

INSURANCE

CHAPTER 228

HOUSE BILL NO. 1117

(Judiciary Committee)
(At the request of the Insurance Commissioner)

AN ACT to create and enact a new section to chapter 26.1-02 of the North Dakota Century Code, relating to consumer assistance records received by the insurance commissioner.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Consumer assistance records - Exempt.

1. Personal, financial, or health information related to requests for consumer assistance received by the commissioner is an exempt record as defined in section 44-04-17.1.
2. As used in this section, "personal, financial, or health information" means information collected from or on behalf of an individual requesting consumer assistance which would reveal:
 - a. The individual's personal health condition, disease, or injury;
 - b. The existence, nature, source, or amount of the individual's personal income;
 - c. The existence, nature, source, or amount of the individual's personal expenses;
 - d. Records of or relating to the individual's personal financial transactions of any kind;
 - e. The existence, identification, nature, or value of the individual's personal assets, liabilities, or net worth;
 - f. A history of the individual's personal medical diagnosis or treatment;
 - g. The existence, identification, nature, value, or content of the individual's coverage or status under any insurance policy;
 - h. The individual's personal contractual rights or obligations; or

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- i. Any social security number, date of birth, file number, bank account number, or other number used for identification of the individual or any account in which the individual has a personal financial interest.
 3. The name of a regulated entity that is the subject of a complaint or inquiry; is not "personal, financial, or health information"; and is not subject to the restrictions in this section.

Approved April 15, 2013
Filed April 16, 2013

CHAPTER 229

SENATE BILL NO. 2074

(Judiciary Committee)
(At the request of the Insurance Commissioner)

AN ACT to amend and reenact subsection 1 of section 26.1-02.1-05 of the North Dakota Century Code, relating to penalties for insurance fraud; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

¹⁰⁴ **SECTION 1. AMENDMENT.** Subsection 1 of section 26.1-02.1-05 of the North Dakota Century Code is amended and reenacted as follows:

1. a. A violation of section 26.1-02.1-02.1 is a:
 - (1) A class A felony if the value of any property or services retained exceeds fifty thousand dollars;
 - (2) A class B felony if the value of any property or services attempted to be obtained exceeds fifty thousand dollars;
 - (3) A class B felony if the value of any property or services retained exceeds ten thousand dollars but does not exceed fifty thousand dollars;
 - (4) A class C felony if the value of any property or services attempted to be obtained exceeds ten thousand dollars but does not exceed fifty thousand dollars;
 - (5) A class C felony if the value of any property or services retained exceeds fiveone thousand dollars but does not exceed ten thousand dollars; and a
 - (6) A class A misdemeanor in all other cases.
- b. 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.~~

Approved April 26, 2013
Filed April 26, 2013

¹⁰⁴ Section 26.1-02.1-05 was also amended by section 13 of Senate Bill No. 2251, chapter 104.

CHAPTER 230

HOUSE BILL NO. 1150

(Representatives Monson, Rust, Vigesaa)
(Senators Klein, Unruh, Dotzenrod)

AN ACT to amend and reenact sections 26.1-13-12 and 26.1-13-15 of the North Dakota Century Code, relating to county mutual insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-13-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-13-12. General powers, liabilities, and duties of county mutual company - Office - Name - Limitations.

A county mutual insurance company ~~possesses~~^{has} the powers and is subject to the liabilities and duties of other insurance companies, except that:

1. The principal office of the company must be located within the company's approved territory of operation.
2. ~~When~~^{if} the company is organized by the residents of a single county, the name of the county together with the word "county" must be embraced in the corporate name of the company.
3. ~~Any company organized under this chapter for mutual protection against loss or damage by tornadoes, windstorms, cyclones, hail, except upon growing crops, and any hazard upon any risk upon livestock, only, may operate and issue policies in all of the counties of the state, but in all other matters is regulated and limited by this chapter. Notwithstanding contrary territorial limitations in this chapter, a county mutual insurance company may operate and issue the following policies in all the counties of the state:~~
 - a. Protection against loss or damage by tornadoes;
 - b. Protection against loss or damage by windstorms;
 - c. Protection against loss or damage by cyclones;
 - d. Protection against loss or damage by hail, except upon growing crops;
 - e. Protection against loss or damage by any hazard upon any risk upon livestock; and
 - f. Protection against loss or damage by any hazard to a seasonal dwelling if the primary residence is insured by the company in an authorized county.

SECTION 2. AMENDMENT. Section 26.1-13-15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-13-15. Territorial limits of county mutual company's operations - Terms of policies - Property insurable.

