of section 26.1-30.1-06 and subsection 1 of section 26.1-39-16 of the North Dakota Century Code, relating to nonrenewal of commercial and homeowner's insurance; and to repeal sections 26.1-01-06, 26.1-03-12, 26.1-03-13, 26.1-03-14, and 26.1-03-15 of the North Dakota Century Code, relating to product liability and legal malpractice reports.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-25-04.4 of the North Dakota Century Code is created and enacted as follows:

26.1-25-04.4. Notice of withdrawal. An insurer must provide the commissioner notice in writing of its plan to cease writing and renewing a property and casualty insurance product before the notification of agents and policyholders. The notice must contain the effective date of the plan, the number of policies affected, and the reason therefor.

SECTION 2. AMENDMENT. Subsection 1 of section 26.1-30.1-06 of the North Dakota Century Code is amended and reenacted as follows:

1. An insurer shall renew the policy, unless at least ~~thirty~~ sixty days prior to the date of expiration provided in the policy, a notice of intention not to renew the policy beyond the agreed expiration date is made to the policyholder. The insurer shall include a statement of the reasons for a nonrenewal with the notice.

SECTION 3. AMENDMENT. Subsection 1 of section 26.1-39-16 of the North Dakota Century Code is amended and reenacted as follows:

1. No insurer may fail to renew a property insurance policy unless a written notice of nonrenewal is mailed or delivered to the named insured, at the last-known address of the named insured, at least ~~thirty~~ forty-five days prior to the expiration date of the policy, except that when the policy provides professional liability coverage for legal and medical services, the nonrenewal notice must be mailed or delivered at least ninety days prior to the policy expiration date. A postal service certificate of mailing to the named insured at the insured's last-known address is conclusive proof of mailing and receipt on the third calendar day after the mailing.

SECTION 4. REPEAL. Sections 26.1-01-06, 26.1-03-12, 26.1-03-13, 26.1-03-14, and 26.1-03-15 of the North Dakota Century Code are repealed.

Approved March 26, 2003
Filed March 26, 2003

CHAPTER 246

HOUSE BILL NO. 1260

(Representatives Koppelman, Grosz, N. Johnson)
(Senators Every, Klein, Krebsbach)

CREDIT INFORMATION USE BY INSURERS

AN ACT to create and enact chapter 26.1-25.1 of the North Dakota Century Code, relating to use of credit information in personal insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-25.1 of the North Dakota Century Code is created and enacted as follows:

26.1-25.1-01. Scope. This chapter applies to personal insurance and does not apply to commercial insurance.

26.1-25.1-02. Definitions. As used in this chapter, unless the context otherwise requires:

1. "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance.

2. "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

3. "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer.

4. "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

5. "Consumer reporting agency" means any person that for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

6. "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. The term does not include information that is not credit related, regardless of whether the information is contained in a credit report or in an application or is used to calculate an insurance score.

7. "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's creditworthiness, credit standing, or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of

serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

8. "Insurance score" means a number or rating that is derived from an algorithm, a computer application, a model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

9. "Personal insurance" means private passenger automobile, homeowners, motorcycle, mobile homeowners, and noncommercial dwelling fire insurance policies. Such policies must be individually underwritten for personal, family, or household use. No other type of insurance is included as personal insurance for the purpose of this chapter.

26.1-25.1-03. Use of credit information. An insurer authorized to do business in this state which uses credit information to underwrite or rate risks may not:

1. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor.

2. Deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by this section.

3. Take an adverse action against a consumer solely because the consumer does not have a credit card account without consideration of any other applicable factor independent of credit information.

4. Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance unless the insurer does one of the following:

   a. Treats the consumer as otherwise approved by the insurance commissioner if the insurer presents information that such an absence or inability relates to the risk for the insurer.

   b. Treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.

   c. Excludes the use of credit information as a factor and use only other underwriting criteria.

5. Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within one hundred twenty days from the date the policy is first written or renewal is issued.

6. Use credit information unless not later than every thirty-six months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score, or obtains an updated credit report. Notwithstanding this section:

a. At annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period.

b. The insurer may obtain current credit information upon any renewal before the thirty-six months if consistent with the insurer's underwriting guidelines.

c. An insurer need not obtain current credit information for an insured, despite the requirements of subdivision a, if one of the following applies:

(1) The insurer is treating the consumer as otherwise approved by the commissioner.

(2) The insured is in the most favorably priced tier of the insurer, within a group of affiliated insurers. However, the insurer may order such report if consistent with the insurer's underwriting guidelines.

(3) Credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer may use credit for underwriting or rating such insured upon renewal if consistent with the insurer's underwriting guidelines.

(4) The insurer reevaluates the insured beginning no later than thirty-six months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

7. Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

a. Credit inquiries not initiated by the consumer or inquiries requested by the consumer for the consumer's own credit information.

b. Inquiries relating to insurance coverage if so identified on a consumer's credit report.

c. Collection accounts with a medical industry code if so identified on the consumer's credit report.

d. Multiple lender inquires, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty days of one another, unless only one inquiry is considered.

e. Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within thirty days of one another, unless only one inquiry is considered.

26.1-25.1-04. Dispute resolution and error correction. If it is determine through the dispute resolution process set forth in the federal Fair Credit Reporting Act [Pub. L. 90-321; 15 U.S.C. 1681i(a)(5)] that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall reunderwrite and rerate the consumer within thirty days of receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with the insurer's underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last twelve months of coverage or the actual policy period.

26.1-25.1-05. Initial notification.

1. If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or the insurer's agent shall disclose, either on the insurance application or at the time the insurance application is taken, that the insurer or the insurer's agent may obtain credit information in connection with such application. Such disclosure must be either written or provided to an applicant in the same medium as the application for insurance. The insurer or the insurer's agent need not provide the disclosure statement required under this section to any insured on a renewal policy if such consumer has previously been provided a disclosure statement.

2. Use of the following example disclosure statement constitutes compliance with this section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score."

26.1-25.1-06. Adverse action notification. If an insurer takes an adverse action based upon credit information, the insurer must meet the notice requirements of this section. The insurer shall:

1. Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act [Pub. L. 90-321; 15 U.S.C. 1681m(a)]; and

2. Provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. The notification must include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet the explanation requirements of this subsection. Standardized credit explanations provided by consumer reporting agencies or other third-party vendors are deemed to comply with this section.

26.1-25.1-07. Filing.

1. An insurer that uses insurance scores to underwrite or rate risks shall file the insurer's scoring models or other scoring processes with the insurance department. A third party may file scoring models on behalf

of an insurer. A filing that includes insurance scoring must include loss experience justifying the use of credit information.

2. Any filing relating to credit information is considered a trade secret under chapter 47-25.1.

26.1-25.1-08. Indemnification. An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of a producer who obtains or uses credit information or insurance scores for an insurer, provided the producer follows the instructions of or procedures established by the insurer and complies with any applicable law or rule. This section does not provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

26.1-25.1-09. Sale of policy term information by consumer reporting agency.

1. A consumer reporting agency may not provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

2. Subsection 1 does not apply to data or lists the consumer reporting agency supplies to the insurance producer from whom information was received, the insurer on whose behalf such producer acted, or such insurer's affiliates or holding companies.