1. A county mutual insurance company may not insure any property beyond the company's authorized territory of operation except as provided in subsection 3 of section 26.1-13-12 and except that this territorial limitation does not apply to reinsurance contracts.
2. A policy may not be issued to exceed five years.
3. A policy may not be issued covering property located within the platted limits of ~~any~~an incorporated city in this state ~~unless, except the policy issued provides~~may provide coverage as specified under sections 26.1-13-14 and 26.1-13-16 within the platted limits of ~~any~~the incorporated city in ~~this state on the actual~~;
 - a. ~~The place of residence occupied by the policyholder and appurtenant structures and the contents thereof and on no more than; or~~
 - b. ~~A rental property that is no larger than a four residential rental units of each policyholder~~unit.
4. The company may insure all property located outside of incorporated cities within the limits of the territory comprised in the formation of the company.
5. Policies issued under subsection 3 on property located within the platted limits of ~~any~~an incorporated city with a population over ten thousand ~~are limited to covering the actual place of residence occupied by the policyholder and appurtenant structures and the contents thereof and no more than four residential rental units of each policyholder and must conform to rules adopted by the commissioner establishing requirements for underwriting risks and safeguarding financial solvency. A company may not exceed twenty-five~~thirty-five percent of the company's gross written premiums of the previous year for the gross written premiums in cities with a population over ten thousand.
6. A policy issued by the company, if it so provides, may cover loss or damage to livestock, personal property, vehicles, and farm machinery while temporarily removed from the premises of the insured to other locations.

Approved April 2, 2013
Filed April 2, 2013

CHAPTER 231

HOUSE BILL NO. 1153

(Representatives Keiser, Kasper, Vigesaa)
(Senators Grindberg, Klein, Laffen)

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

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

26.1-17-33.1. Nonprofit health service corporation - Conversion to nonprofit mutual insurance company - Application of law.

1. Any nonprofit health service corporation organized under chapter 26.1-17, having admitted assets in excess of all liabilities at least equal to the original surplus required of a mutual insurance company by section 26.1-12-10, without reincorporation, and upon adoption of a resolution by its board of directors, may petition the insurance commissioner for an order to become a nonprofit mutual insurance company subject to chapter 26.1-12. For the purpose of obtaining approval from the insurance commissioner, conversion to a nonprofit mutual insurance company under this section is deemed a consolidation pursuant to chapter 26.1-07 and the procedure described therein must be followed.
2. Upon becoming subject to chapter 26.1-12, the company may continue to provide health care and related services to its present or future members and subscribers by health care contracts and may make provision for the payment of health care services directly to hospitals and other agencies or institutions or persons rendering health care services or related services or may make direct payment to the member or subscriber. The conversion of a nonprofit health service corporation into a mutual insurance company must not impair the rights or obligations or any existing contractual rights of a health care service corporation or its members. Except as provided in this section, the laws that apply to mutual insurance companies, and insurance companies generally, apply to a nonprofit mutual insurance company converted from a nonprofit health service corporation pursuant to this section.
3. The nonprofit corporation laws apply to the operation and control of a nonprofit mutual insurance company converted from a nonprofit health service corporation under this section and supersede any conflicting provisions in title 26.1 unless title 26.1 is more restrictive. ~~Except as authorized in subsections 4 and 5, a nonprofit mutual insurance company may not sell, lease, transfer, or dispose of all or substantially all property or assets, and may not merge or consolidate with, or acquire, a stock insurance company or agency, for-profit subsidiary, or any other corporation. Except as provided in subsection 5, a nonprofit mutual insurance company may not issue stock.~~