3. This section does not restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

26.1-25.1-10. Severability. If any provision of this chapter is declared invalid due to an interpretation of or a future change in the federal Fair Credit Reporting Act [Pub. L. 90-321; 15 U.S.C. 1681 et seq.], the remaining provisions of this chapter are not affected and remain in effect.

26.1-25.1-11. Application. This chapter applies to personal insurance policies either written to be effective or renewed after April 30, 2004.

Approved April 4, 2003
Filed April 7, 2003

CHAPTER 247

HOUSE BILL NO. 1264
(Representative Wald)

CONTROLLED INSURANCE BUSINESS PROHIBITED

AN ACT to create and enact a new section to chapter 26.1-26 of the North Dakota Century Code, relating to a controlled insurance business.

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:

Controlled business prohibited - Definition - Formula for determination.

1. As used in this section, unless the context otherwise requires, "controlled business" means insurance written on the interests of the licensee, licensee's immediate family, or licensee's employer; or insurance covering the licensee, the members of the licensee's immediate family, a business entity, or the officers, directors, substantial stockholders, partners, or employees of such a business entity of which the licensee or a member of the licensee's immediate family is an officer, a director, a substantial stockholder, a partner, an associate, or an employee. "Controlled business" does not include crop insurance business sold by a business entity licensed as an insurance producer for crop insurance between August 1, 2001, and December 31, 2002.

2. The commissioner may not grant, renew, continue, or permit to continue any license if the commissioner determines that the license is being or will be used by the applicant or licensee for the purpose of writing controlled business. A license is deemed to have been or intended to be used for the purpose of writing controlled business if the commissioner determines that during any twelve-month period the aggregate commissions earned from the controlled business exceeded thirty-five percent of the aggregate commissions earned on all business written by the licensee during the same period.

3. This section does not apply to insurance written in connection with credit transactions, including title insurance.

Approved April 21, 2003
Filed April 22, 2003

CHAPTER 248

SENATE BILL NO. 2184

(Senators Brown, J. Lee)
(Representatives Devlin, Price)

UTILIZATION REVIEW AGENT STANDARDS

AN ACT to amend and reenact section 26.1-26.4-04 of the North Dakota Century Code, relating to minimum standards for utilization review agents.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-26.4-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.4-04. Minimum standards of utilization review agents. All utilization review agents must meet the following minimum standards:

1. Notification of a determination by the utilization review agent must be ~~mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of the request for determination and the receipt of all information necessary to complete the review. In the case of a retrospective review, the utilization review agent has five business days after receipt of all information necessary to complete the review to notify the provider of record, enrollee, or appropriate individual~~ provided to the enrollee or other appropriate individual in accordance with 29 U.S.C. 1133 and the timeframes set forth in 29 CFR 2560.503-1.

2. Any determination by a utilization review agent as to the necessity or appropriateness of an admission, service, or procedure must be reviewed by a physician or, if appropriate, a licensed psychologist, or determined in accordance with standards or guidelines approved by a physician or licensed psychologist.

3. Any notification of a determination not to certify an admission or service or procedure must include the ~~principal reason for the determination and the procedures to initiate an appeal of the determination~~ information required by 29 U.S.C. 1133 and 29 CFR 2560.503-1.

4. Utilization review agents shall maintain and make available a written description of the appeal procedure by which enrollees or the provider of record may seek review of determinations by the utilization review agent. The appeal procedure must provide for the following:

   a. On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate must be made by a physician or, if appropriate, a licensed psychologist.

   b. Utilization review agents shall complete the adjudication of appeals of determinations not to certify admissions, services, and procedures ~~no later than thirty days from the date the appeal is filed and the receipt of all information necessary to complete the~~

~~appeal~~ in accordance with 29 U.S.C. 1133 and the timeframes for appeals set forth in 29 CFR 2560.503-1.

c. Utilization review agents shall provide for an expedited appeals process ~~for emergency or life-threatening situations~~ complying with 29 U.S.C. 1133 and 29 CFR 2560.503-1. ~~Utilization review agents shall complete the adjudication of expedited appeals within forty-eight hours of the date the appeal is filed and the receipt of all information necessary to complete the appeal. The expedited appeals process is not applicable to retrospective reviews.~~

5. Utilization review agents shall make staff available by toll-free telephone at least forty hours per week during normal business hours.

6. Utilization review agents shall have a telephone system capable of accepting or recording incoming telephone calls during other than normal business hours and shall respond to these calls within two working days.

7. Utilization review agents shall comply with all applicable laws to protect confidentiality of individual medical records.

8. Psychologists making utilization review determinations shall have current licenses from the state board of psychologist examiners. Physicians making utilization review determinations shall have current licenses from the state board of medical examiners.

9. When 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.

10. When an initial appeal to reverse a determination is unsuccessful, a subsequent determination regarding hospital, medical, or other health care services provided or to be provided to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service must include the evaluation, findings, and concurrence of a physician trained in the relevant specialty to make a final determination that care provided or to be provided was, is, or may be medically inappropriate. ~~Subsequent determinations for retrospective reviews must be completed no later than thirty days from the date the appeal is filed and all information necessary to complete the appeal is received.~~

However, the commissioner may find that the standards in this section have been met if the utilization review agent has received approval or accreditation by a utilization review accreditation organization.

Approved March 20, 2003
Filed March 20, 2003

CHAPTER 249

HOUSE BILL NO. 1371
(Representative Ruby)

BAIL BONDSMAN MAXIMUM FEE

AN ACT to amend and reenact section 26.1-26.6-08 of the North Dakota Century Code, relating to the maximum commission or fee of a bail bondsman.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-26.6-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.6-08. Maximum commission or fee. A professional bondsman may not charge a premium, commission, or fee for a bond in an amount more than ten percent of the amount of bail furnished by the bondsman, or ~~fifty~~ seventy-five dollars, whichever is greater.

Approved April 7, 2003
Filed April 7, 2003

CHAPTER 250

HOUSE BILL NO. 1415

(Representatives Maragos, Kretschmar)

FORFEITURE RETURN TO BONDSMAN

AN ACT to amend and reenact section 26.1-26.6-09 of the North Dakota Century Code, relating to the return of a forfeiture to a bondsman.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-26.6-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26.6-09. Failure to appear. If a defendant fails to appear for a scheduled court appearance, the clerk of court ~~will~~ shall notify the bondsman. If the bondsman returns the defendant to the jurisdiction of the court, the bondsman may petition the court for a return of the forfeiture. If the bondsman returns the defendant to the jurisdiction of the court within six months of receiving notice of the failure to appear, the court shall return the forfeiture upon petition by the bondsman, less five percent for court costs. If the bondsman returns the defendant to the jurisdiction of the court beyond six months of receiving notice of the failure to appear, the court may return the forfeiture upon receipt of a petition from the bondsman, less five percent for court costs.