4. The funds of a nonprofit mutual insurance company may be invested in those investments authorized to be made by domestic insurance companies under section 26.1-05-19, as limited by section 26.1-05-18.
5. A nonprofit mutual insurance company may form a 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.
6. ~~A~~Except as authorized under subsection 12, a nonprofit mutual insurance company may not demutualize ~~or be converted to a for-profit mutual or stock company.~~ A nonprofit mutual insurance company may not be converted to a for-profit mutual company or to a for-profit stock company.
7. A nonprofit mutual insurance company may ~~not~~ avail itself of the additional investment authority under chapter 26.1-10. Upon approval by the commissioner after a showing of good cause by the nonprofit mutual insurance company, aggregate investments in all subsidiaries of the company under subsection 21 of section 26.1-05-19 and under chapter 26.1-10 may exceed an amount equal to twenty-five percent of the company's admitted assets.
8. A conversion of a nonprofit health service corporation to a nonprofit mutual insurance company under this section or the restructuring of a nonprofit mutual insurance company under subsection 12, to the extent that any assets of the nonprofit health service corporation or the restructured nonprofit mutual insurance company and the restructured nonprofit mutual insurance company's nonprofit holding corporation parent formed pursuant to subsection 12 are impressed with a charitable trust immediately before the conversion or restructuring, does not give rise to a breach of the charitable trust or violate any fiduciary duty laws, and does not constitute grounds for disapproval of either the petition to convert to a nonprofit mutual insurance company or the articles of incorporation of the company under section 26.1-12-04, or application for restructuring of a nonprofit mutual insurance company under subsection 12. ~~The~~A conversion or restructuring authorized by this section does not diminish the application of charitable trust or fiduciary duty laws that may apply to the converted or restructured company immediately before the conversion.
9. A nonprofit mutual insurance company may not engage in the practice of medicine, dentistry, optometry, or any other profession for which a license or registration is required.
10. ~~Every~~Each nonprofit mutual insurance company ~~is~~ and each nonprofit mutual insurance company and its nonprofit holding corporation parent are charitable and benevolent ~~organization~~organizations and the laws of this state relating to and affecting nonprofit charitable and benevolent corporations are applicable to all nonprofit mutual insurance companies and restructured nonprofit mutual insurance companies and their nonprofit holding corporation parents.

11. Except as authorized under subsection 12, a nonprofit mutual insurance company may not form a mutual insurance holding company.
12. Upon approval of the nonprofit mutual insurance company's board of directors, the approval of the commissioner pursuant to this subsection, and any necessary approval of the nonprofit mutual insurance company's members, a nonprofit mutual insurance company may restructure, while remaining a nonprofit corporation, by forming a nonprofit holding corporation that will be the sole member of the restructured company.
 - a. The restructured company shall retain any additional authority granted to the restructured company as a nonprofit mutual insurance company under this section and the restructured company shall remain subject to subsections 3, 4, 5, 6, 7, 8, 9, and 10, except to the extent inconsistent with this subsection and chapter 10-33.
 - b. The restructured company must be treated as a mutual insurance company subject to the provisions of chapter 26.1-12, except for sections 26.1-12-01, 26.1-12-02, 26.1-12-03, 26.1-12-05, 26.1-12-06, 26.1-12-07, 26.1-12-08, 26.1-12-09, 26.1-12-10, 26.1-12-14, 26.1-12-16, 26.1-12-18, 26.1-12-19, 26.1-12-23, 26.1-12-24, 26.1-12-25, 26.1-12-26, 26.1-12-29, 26.1-12-30, and 26.1-12-32.
 - c. The restructured company may elect to use the term "mutual" in the company's name, marketing materials, and other communications.
 - d. The nonprofit holding corporation is subject to the provisions of sections 26.1-12-06, 26.1-12-07, 26.1-12-14, and 26.1-12-16. After restructuring under this subsection, chapter 26.1-12.1 does not apply to the restructured company or the restructured company's nonprofit holding corporation parent.
 - e. The membership interests of the members of the restructuring company must be converted into membership interests in the nonprofit holding corporation; however, notwithstanding section 26.1-12-14, upon the effective date of the restructuring, such membership interests may be weighted or otherwise adjusted to reflect the number of subscribers covered under a particular policy. Concomitantly with the restructuring, and without complying with sections 26.1-10-05 and 26.1-10-05.1, the restructuring company may transfer or assign the restructuring company's shares, membership units, or other incidents of ownership in one or more of the restructuring company's subsidiaries and affiliates, as well as the restructuring company's workforce, to the nonprofit holding corporation.
 - f. The restructuring company shall submit an application for restructuring, consisting of revised articles and bylaws, the articles and bylaws of the nonprofit holding company, any share or membership interest transfer documents, authorizing resolutions and other materials the restructuring company deems pertinent to the restructuring to the commissioner. The commissioner shall approve the restructuring unless, after a public hearing, the commissioner finds:
 - (1) After the change of control, the domestic insurance company referenced in subsection 1 would not be able to satisfy the requirements for the issuance of a certificate of authority to write the

lines of insurance for which the domestic insurance company is presently licensed;

- (2) The effect of the merger or other acquisition of control would be to substantially lessen competition in insurance in this state or tend to create a monopoly in this state;
 - (3) The financial condition of any acquiring party might jeopardize the financial stability of the insurance company or prejudice the interest of the insurance company's policyholders;
 - (4) The acquiring party's plans or proposals to liquidate the insurance company, to sell the insurance company's assets, to consolidate or merge with any person, or to make any other material change in the insurance company's business or corporate structure or management are unfair and unreasonable to policyholders of the company and are not in the public interest;
 - (5) The competence, experience, and integrity of those persons that would control the operation of the insurance company are such that it would not be in the interest of policyholders of the company and of the public to permit the merger or other acquisition of control; or
 - (6) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.
- g. Within thirty days of submission of the application to the commissioner under this subsection, the commissioner shall make written findings, conclusions, and a determination on the application.
13. A merger or consolidation of a nonprofit mutual insurance company that has been restructured under subsection 12, merger or consolidation of the restructured nonprofit mutual insurance company's nonprofit holding corporation parent, acquisition of control of either, or acquisition of another insurer by the restructured company or the restructured company's nonprofit holding corporation parent is subject to the provisions of sections 26.1-10-03 and 26.1-10-03.1 and chapter 26.1-07 which would be applicable to the type of transaction involved.
 14. This section does not supersede or impair the rights, powers, or authority of the attorney general or courts of this state established by statute, case law, or common law with respect to charitable or benevolent corporations.

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

Approved April 3, 2013
Filed April 3, 2013

CHAPTER 232

SENATE BILL NO. 2304

(Senators Larsen, Klein)
(Representatives Beadle, Kasper)

AN ACT to create and enact a new subdivision to subsection 2 of section 12-60-24 of the North Dakota Century Code, relating to insurance producer criminal history record checks; to amend and reenact section 26.1-26-13.3 of the North Dakota Century Code, relating to insurance producer criminal history record checks; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

¹⁰⁵ **SECTION 1.** A new subdivision to subsection 2 of section 12-60-24 of the North Dakota Century Code is created and enacted as follows:

The insurance department for criminal history record checks authorized under chapter 26.1-26.

SECTION 2. AMENDMENT. Section 26.1-26-13.3 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-13.3. Application for license.

1. An individual applying for a resident insurance producer license shall make application to the commissioner on the uniform application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner must find that the individual:
 - a. Is at least eighteen years of age;
 - b. Has not committed any act that is a ground for denial, suspension, or revocation set forth in section 26.1-26-42;
 - c. Has paid the fees set forth in section 26.1-01-07; and
 - d. Has successfully passed the examinations for the lines of authority for which the individual has applied.
2. An individual applying for a resident producer license shall complete a criminal history record check as provided in section 12-60-24. All costs associated with the criminal history record check are the responsibility of the applicant. This subsection does not apply to license continuation under section 26.1-26-13.4 or individuals who apply for an insurance producer license within twelve

¹⁰⁵ Section 12-60-24 was also amended by section 7 of House Bill No. 1012, chapter 12, section 1 of House Bill No. 1327, chapter 491, section 1 of House Bill No. 1389, chapter 325, and section 1 of Senate Bill No. 2110, chapter 324.

months following the cancellation or expiration of a valid resident insurance producer license issued by the North Dakota insurance department, unless the license was suspended or revoked.

3. The commissioner may make arrangements, including contracting with an outside service, for the collection and transmission of fingerprints for conducting criminal history record checks.
4. A business entity acting as an insurance producer must obtain an insurance producer license. Application must be made using the uniform business entity application. Before approving the application, the commissioner must find that:
 - a. The business entity has paid the fee set forth in section 26.1-01-07;
 - b. The business entity has designated a licensed individual principal insurance producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state; and
 - c. The individual designated as the licensed principal insurance producer of the business entity has taken the examination required by section 26.1-26-13.2. The business entity may only be licensed for those lines of insurance for which one or more of its principal insurance producers is licensed. The business entity shall inform the commissioner within ten working days of any change in the status of its principal insurance producer or producers.
 - d. The commissioner may require any documents reasonably necessary to verify the information contained in an application.

SECTION 3. EFFECTIVE DATE. This Act becomes effective on September 1, 2013.

Approved March 19, 2013
Filed March 19, 2013

CHAPTER 233

HOUSE BILL NO. 1196

(Representatives Keiser, Frantsvog, Ruby, Vigesaa)
(Senators Andrist, O'Connell)

AN ACT to create and enact section 26.1-30-03.1 of the North Dakota Century Code, relating to issuance of insurance policies in foreign languages.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-30-03.1 of the North Dakota Century Code is created and enacted as follows:

26.1-30-03.1. Issuance of foreign language policies.