Approved April 9, 2003
Filed April 9, 2003

CHAPTER 251

SENATE BILL NO. 2224

(Senator Klein)
(Representative Wald)

EFFICIENT PROXIMATE CAUSE DOCTRINE APPLICATION

AN ACT to amend and reenact sections 26.1-32-01 and 26.1-32-03 of the North Dakota Century Code, relating to liability of the insurer for loss.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-32-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-32-01. Liability of insurer for loss - Proximate and remote cause. An insurer is liable for a loss proximately caused by a peril insured against even though a peril not contemplated by the insurance contract may have been a remote cause of the loss. An insurer is not liable for a loss of which the peril insured against was only a remote cause. The efficient proximate cause doctrine applies only if separate, distinct, and totally unrelated causes contribute to the loss.

SECTION 2. AMENDMENT. Section 26.1-32-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-32-03. Insurer not liable for excepted peril. When a peril is excepted specially in an insurance contract, a loss which would not have occurred but for that peril is excepted although the immediate cause of the loss was a peril which was not excepted. An insurer may contract out of the efficient proximate cause doctrine.

Approved March 24, 2003
Filed March 24, 2003

CHAPTER 252

HOUSE BILL NO. 1139

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

INSURABLE INTEREST AND INTEREST ON CLAIMS

AN ACT to create and enact a new subsection to section 26.1-33-11 of the North Dakota Century Code, relating to interest paid on death claims by insurance companies; and to amend and reenact subdivision e of subsection 3 of section 26.1-29-09.1, subdivision c of subsection 2 of section 26.1-37-01, and subdivision a of subsection 1 of section 26.1-38.1-03 of the North Dakota Century Code, relating to insurable interest in personal insurance, credit insurance on motor vehicles, and life insurance and annuity accounts maintained by the life and health insurance guaranty association.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-33-11 of the North Dakota Century Code is created and enacted as follows:

A provision that the settlement of a death claim must be made upon receipt of due proof of death, or not later than two months after receipt of the proof of death, and must include reasonable interest accrued from the date of death so long as a proof of death is filed within one hundred eighty days after the date of the death.

SECTION 2. AMENDMENT. Subdivision e of subsection 3 of section 26.1-29-09.1 of the North Dakota Century Code is amended and reenacted as follows:

e. In the case of a corporation or the trustee of a trust providing life, health, disability, retirement, or similar benefits to employees of one or more corporations, and acting in a fiduciary capacity with respect to the employees, retired employees, or their dependents or beneficiaries, a corporation or the trustee of a trust has an insurable interest in the lives of employees for whom the benefits are to be provided and the corporation or trustee of a trust may purchase, accept, or otherwise acquire an interest in personal insurance as a beneficiary or owner. ~~The~~ Written consent of the insured individual is required if the personal insurance purchased names the corporation or the trustee of a trust as a beneficiary. ~~The consent requirement is satisfied if the insured individual is provided written notice of the coverage and does not reject the coverage within thirty days of receipt of the notice.~~

SECTION 3. AMENDMENT. Subdivision c of subsection 2 of section 26.1-37-01 of the North Dakota Century Code is amended and reenacted as follows:

c. ~~Insurance on motor vehicles designed for highway use and on mobile homes~~ Private passenger motor vehicle insurance or mobile homeowner's insurance;

SECTION 4. AMENDMENT. Subdivision a of subsection 1 of section 26.1-38.1-03 of the North Dakota Century Code is amended and reenacted as follows:

a. The life insurance and annuity account that includes the following subaccounts:

(1) Life insurance account;

(2) Annuity account, which includes annuity contracts owned by a governmental retirement plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities; and

(3) Unallocated annuity account that ~~includes~~ excludes contracts owned by a governmental retirement benefit plan or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code.

Approved March 26, 2003
Filed March 26, 2003

CHAPTER 253

SENATE BILL NO. 2122

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

VIATICAL SETTLEMENT PROVIDER LICENSING

AN ACT to amend and reenact subsection 4 of section 26.1-33.2-02 of the North Dakota Century Code, relating to annual licenses of viatical settlement providers; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 4 of section 26.1-33.2-02 of the North Dakota Century Code is amended and reenacted as follows:

4. Licenses must be renewed from year to year on ~~the anniversary date~~ May first upon payment of the annual renewal ~~fees~~ fee of one hundred fifty dollars. ~~Failure to pay the fees by the renewal date results in expiration of the license.~~ A license not renewed by May first automatically expires. License fees due May 1, 2003, must be prorated in relation to the prior year's renewal date.

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

Approved March 14, 2003
Filed March 17, 2003

CHAPTER 254

SENATE BILL NO. 2235
(Senators Every, Klein)

ANNUITY CONTRACT NONFORFEITURE AMOUNTS

AN ACT to amend and reenact section 26.1-34-02 of the North Dakota Century Code, relating to minimum nonforfeiture amounts of annuity contracts.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-34-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-34-02. Minimum nonforfeiture amount defined. The minimum values as specified in sections 26.1-34-03 through 26.1-34-06 and section 26.1-34-08 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract must be based upon minimum nonforfeiture amounts as defined in this section~~:~~.

1. For an annuity contract issued before August 1, 2003:

   a. With respect to annuity contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments must be equal to an accumulation up to such time at a rate of interest of three percent per year of percentages of the net considerations, as hereinafter defined, paid prior to such time, decreased by the sum of any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent per year and the amount of any indebtedness to the company on the contract, including interest due and accrued; and increased by any existing additional amounts credited by the company to the contract. The net considerations for a given contract year used to define the minimum nonforfeiture amount must be an amount not less than zero and must equal the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars and less a collection charge of one dollar and twenty-five cents for each consideration credited to the contract during that contract year. The percentages of net considerations must be sixty-five percent of the net consideration for the first contract year and eighty-seven and one-half percent of the net considerations for the second and later contract years. Notwithstanding the preceding sentence, the percentage must be sixty-five percent of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent.

   ~~2.~~ b. With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts must be calculated on the assumption that considerations are paid annually in

advance and must be defined as for contracts with flexible considerations which are paid annually, with two exceptions:

~~a.~~ (1) The portion of the net consideration for the first contract year to be accumulated is the sum of sixty-five percent of the net consideration for the first contract year plus twenty-two and one-half percent of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years.

~~b.~~ (2) The annual contract charge is the lesser of thirty dollars or ten percent of the gross annual considerations.

~~3.~~ c. With respect to contracts providing for a single consideration, minimum nonforfeiture amounts must be defined as for contracts with flexible considerations except that the percentage of net consideration used to determine the minimum nonforfeiture amount must equal ninety percent and the net consideration must be the gross consideration less a contract charge of seventy-five dollars.

2. For an annuity contract issued after July 31, 2005:

a. The minimum nonforfeiture amount at any time at or before the commencement of any annuity payments must be equal to an accumulation up to such time at rates of interest, as provided under subdivision c, of the net considerations, as defined under subdivision b, paid before such time, decreased by the sum of:

(1) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as provided under subdivision c;

(2) An annual contract charge of fifty dollars, accumulated at rates of interest as provided under subdivision c;

(3) Any premium tax paid by the company for the contract, accumulated at rates of interest as provided under subdivision c; and

(4) The amount of any indebtedness to the company on the contract, including interest due and accrued.

b. The net considerations for a given contract year used to define the minimum nonforfeiture amount under subdivision a must be an amount equal to eighty-seven and one-half percent of the gross considerations credited to the contract during that contract year.

c. The interest rate used in determining minimum nonforfeiture amounts must be determined as the lesser of:

(1) Three percent per annum; or

(2) The five-year constant maturity rate reported by the federal reserve as of a date or average over a period, reduced by one hundred twenty-five basis points. The rate calculated under this paragraph may not be less than one percent,

must be specified in the contract, and must be determined no more than fifteen months before the contract issue date or redemption date.

d. The interest rate used in determining minimum nonforfeiture amounts applies for an initial period and may be redetermined for additional periods. The redetermination date basis and period, if any, must be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

e. Notwithstanding subdivisions a, b, c, and d, during the period or term that a contract provides substantive participation in an equity indexed benefit, the contract may increase the reduction of one hundred twenty-five basis points under paragraph 2 of subdivision c by an amount not to exceed one hundred basis points, in order to reflect the value of the equity index benefit. The present value at the contract issue date, the present value at each redetermination date, or the additional reduction may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the reduction does not exceed the market value of the benefit. Lacking such a demonstration acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

f. The commissioner may adopt rules to implement the provisions of subdivision e and to provide further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts if the commissioner determines that adjustments are justified.

3. For an annuity contract issued after July 31, 2003, and before August 1, 2005, on a contract form by contract form basis, a company may elect to apply the provisions of subsection 1 or subsection 2.

Approved April 23, 2003
Filed April 23, 2003

CHAPTER 255

SENATE BILL NO. 2210

(Senators Nelson, Grindberg, Kilzer)
(Representatives Keiser, Metcalf, Price)

SUBSTANCE ABUSE TREATMENT COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to alternative group health policy and health service contract substance abuse coverage; and to amend and reenact section 26.1-36-08 of the North Dakota Century Code, relating to group health policy and health service contract substance abuse coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

[125] **SECTION 1. AMENDMENT.** Section 26.1-36-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-08. Group health policy and health service contract substance abuse 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~~ individual covered under the policy or contract, for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness, which benefits meet or exceed the benefits provided in subsection 2.

2. The benefits must be provided for inpatient treatment ~~and~~, treatment by partial hospitalization, and outpatient treatment:

   a. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of sixty days of services covered under this section and section 26.1-36-09 in any calendar year ~~if provided by a hospital as defined in subsection 25 of section 52-01-01 and rules of the state department of health pursuant thereto, or as licensed under section 23-17.1-01 offering treatment for the prevention or cure of alcoholism, drug addiction, or other related illness~~. Services provided under this subdivision must be provided by an addiction treatment program licensed under chapter 50-31.

   b. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred twenty

[125] Section 26.1-36-08 was also amended by section 2 of House Bill No. 1165, chapter 432.

days of services covered under this section and section 26.1-36-09 in any calendar year ~~if~~. Services provided under this subdivision must be provided by ~~a hospital as defined in subsection 25 of section 52-01-01 and rules of the state department of health pursuant thereto or as licensed under section 23-17.1-01, or by a regional human service center~~ an addiction treatment program licensed under ~~section 50-06-05.2, offering treatment for the prevention or cure of alcoholism, drug addiction, or other related illness~~ chapter 50-31. 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.

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

d. In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of twenty visits for services covered under this section in any calendar year, provided 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 the treatment services are provided within the scope of licensure by a licensed addiction counselor. The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a deductible or a copayment for the first five visits in any calendar year, and may not establish a copayment greater than twenty percent for the remaining visits.

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

f. ~~"Partial hospitalization"~~ As used in this section and section 2 of this Act, 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.

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, when the policy or contract is not subject to such provisions.

SECTION 2. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Alternative group health policy and health service contract substance abuse coverage.

1. As an alternative to the substance abuse coverage required under subsection 2 of section 26.1-36-08, an insurance company, a nonprofit health service corporation, or a health maintenance organization may provide substance abuse coverage under this section.

2. The provisions of section 26.1-36-08 apply to this alternative, except:

   a. In addition to the inpatient treatment, treatment by partial hospitalization, and outpatient treatment coverage required under section 26.1-36-08, the coverage must include residential treatment.

   b. In the case of coverage for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-09 in any calendar year.

   c. For the purpose of computing the period for which benefits are payable for a combination of inpatient and partial hospitalization, no more than twenty-three days of inpatient treatment benefits required under subdivision a may be traded for treatment by partial hospitalization.

   d. In the case of coverage for residential treatment, the benefits must be provided for a minimum of sixty days of services covered under this section in any calendar year. This residential treatment must be provided by an addiction treatment program licensed under chapter 50-31. If an individual receiving residential treatment services requires more than sixty days of residential treatment services, unused inpatient treatment benefits provided for under subdivision b may be traded for residential treatment benefits. 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 a residential treatment program, provided that no more than twenty-three days of inpatient treatment benefits required by this section may be traded for residential treatment benefits required under this section.

Approved April 8, 2003
Filed April 9, 2003

CHAPTER 256

SENATE BILL NO. 2120

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

SMALL EMPLOYER REINSURANCE PROGRAM

AN ACT to amend and reenact section 26.1-36.3-01 and subsection 2 of section 26.1-36.3-04 of the North Dakota Century Code, relating to the small employer carrier health reinsurance program; and to repeal sections 26.1-36.3-07 and 26.1-36.3-09 of the North Dakota Century Code, relating to the small employer carrier health reinsurance program.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36.3-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-01. Definitions. As used in this chapter and section 26.1-36-37.2, unless the context otherwise requires:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the insurance commissioner, that a small employer carrier is in compliance with section 26.1-36.3-04, based upon the person's examination of the small employer carrier, including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

3. "Association" means, with respect to health insurance coverage offered in this state, an association that:

   a. Has been actively in existence for at least five years;

   b. Has been formed and maintained in good faith for purposes other than obtaining insurance;

   c. Does not condition membership in the association on any health status-related factor relating to an individual, including an employee or dependent of an employee;

   d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members, or individuals eligible for coverage through a member; and

   e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

4. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

5. "Basic health benefit plan" means a lower cost health benefit plan developed under section 26.1-36.3-08.

6. ~~"Board" means the board of directors of the program established under section 26.1-36.3-07.~~

~~7.~~ "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer; however, claim experience, health status, and duration of coverage are not case characteristics.

~~8.~~ 7. "Church plan" has the meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

~~9.~~ 8. "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.

~~10.~~ 9. "Committee" means the health benefit plan committee created under section 26.1-36.3-08.

~~11.~~ 10. "Control" is as defined in section 26.1-10-01.

~~12.~~ 11. "Dependent" means a spouse, an unmarried child, including a dependent of an unmarried child, under the age of twenty-two, an unmarried child who is a full-time student under the age of twenty-six and who is financially dependent upon the enrollee, and an unmarried child, including a dependent of an unmarried child, of any age who is medically certified as disabled and dependent upon the enrollee as set forth in section 26.1-36-22.

~~13.~~ 12. "Eligible employee" means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

~~14.~~ 13. "Enrollee" means a person covered under a small employer health benefit plan.