An insurance carrier or producer licensed to provide insurance under this title may provide insurance policies, endorsements, or riders in a language other than English. All policies, endorsements, and riders written in languages other than English must be filed pursuant to sections 26.1-30-19, 26.1-30-20, and 26.1-30-21 and must include a written certification declaring to the commissioner that the non-English documents are accurate translations of the benefits provided in the English version pursuant to sections 26.1-30-19, 26.1-30-20, and 26.1-30-21. If there is a dispute or complaint regarding the non-English documents, the English language version of the insurance coverage controls the resolution of the dispute or complaint. This section does not abrogate or supersede the provisions of chapter 26.1-04 relating to prohibited practices within insurance business.

Approved April 10, 2013
Filed April 10, 2013

CHAPTER 234

HOUSE BILL NO. 1168

(Representative Keiser)
(Senator Klein)

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to health insurance enrollment periods in the individual market; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Individual health plans - Open enrollment periods - Rules.

1. As used in this section:

- a. "Adverse selection" occurs when an individual who experiences greater than average health risks seeks to purchase an individual health plan.
- b. "Annual open enrollment period" means a period each year during which an individual may enroll or change coverage in an individual health plan that is not sold through a health benefit exchange.
- c. "Health benefit exchange" means a governmental agency or nonprofit entity that:
 - (1) Meets the applicable requirements of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148] and the provisions of the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]; and
 - (2) Makes qualified health plans available to qualified individuals and qualified employers through a state health benefit exchange, regional health benefit exchange, subsidiary health benefit exchange, or a federally facilitated health benefit exchange.
- d. "Individual health plan" means health insurance coverage offered to individuals, other than in connection with a group health plan. The term does not include limited scope dental or vision benefits, coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance, or other similar limited benefit health plans.
- e. "Initial enrollment period" means a period during which an individual may enroll in individual health plan coverage sold outside a health benefit exchange for coverage during the 2014 benefit year.
- f. "Special enrollment period" means a period that is outside of the initial and annual open enrollment periods, during which an individual or enrollee who experiences certain qualifying events may enroll in or change

- enrollment in an individual health plan not sold through a health benefit exchange.
2. The commissioner may adopt rules reasonably necessary to mitigate adverse selection or other undesirable market effect among individual health plans sold inside and among individual health plans sold outside a health benefit exchange. The rules may contain:
- a. Requirements for the initial enrollment period;
 - b. Requirements for an annual open enrollment period;
 - c. Requirements for a special enrollment period;
 - d. Requirements for an individual who purchases individual health plan coverage during a special enrollment period; and
 - e. Any other provision reasonably required to mitigate adverse selection or other undesirable market effect in individual health plans sold inside or outside a health benefit exchange.

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

Approved April 10, 2013
Filed April 10, 2013

CHAPTER 235

HOUSE BILL NO. 1194

(Representatives Keiser, Porter)
(Senators Klein, Sitte)

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to short-term insurance; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Short-term care insurance - Rules - Penalty.

1. "Short term care" means any insurance policy, group certificate of insurance, or rider advertised, marketed, offered, or designed to provide coverage for less than twelve consecutive months for each covered period on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, adult day care, or personal care services provided in an insured's own home or a licensed facility setting other than an acute care unit of a hospital.
2. Any policy or rider advertised, marketed, or offered as short-term care insurance must comply with this section and all other applicable insurance laws to the extent the other laws do not conflict with this section.
3. The insurance commissioner:
 - a. May adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of short-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, incontestability, rescission, return of policy provisions, and definitions of terms.
 - b. May adopt rules establishing loss ratio standards for short-term care insurance policies; provided, that a specific reference to short-term care insurance policies is contained in the rules.
 - c. May adopt 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 short-term care insurance.

4. In addition to any other penalties provided by the laws of this state, any insurer and any insurance producer found to have violated any requirement of this title relating to the regulation of short-term care insurance or the marketing of such insurance is subject to a fine of up to three times the amount of any commission paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

Approved April 1, 2013
Filed April 1, 2013

CHAPTER 236

SENATE BILL NO. 2337

(Senators Sinner, Carlisle, Klein)
(Representatives Keiser, Porter)

AN ACT to amend and reenact subsection 4 of section 14-09-08.20, section 26.1-36.3-01, subsection 4 of section 26.1-36.3-04, and sections 26.1-36.3-06 and 26.1-36.3-11 of the North Dakota Century Code, relating to basic health benefit plans and standard health benefit plans; to repeal sections 26.1-36-09.4, 26.1-36.3-08, 26.1-36.3-10, and 26.1-36.4-07 of the North Dakota Century Code, relating to basic health benefit plans and standard health benefit plans; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 4 of section 14-09-08.20 of the North Dakota Century Code is amended and reenacted as follows:

4. For purposes of this section:
 - a. "Basic coverage" means:
 - (1) Health health insurance that includes coverage for the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital care, physician services whether provided within or outside a hospital setting, diagnostic laboratory, and diagnostic and therapeutic radiological services; or
 - (2) ~~A basic group health benefit plan approved under section 26.1-36.3-08;~~
 - b. "Employer" means an entity or individual who would be determined to be an employer under section 3401(d) of the Internal Revenue Code of 1986, as amended [26 U.S.C. 3401(d)], and includes any governmental entity and any labor organization;
 - c. "Insurer" has the meaning provided in section 26.1-36.5-01;
 - d. "National medical support notice" means the notice promulgated pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 [Pub. L. 105-200; 112 Stat. 645] and regulations adopted thereunder; and
 - e. "Title IV-D" has the meaning provided in section 50-09-01.

SECTION 2. 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. "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.
- ~~7-6.~~ "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.].

- ~~8-7.~~ "Class of business" means all or a separate grouping of small employers established under section 26.1-36.3-03.
- ~~9.~~ "~~Committee~~" means the ~~health benefit plan committee created under section 26.1-36.3-08.~~
- ~~10-8.~~ "Control" is as defined in section 26.1-10-01.
- ~~11-9.~~ "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.
- ~~12-10.~~ "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.
- ~~13-11.~~ "Enrollee" means a person covered under a small employer health benefit plan.
- ~~14-12.~~ "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.
- ~~15-13.~~ "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.
- ~~16-14.~~ "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

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- 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.
- 47.15. 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) Workforce safety and insurance 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.

48-16. "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.

49-17. "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.

20-18. "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.

21-19. "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.

22-20. "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.

- 23-21. "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.
- 24-22. "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.
- 25-23. "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.].
- 26-24. "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.
- 27-25. "Producer" means insurance producer.
- 28-26. "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, including a plan maintained by a state government, the United States government, or a foreign government;
 - 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)]; and
 - k. A state's children's health insurance program funded through title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].

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

- ~~29-27.~~ "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.
- ~~30-28.~~ "Reinsuring carrier" means a small employer carrier which reinsures individuals or groups with the program.
- ~~31-29.~~ "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.
- ~~32-30.~~ "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.
- ~~33-31.~~ "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.
- ~~34. "Standard health benefit plan" means a health benefit plan developed under section 26.1-36.3-08.~~

SECTION 3. AMENDMENT. Subsection 4 of section 26.1-36.3-04 of the North Dakota Century Code is amended and reenacted as follows:

4. The commissioner may suspend for a specified period the application of subdivision a of subsection 2 as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that the suspension is reasonable in light of the financial condition of the small employer carrier or, ~~with the prior approval of the committee established pursuant to section 26.1-36.3-08,~~ that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

SECTION 4. AMENDMENT. Section 26.1-36.3-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-06. Availability of coverage.

1. a. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer small employers all health benefit plans it actively markets to small employers in this state, ~~including a basic health benefit plan and a standard health benefit plan.~~
- b. (1) Subject to subdivision a of subsection 1, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter and section 26.1-36-37.2. However, a carrier may not be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

- (2) In the case of a small employer carrier that establishes more than one class of business pursuant to section 26.1-36.3-03, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans it actively markets to small employers, ~~including at least one basic health benefit plan and at least one standard health benefit plan in each established class of business.~~ A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan, are not related to a health status-related factor of the small employer, and are applied consistently to all small employers applying for coverage in the class of business. The small employer carrier shall provide for the acceptance of all eligible small employers into one or more classes of business. This paragraph does not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.
2. a. ~~A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed under this subdivision may be used by a small employer carrier beginning sixty days after it is filed unless the commissioner disapproves its use.~~
- b. ~~The commissioner after providing notice and an opportunity for a hearing to the small employer carrier may disapprove, at any time, the continued use by a small employer carrier of a basic or standard health benefit plan if the plan does not meet the requirements of this chapter and section 26.1-36-37.2.~~
3. Health benefit plans covering small employers must comply with the following:
- a. A health benefit plan may impose a preexisting condition exclusion only if:
- (1) The exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage;
 - (2) The exclusion extends for a period of not more than twelve months after the effective date of coverage;
 - (3) The exclusion does not relate to pregnancy as a preexisting condition; and
 - (4) The exclusion does not treat genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.
- b. A small employer carrier shall reduce any time period applicable to a preexisting condition exclusion or limitation period by the aggregate of periods the individual was covered by qualifying previous coverage, if any, if the qualifying previous coverage was continuous until at least sixty-three days prior to the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a group health benefit plan

may not be taken into account in determining the period of continuous coverage. This subdivision does not preclude application of an employer waiting period applicable to all new enrollees under the health benefit plan. Small employer carriers shall credit coverage by either a standard method or an alternative method. The commissioner shall adopt rules for crediting coverage under the standard and alternative method. These rules must be consistent with the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.] and any federal rules adopted pursuant thereto.