~~15.~~ 14. "Established geographic service area" means a geographic area, as approved by the insurance commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

~~16.~~ 15. "Governmental plan" means an employee welfare benefit plan as defined in section 3(32) of the Employee Retirement Income Security

Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] or any federal government plan.

~~17.~~ 16. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.] to the extent that the plan provides medical care as defined in this section and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of this chapter:

a. A plan, fund, or program that would not be, but for this section, an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, must be treated as an employee welfare benefit plan which is a group health benefit plan;

b. In the case of a group health benefit plan, the term "employer" also includes the partnership in relationship to any partner; and

c. In the case of a group health benefit plan, the term "participant" also includes:

(1) In connection with a group health benefit plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(2) In connection with a group health benefit plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual, if the individual is, or may become, eligible to receive benefits under the plan or the beneficiaries may be eligible to receive any benefit.

~~18.~~ 17. a. "Health benefit plan" means any hospital or medical or major medical policy, certificate, or subscriber contract.

b. "Health benefit plan" does not include one or more, or any combination of, the following:

(1) Coverage only for accident, or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance.

c. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(3) Such other similar, limited benefits as are specified in federal regulations.

d. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits, and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

e. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and

(3) Similar supplemental coverage provided under a group health plan.

f. A carrier offering a policy or certificate of specified disease, hospital confinement indemnity, or limited benefit health insurance shall comply with the following:

(1) File with the insurance commissioner on or before March first of each year a certification that contains:

(a) A statement from the carrier certifying that the policy or certificate is being offered and marketed as supplemental health insurance and not as a substitute

for hospital or medical expense insurance or major medical expense insurance.

(b) A summary description of the policy or certificate, including the average annual premium rates, or range of premium rates in cases when premiums vary by age, gender, or other factors, charged for the policy and certificate in this state.

(2) When the policy or certificate is offered for the first time in this state on or after August 1, 1993, file with the commissioner the information and statement required in paragraph 1 at least thirty days before the date the policy or certificate is issued or delivered in this state.

~~19.~~ 18. "Health carrier" or "carrier" means any entity that provides health insurance in this state. For purposes of this chapter, health carrier includes an insurance company, a prepaid limited health service corporation, a fraternal benefit society, a health maintenance organization, nonprofit health service corporation, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

~~20.~~ 19. "Health status-related factor" means any of the following factors:

a. Health status;

b. Medical condition, including both physical and mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including condition arising out of acts of domestic violence; or

h. Disability.

~~21.~~ 20. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

~~22.~~ 21. "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 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.

~~23.~~ 22. "Medical care" means amounts paid for:

a. The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

b. Transportation primarily for and essential to medical care referred to in subdivision a; and

c. Insurance covering medical care referred to in subdivisions a and b.

~~24.~~ 23. "Network plan" means health insurance coverage offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

~~25.~~ 24. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

~~26. "Plan of operation" means the plan of operation of the program established under section 26.1-36.3-07.~~

~~27.~~ 25. "Plan sponsor" has the meaning given the term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829; 29 U.S.C. 1001 et seq.].

~~28.~~ 26. "Premium" means money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~29.~~ 27. "Producer" means insurance producer.

~~30. "Program" means the state small employer carrier reinsurance program created under section 26.1-36.3-07.~~

~~31.~~ 28. "Qualifying previous coverage" and "qualifying existing coverage" mean, with respect to an individual, health benefits or coverage provided under any of the following:

a. A group health benefit plan;

b. A health benefit plan;

c. Medicare;

d. Medicaid;

e. Civilian health and medical program for uniformed services;

f. A medical care program of the Indian health service or of a tribal organization;

g. A state health benefit risk pool, including coverage issued under chapter 26.1-08;

h. A health plan offered under 5 U.S.C. 89;

i. A public health plan as defined in federal regulations; and

j. A health benefit plan under section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)].

The term "qualifying previous coverage" does not include coverage of benefits excepted from the definition of a "health benefit plan" under subsection ~~18~~ 17.

~~32.~~ 29. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~33.~~ 30. "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.

~~34.~~ 31. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier under chapters 26.1-17, 26.1-18, and 26.1-47 to provide health care services to covered individuals.

~~35.~~ 32. "Small employer" means, in connection with a group health plan with respect to a calendar and a plan year, an employer who employed an average of at least two but not more than fifty eligible employees on

business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

~~36.~~ 33. "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

~~37.~~ 34. "Standard health benefit plan" means a health benefit plan developed under section 26.1-36.3-08.

SECTION 2. AMENDMENT. Subsection 2 of section 26.1-36.3-04 of the North Dakota Century Code is amended and reenacted as follows:

2. Premium rates for health benefit plans subject to this section and section 26.1-36-37.2 are subject to the following:

   a. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than fifteen percent.

   b. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to the employers under the rating system for that class of business, may not vary from the index rate by more than twenty percent of the index rate.

   c. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

      (1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

      (2) Any adjustment due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; however, the adjustment may not exceed fifteen percent annually and must be adjusted pro rata for rating periods of less than one year; and

      (3) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

d. Adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents. Premium rates charged for a health benefit plan may not vary by a ratio of greater than four to one after January 1, 1997. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

e. ~~Premium rates for health benefit plans must comply with the requirements of this section notwithstanding any assessment paid or payable by a small employer carrier pursuant to section 26.1-36.3-07.~~

~~f.~~ A small employer carrier may utilize industry as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

~~g.~~ f. In the case of health benefit plans delivered or issued for delivery before August 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions a and b for a period of three years following August 1, 1993. Under this subdivision, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business.

~~h.~~ g. (1) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(2) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

~~i.~~ h. For the purposes of this subsection, a health benefit plan that uses a restricted provider network may not be considered similar coverage to a health benefit plan that does not use a restricted

provider network, if the use of the restricted provider network results in substantial differences in claims costs.

~~j.~~ i. A small employer carrier may not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size, without prior approval of the commissioner. Gender may not be used as a case characteristic after January 1, 1996.

~~k.~~ j. The commissioner shall adopt rules to:

(1) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans;

(2) Prescribe the manner in which case characteristics may be used by small employer carriers; and

(3) Otherwise implement this section.

SECTION 3. REPEAL. Sections 26.1-36.3-07 and 26.1-36.3-09 of the North Dakota Century Code are repealed.

Approved March 14, 2003
Filed March 17, 2003

CHAPTER 257

SENATE BILL NO. 2281

(Senators Nething, Heitkamp)
(Representatives Ekstrom, Severson)

SMALL EMPLOYER HEALTH BENEFIT PLANS

AN ACT to amend and reenact subparagraph a of paragraph 3 of subdivision d of subsection 3 of section 26.1-36.3-06 of the North Dakota Century Code, relating to small employer health benefit plans.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subparagraph a of paragraph 3 of subdivision d of subsection 3 of section 26.1-36.3-06 of the North Dakota Century Code is amended and reenacted as follows:

(3) (a) Except as provided in subparagraph b, a small employer carrier, in applying minimum participation requirements with respect to a small employer, ~~shall~~ may not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met. For purposes of determining the applicable percentage of participation under this subparagraph only, individual health benefit plans are not included in the definition of "qualifying existing coverage" under section 26.1-36.3-01.

Approved March 26, 2003
Filed March 26, 2003

CHAPTER 258

HOUSE BILL NO. 1190
(Representative Wald)

MOTORIST INSURANCE AND SALVAGE TITLES

AN ACT to create and enact a new subsection to section 26.1-40-15.2 and a new subsection to section 26.1-40-15.3 of the North Dakota Century Code, relating to uninsured and underinsured motorists; and to amend and reenact sections 26.1-41-20 and 39-05-20.2 of the North Dakota Century Code, relating to motor vehicle accidents and salvage certificates of title.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-40-15.2 of the North Dakota Century Code is created and enacted as follows:

In any claim for uninsured motorist benefits, the insured and the insurer each bear responsibility for one's own attorney's fees incurred unless the insurance contract specifically provides otherwise or the insurance company is found to have acted in bad faith. It is neither a conflict of interest nor bad faith for an insurer to contest and press all defenses that the uninsured motorist could press.

SECTION 2. A new subsection to section 26.1-40-15.3 of the North Dakota Century Code is created and enacted as follows:

In any claim for underinsured motorist benefits, the insured and the insurer each bear responsibility for one's own attorney's fees incurred unless the insurance contract specifically provides otherwise or the insurance company is found to have acted in bad faith. It is neither a conflict of interest nor bad faith for an insurer to contest and press all defenses that the underinsured motorist could press.

SECTION 3. AMENDMENT. Section 26.1-41-20 of the North Dakota Century Code is amended and reenacted as follows:

26.1-41-20. ~~(Effective through July 31, 2003)~~ 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~~ one prior unrelated conviction 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 4. AMENDMENT. Section 39-05-20.2 of the North Dakota Century Code is amended and reenacted as follows:

39-05-20.2. Issuance of salvage certificate of title. The owner of a vehicle that is damaged in excess of seventy-five percent of ~~its~~ the vehicle's retail value as determined by the national automobile dealers association official used car guide~~,~~

shall forward the title for that vehicle to the department within ten days and the department shall issue a salvage certificate of title. Glass damage and hail damage must be excluded in the determination of whether a vehicle has been damaged in excess of seventy-five percent of the vehicle's retail value.

If a vehicle for which a salvage certificate of title has been issued is reconstructed, a regular certificate of title may be obtained by completing an application for the certificate. The applicant shall include with the application a certificate of inspection in the form required by the department, the salvage certificate of title, and a five dollar fee. The department shall place on the regular certificate of title and on all subsequent certificates of title issued for the vehicle the words "previously salvaged" and a notation that damage disclosure information is available from the department. The department may not issue a new certificate unless the vehicle identification number of the vehicle has been inspected and found to conform to the description given in the application or unless other proof of the identity of the vehicle has been provided to the satisfaction of the department.

Approved April 21, 2003
Filed April 21, 2003

CHAPTER 259

SENATE BILL NO. 2238

(Senators Heitkamp, Erbele, Lyson)
(Representatives Belter, DeKrey, Gulleson)

INSURANCE NOTICE FOLLOWING TOTAL LOSS

AN ACT to provide for automobile insurance notice requirements following total loss.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Notice requirements following total loss. If an insurer determines an automobile with physical damage coverage has incurred a total loss or constructive total loss and that insurer continues to write comprehensive or collision coverage on that automobile, the insurer shall provide notice to the insured that:

1. The insurer determined the automobile is a total loss;

2. The insured's current coverage on that automobile includes comprehensive or collision coverage;

3. If the insured does not repair the automobile, the insurer will reduce the amount of any future physical damage claim for that automobile by the amount paid for the total loss; and

4. If the insured does not repair that automobile, the insured should contact the agent to request that the comprehensive or collision coverage on that automobile be discontinued.

Approved March 21, 2003
Filed March 21, 2003

CHAPTER 260

SENATE BILL NO. 2275

(Senators Fischer, Heitkamp, J. Lee)
(Representatives Delmore, Hawken, Nottestad)

AUTOMOBILE INSURANCE BENEFITS COORDINATION

AN ACT to amend and reenact section 26.1-41-13 of the North Dakota Century Code, relating to coordination of benefits for automobile insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-41-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-41-13. Priority of applicable security - Coordination of benefits.

1. A basic no-fault insurer has the primary obligation to make payment for economic loss because of accidental bodily injury arising out of the operation of a motor vehicle; provided, that the amount of all benefits a claimant recovered or is entitled to recover for the same elements of loss under any workers' compensation law must be subtracted from the basic no-fault benefits otherwise payable for the injury.

2. As between applicable security basic no-fault benefits are payable as follows:

   a. As to any person injured while occupying a secured motor vehicle, or injured as a pedestrian by a secured motor vehicle, the basic no-fault insurer of the secured motor vehicle shall pay the benefits.

   b. As to any person who is injured while occupying an unsecured motor vehicle, or while being struck as a pedestrian by an unsecured motor vehicle, the basic no-fault insurer affording the benefits to the injured person shall pay the benefits.

   c. As to any person injured while occupying a bus that is a secured motor vehicle, the basic no-fault insurer affording benefits to the injured person as the owner of a secured motor vehicle or as a relative of the owner of a secured motor vehicle shall pay the benefits; and, if there is no basic no-fault insurer affording benefits to the injured person, then the basic no-fault insurer of the bus shall pay the benefits.

   d. As to any person injured while occupying a secured motor vehicle that is transporting persons under a ridesharing arrangement, as defined in section 8-02-07, the basic no-fault insurer affording benefits to the injured person as the owner of a secured motor vehicle or as a relative of the owner of a secured motor vehicle shall pay the benefits; and, if there is no basic no-fault insurer

affording benefits to the injured person, then the basic no-fault insurer of the secured motor vehicle shall pay the benefits.

3. An insurer, health maintenance organization, or nonprofit health service corporation, other than a basic no-fault insurer, authorized to do business in this state may coordinate any benefits it is obligated to pay for economic loss incurred as a result of accidental bodily injury, with the first ~~five~~ ten thousand dollars of basic no-fault benefits. A basic no-fault insurer authorized to do business in this state may coordinate any benefits it is obligated to pay for medical expenses incurred as a result of accidental bodily injury in excess of ~~five~~ ten thousand dollars. An insurer, health maintenance organization, or nonprofit health service corporation, other than a basic no-fault insurer, may not coordinate benefits unless it provides those persons who purchase benefits from it with an equitable reduction or savings in the direct or indirect cost of purchased benefits. The commissioner shall approve any coordination of benefits plan.