- c. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.
- d.
 - (1) Except as provided in this subdivision, a small employer carrier shall apply requirements used to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, uniformly among all small employers with the same number of eligible employees who are applying for coverage or receiving coverage from the small employer carrier.
 - (2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.
 - (3)
 - (a) Except as provided in subparagraph b, a small employer carrier, in applying minimum participation requirements with respect to a small employer, 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.
 - (b) With respect to a small employer, with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by the small employer in applying minimum participation requirements.
 - (4) A small employer carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.
- e.
 - (1) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a

small employer group or only to part of the group, except in the case of late enrollees as provided in subdivision c.

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

4-3. a. A small employer carrier offering coverage through a network plan is not required to offer coverage or accept applications under subsection 1 to a small employer if:

- (1) The small employer does not have eligible individuals who live, work, or reside in the service area for such network plan; or
- (2) The small employer does have eligible individuals who live, work, or reside in the service area for the network plan, but the carrier has demonstrated, if required, to the commissioner that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contractholders and enrollees, and that it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

b. A small employer carrier, upon denying health insurance coverage in any service area in accordance with paragraph 2 of subdivision a, may not offer coverage in the small employer market within the service area for a period of one hundred eighty days after the date the coverage is denied.

5-4. A small employer carrier is not required to provide coverage to small employers pursuant to subsection 1 for any period of time for which the commissioner determines that the carrier does not have the financial reserves to underwrite additional coverage and is applying this section uniformly without regard to the claims experience of small employers or any health status-related factor relating to employees and their dependents. A small employer carrier denying coverage in accordance with this section may not offer coverage in connection with a group health benefit plan in the small group market for a period of one hundred eighty days after the health coverage is denied or until the carrier has demonstrated to the commissioner sufficient financial reserves to underwrite financial coverage, whichever is later.

6-5. Subsection 1 does not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more associations.

SECTION 5. AMENDMENT. Section 26.1-36.3-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.3-11. Standards to assure fair marketing.

1. Each small employer carrier shall actively market health benefit plan coverage, ~~including the basic and standard health benefit plans,~~ to eligible small employers in the state.
2. a. A small employer carrier or producer may not engage in the following activities, directly or indirectly:
 - (1) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.
 - (2) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.
- b. Subdivision a does not apply to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.
3. a. A small employer carrier may not enter into any contract, agreement, or arrangement, directly or indirectly, with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.
- b. Subdivision a does not apply to a compensation arrangement that provides compensation to a producer on the basis of percentage of premium, provided the percentage does not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.
4. ~~A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.~~
5. No small employer carrier may terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.
- ~~6-5.~~ No small employer carrier or producer may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.
- ~~7-6.~~ Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.
- ~~8-7.~~ A violation of this section by a small employer carrier or a producer is an unfair trade practice under section 26.1-04-03.

9-8. If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator is subject to this section as if it were a small employer carrier.

SECTION 6. REPEAL. Sections 26.1-36-09.4, 26.1-36.3-08, 26.1-36.3-10, and 26.1-36.4-07 of the North Dakota Century Code are repealed.

SECTION 7. EFFECTIVE DATE. This Act becomes effective on January 1, 2014.

Approved April 2, 2013
Filed April 2, 2013

CHAPTER 237

HOUSE BILL NO. 1181

(Representatives Keiser, Frantsvog, Ruby, Vigesaa)
(Senators Andrist, Klein)

AN ACT to create and enact section 26.1-44-03.2 of the North Dakota Century Code, relating to domestic surplus lines insurers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-44-03.2 of the North Dakota Century Code is created and enacted as follows:

26.1-44-03.2. Domestic surplus lines insurers.