Approved April 11, 2003
Filed April 11, 2003

CHAPTER 261

SENATE BILL NO. 2123

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

SURPLUS LINES INSURANCE FILINGS

AN ACT to amend and reenact sections 26.1-44-02 and 26.1-44-08 of the North Dakota Century Code, relating to surplus lines insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-44-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-44-02. Affidavit as prerequisite of insurance - Contents. A surplus lines insurance producer licensed under chapter 26.1-26 shall in every case execute and file with the commissioner within ~~fifteen~~ sixty days of the effective date of any surplus line insurance policy, indemnity contract, or surety bond an affidavit in acceptable form that after a diligent search, an inability exists to procure the insurance, indemnity contract, or surety bond desired from an insurer authorized to do business in this state. There is a presumption that such inability exists and that a diligent search has been made if the insurance, indemnity contract, or surety bond provides coverage listed by the commissioner as an approved surplus lines coverage. If the commissioner concurs in the allegation in the affidavit, the commissioner may authorize the procuring of the insurance, indemnity contract, or bond from an insurer not authorized to do business in this state.

SECTION 2. AMENDMENT. Section 26.1-44-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-44-08. Civil penalty for failure to file statement and pay tax - Action for recovery - Revocation of license - Conditions prerequisite to reissuance - Hearing procedure and judicial review. Every such surplus lines insurance producer who fails or refuses to make and file the annual statement, and to pay the taxes required to be paid prior to the first day of May after such tax is due, is liable for a fine of twenty-five dollars for each day of delinquence. The tax and fine may be recovered in an action to be instituted by the commissioner in the name of the state, the attorney general representing the commissioner, in any court of competent jurisdiction, and the fine, when so collected, must be paid to the state treasurer and placed to the credit of the general fund. The commissioner, if satisfied that the delay in filing the annual statement and the payment of the tax was excusable, may waive all or any part of the fine. The commissioner ~~shall~~ may revoke or suspend the surplus lines insurance producer's license of the producer if any surplus lines insurance producer fails to make and file the annual statement and pay the taxes, or refuses to allow the commissioner to inspect and examine the producer's records of the business transacted by the producer pursuant to this chapter, or fails to keep the records in the manner required by the commissioner, or falsifies the affidavit referred to in section 26.1-44-02.

If the license of a surplus lines insurance producer is revoked, whether by the action of the commissioner or by judicial proceedings, another license may not be issued to that surplus lines insurance producer until two years have elapsed from the effective date of the revocation, nor until all taxes and fines are paid, nor until the commissioner is satisfied that full compliance with this chapter will be had.

Approved March 14, 2003
Filed March 17, 2003

CHAPTER 262

HOUSE BILL NO. 1061

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

LONG-TERM CARE INSURANCE POLICY REQUIREMENTS

AN ACT to create and enact subsection 6 of section 26.1-45-01 and section 26.1-45-14 of the North Dakota Century Code, relating to long-term care insurance; and to amend and reenact subsections 3, 4, and 5 of section 26.1-45-01, section 26.1-45-05.1, subdivision b of subsection 2 of section 26.1-45-07, and sections 26.1-45-09 and 26.1-45-11 of the North Dakota Century Code, relating to long-term care insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsections 3, 4, and 5 of section 26.1-45-01 of the North Dakota Century Code are amended and reenacted as follows:

3. "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state to:

   a. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or ~~both~~ a combination thereof, or for members or former members or ~~both~~ a combination thereof, of the labor organizations.

   b. Any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association:

      (1) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

      (2) Has been maintained in good faith for purposes other than obtaining insurance.

   c. An association, a trust, or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations meeting the requirements of section 26.1-45-02.

   d. A group other than a group described in subdivision a, b, or c if the commissioner finds that:

      (1) The issuance of the group policy is not contrary to the best interest of the public;

      (2) The issuance of the group policy would result in economies of acquisition or administration; and

(3) The benefits are reasonable in relation to the premiums charged.

4. "Long-term care insurance" means any insurance policy or rider primarily advertised, marketed, offered, or designed to provide coverage for not less than ~~one year~~ twelve consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders, whether issued by insurers, fraternal benefit societies, nonprofit health service corporations, prepaid health plans, health maintenance organizations, or any similar entity, which provide directly or which supplement long-term care insurance. The term also includes home health care type insurance policies or riders which provide directly or which supplement long-term care insurance; and include a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term includes qualified long-term care insurance contracts. The term includes long-term care insurance products issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations; or a similar organization to the extent that the organization is otherwise authorized to issue life or health insurance. The term does not include any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expenses coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as a long-term care insurance is subject to the provisions of this chapter.

5. "Policy" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, or any similar entity.

SECTION 2. Subsection 6 of section 26.1-45-01 of the North Dakota Century Code is created and enacted as follows:

6. a. "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract satisfies the requirements of this paragraph even if payments are made on a per diem or other periodic basis without regard to the period in which the expenses are incurred;

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under title XVIII of the Social Security Act only as a secondary payor. A contract satisfies the requirements of this paragraph even if payments are made on a per diem or other periodic basis without regard to the period in which the expenses are incurred;

(3) The contract is guaranteed renewable, within the meaning of section 7702B(b)(1)(c) of the Internal Revenue Code of 1986, as amended;

(4) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in paragraph 5;

(5) All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

(6) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code of 1986, as amended.

b. "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

SECTION 3. AMENDMENT. Section 26.1-45-05.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-05.1. Incontestability and rescission of long-term care insurance policy or certificate. ~~After six months from the effective date of the~~

1. If a policy or certificate has been in force for less than six months, an insurer may not ~~contest or~~ rescind a long-term care insurance policy or certificate or deny ~~a~~ an otherwise valid long-term care insurance claim

~~on the basis of representations made by an insured on the application for insurance~~ except upon a showing ~~by the insurer that the insured knowingly and intentionally misrepresented relevant facts on the application form~~ of misrepresentation that is material to the acceptance for coverage.

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

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

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

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

6. In the event of the death of the insured, this section does not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies are governed by section 26.1-33-05. In all other situations, this section applies to life insurance policies that accelerate benefits for long-term care.

SECTION 4. AMENDMENT. Subdivision b of subsection 2 of section 26.1-45-07 of the North Dakota Century Code is amended and reenacted as follows:

b. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than ~~ten~~ thirty days.

SECTION 5. AMENDMENT. Section 26.1-45-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-09. Right to return policy - Outline of coverage required - Contents of certificate - Summary of policy provisions - Report of benefits status.

1. Long-term care insurance applicants have the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance

policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return the policy or certificate within thirty days of the date of its delivery or within thirty days of its effective date, whichever occurs later, and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in subdivision a of subsection 3 of section 26.1-45-01, the applicant is not satisfied for any reason.

2. a. An outline of coverage must be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(1) The commissioner shall prescribe a standard format including style, arrangement, overall appearance, and the content of an outline of coverage.

(2) In the case of insurance producer solicitations, an insurance producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(4) In the case of a policy issued to a group defined in subdivision a of subsection 3 of section 26.1-45-01, an outline of coverage is not required to be delivered, provided that the information described in paragraphs 1 through 7 of subdivision b is contained in other materials relating to enrollment. Upon request, these other materials must be made available to the commissioner.

b. The outline of coverage must include:

(1) A description of the principal benefits and coverage provided in the policy.

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy.

(3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage must be specifically described.

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains the governing contractual provisions.

(5) A description of the terms under which the policy or certificate may be returned and premium refunded.

(6) A brief description of the relationship of cost of care and benefits.

(7) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under 7702B(b) of the Internal Revenue Code of 1986, as amended.

3. A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state must include:

a. A description of the principal benefits and coverage provided in the policy.

b. A statement of the principal exclusions, reductions, and limitations contained in the policy.

c. A statement that the group master policy determines governing contractual provisions.

4. If an application for a long-term care insurance contract or certificate is approved and issued, the issuer, directly or through an authorized representative, shall deliver the contract or certificate of insurance to the applicant no later than thirty days after the date of approval.

5. At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration on the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

c. Any exclusions, reductions, and limitations on benefits of long-term care; ~~and~~

d. A statement as to whether a long-term care inflation protection option is available under this policy;

e. If applicable to the policy type, the summary shall also include:

(1) A disclosure of the effects of exercising other rights under the policy;

(2) A disclosure of guarantees relating to long-term care costs of insurance charges; and

(3) Current and projected maximum lifetime benefits.

f. The provisions of the policy summary listed above may be incorporated into a basic illustration or into a life insurance policy summary delivered to the consumer.

~~5.~~ 6. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status a monthly report must be provided to the policyholder. Such report must include:

a. Any long-term care benefits paid out during the month;

b. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

c. The amount of long-term care benefits existing or remaining.

7. If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

a. Provide a written explanation of the reasons for the denial; and

b. Make available all information directly related to the denial.

SECTION 6. AMENDMENT. Section 26.1-45-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-11. Rulemaking authority. The commissioner may adopt reasonable rules to promote premium adequacy, protect the policyholder in the event of substantial rate increases, and to establish minimum standards for correcting abusive marketing practices, replacement forms, insurance producer testing, penalties, and reporting practices for long-term care insurance.

SECTION 7. Section 26.1-45-14 of the North Dakota Century Code is created and enacted as follows:

26.1-45-14. Nonforfeiture benefits.

1. Except as provided in subsection 2, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate, including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefits, the insurer shall provide a contingent benefit upon lapse that is available for a specific period of time following a substantial increase in premium rates.

2. When a group long-term care insurance policy is issued, the offer required in subsection 1 must be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in subdivision d of subsection 3 of section 26.1-45-01, other than to a continuing care retirement community or other similar entity, the offering must be made to each proposed certificate holder.

3. The commissioner shall adopt rules specifying the type of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determining of the specific period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection 1.

Approved March 7, 2003
Filed March 7, 2003

CHAPTER 263

SENATE BILL NO. 2251

(Senators Espegard, Heitkamp, Krebsbach)
(Representatives Ekstrom, Ruby, Severson)

PROPERTY INSURANCE PLACEMENT FACILITY

AN ACT to create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to creation of a property insurance placement facility.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Sunrise - Trigger. The commissioner may implement a property insurance placement facility for those residents who are unable to obtain necessary property insurance through the standard insurance market. The commissioner shall hold a public hearing upon notice of not less than twenty days to determine the reasonable availability of property insurance in the market. Upon a finding by the commissioner that there is a lack of availability of property insurance in the market, the commissioner shall by order authorize the implementation of a property insurance placement facility as set forth in this chapter.

Definitions. As used in this chapter:

1. "Basic property insurance" means insurance against direct loss to property as defined and limited in standard fire policies and extended coverage endorsements thereon.

2. "Homeowners insurance" means insurance on owner-occupied dwellings providing personal multi-peril property and liability coverage.

3. "Insurer" means an insurance company authorized to write and that is engaged in writing in North Dakota, on a direct basis, basic property and homeowners insurance or components thereof.

4. "North Dakota property insurance placement facility" or "facility" means the organization formed by insurers to assist applicants in securing basic property or homeowners insurance.

Board.

1. A board of directors consisting of seven members shall direct the operations of the property insurance placement facility. The seven members are comprised of five directors from the insurance industry and two public directors as follows:

   a. Two of the five industry representatives must come from domestic insurance companies, one must come from county mutual insurance companies, one from foreign stock companies, and one from foreign mutual companies. The commissioner shall appoint

the first board on a staggered basis. Subsequent board members are to be elected by facility members.

b. The public directors must be appointed by the commissioner. Public directors may include licensed insurance agents.

c. The term of each director is three years beginning on January first of the year the director is elected or appointed, except as staggered in the initial appointment process. A vacancy must be filled by election by the other directors for the remainder of the term. A vacancy to a public directorship must be filled by appointment by the commissioner for the remainder of the term. If the board fails to elect a replacement for an industry vacancy within thirty days, the commissioner shall appoint a replacement for the remainder of the term.

2. The board shall prepare and maintain a plan of operation which provides for the management of the facility, including the hiring of employees or contracting services to carry out the plan of operation, establishment of necessary facilities within the state, assessment of members to defray losses and expenses, negotiating commission agreements, establishing reasonable underwriting standards, developing reasonable cancellation and nonrenewal standards, acceptance and cession of reinsurance, adopting procedures for determining amounts of insurance to be provided, procedures for payment of claims, procedures for appealing adverse actions, procedures for reporting the plan experience to a statistical agent, and procedures for contracting facility functions to the private sector. The board has ninety days to submit the initial plan of operation to the commissioner for approval. All subsequent amendments to the plan of operation must be submitted to the commissioner for approval. The commissioner may require the board to waive the assessment requirement for an insurer if the assessment would cause a significant financial impairment to the insurer or would jeopardize the solvency of the insurer.

Facility membership. Each insurer authorized to write and who is engaged in writing within this state, on a direct basis, basic property insurance or any component thereof in multi-peril policies or homeowners insurance shall participate in the facility as a condition of its authority to do the business of insurance in this state. Members of the facility are responsible for the cost of funding the operations, expenses, and losses of the facility. Each year the board shall assess the members based upon each member's pro rata share of the aggregate property insurance premium written in the second preceding calendar year as disclosed in the annual statement and other reports filed by members with the commissioner. The assessment must be based on the premiums reported from income from this state in the following lines of the annual statement: fire, allied lines, and homeowners multiple peril.

Coverage and forms. The plan must use standard policy forms to provide coverage for basic property and homeowners insurance. The plan may not provide coverage for automobile or commercial risks.

Rates. The facility shall establish rates and may include data from an advisory or statistical organization in the development of its rates. Rates must be submitted to the commissioner for approval prior to use. Rates must be actuarially

sound under chapter 26.1-25 and may not actively compete with rates in the voluntary market.

Underwriting. A person who has been refused coverage, in writing, by at least five standard carriers based on an underwriting, claims, or credit history is eligible to apply to the facility for coverage.

Agents. A licensed property and casualty agent may submit an application on behalf of an applicant to the facility. The agent is entitled to receive a commission for the service. The agent is not a representative of the facility.

Immunity. The facility, its members, employees, contractors, agents, and the commissioner are not liable for, nor may a cause of action be brought against them, for statements made in good faith in the course of conducting facility operations and procedures.

Examinations and audits. The commissioner shall examine the facility every three years. The facility shall submit a financial report and an annual report to the commissioner by April first of each year. The report must include premiums written, losses incurred, loss adjusting expenses incurred, underwriting expenses, claims losses, and assessments.

Approved April 9, 2003
Filed April 9, 2003