1. A North Dakota domestic insurer may be designated a domestic surplus lines insurer if:
 - a. The insurer possesses a policyholder surplus of at least fifteen million dollars;
 - b. The designation is in compliance with a resolution of the insurer's board of directors; and
 - c. The commissioner has provided written approval of the designation.
2. A domestic surplus lines insurer may write surplus lines insurance in North Dakota and any other jurisdiction in which the insurer is eligible. A domestic surplus lines insurer may insure in this state any risk if:
 - a. Produced pursuant to chapter 26.1-44;
 - b. The premium is subject to surplus lines premium tax pursuant to section 26.1-44-03.1; and
 - c. Issued pursuant to the surplus lines insurance multistate compliance compact.
3. For purposes of the federal Nonadmitted and Reinsurance Reform Act of 2010 [15 U.S.C. 8201 et seq.], a domestic surplus lines insurer is considered a nonadmitted insurer as defined under that Act, with respect to risks insured in this state.
4. A domestic surplus lines insurer may not issue a policy designed to satisfy the motor vehicle financial responsibility requirements in chapter 26.1-41 or any other law mandating insurance coverage by a licensed insurance company.
5. Except as specifically exempted from such requirements, a domestic surplus lines insurer is subject to compliance with all financial examination and solvency requirements that apply to domestic insurers under chapter 26.1-03 regarding examinations and reports.

6. A domestic surplus lines insurer is not subject to the provisions of chapter 26.1-38.1 regarding the life and health insurance guaranty association nor to chapter 26.1-39 regarding property and casualty insurance.

Approved April 2, 2013
Filed April 2, 2013

CHAPTER 238

HOUSE BILL NO. 1171

(Representatives Keiser, Kasper)
(Senators Klein, O'Connell)

AN ACT to create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to unclaimed life insurance benefits; and to amend and reenact section 47-30.1-07 of the North Dakota Century Code, relating to the state's unclaimed property act.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Definitions.

As used in this chapter:

1. "Contract" means an annuity contract issued in this state. The term does not include an annuity used to fund an employment-based retirement plan or program in which the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.
2. "Death master file" means the United States social security administration's death master file or any other database or service the commissioner has determined is at least as comprehensive as the United States social security administration's death master file for determining that an individual has reportedly died.
3. "Death master file match" means a search of the death master file or revised death master file which results in a match of the social security number or of the name and date of birth of an insured, annuity owner, or retained asset accountholder.
4. "Policy" means any policy or certificate of life insurance issued in this state which provides a death benefit. The term does not include:
 - a. A policy or certificate of life insurance which provides a death benefit under an employee benefit plan subject to the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 29 U.S.C. 1002 et seq.];
 - b. A policy or certificate of life insurance which provides a death benefit under an employee benefit plan under any federal employee benefit program;
 - c. A policy or certificate of life insurance which is used to fund a pre-need funeral contract or prearrangement; or
 - d. A policy or certificate of credit life or accidental death insurance.

5. "Revised death master file" means the names added to the death master file since the insurer's most recent semiannual comparison required under this chapter.

Insurer conduct.

1. Before November 1, 2014, an insurer shall perform a comparison of the insurer's insureds' in-force life insurance policies and retained asset accounts against a death master file in order to identify potential matches of the insurer's insureds. Semiannually, an insurer shall perform a comparison of the insurer's insureds' in-force life insurance policies and retained asset accounts against the revised death master file in order to identify the potential matches of the insurer's insureds.
2. For each potential match identified as a result of a death master file or revised death master file match, within twelve months of the potential match, the insurer shall:
 - a. Complete a good-faith effort, which the insurer shall document, to confirm the death of the insured or retained asset accountholder against other available records and information;
 - b. Review the insurer's records to determine whether the individual who has died purchased any other products with the insurer; and
 - c. Determine whether benefits are due in accordance with the applicable policy or contract, and if benefits are due in accordance with the applicable policy or contract the insurer shall:
 - (1) Use good-faith efforts, which the insurer shall document, to locate the beneficiary or beneficiaries; and
 - (2) Provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim, including the need to provide an official death certificate, if applicable under the policy or contract.
3. With respect to group life insurance, for each potential match identified as a result of a death master file or revised death master file match, the insurer shall confirm the possible death of an insured if the insurer maintains at least the following information of those covered under a policy or certificate:
 - a. The social security number or the name and date of birth;
 - b. Beneficiary designation information;
 - c. Coverage eligibility;
 - d. Benefit amount; and
 - e. Premium payment status.
4. Every insurer shall implement procedures to account for:

- a. Nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;
 - b. Compound last names, maiden or married names, and hyphens, blank spaces, and apostrophes in last names;
 - c. Incomplete date of birth data and transposition of the month and date portions of a date of birth; and
 - d. Incomplete social security numbers.
5. To the extent permitted by law, for each potential match identified as a result of a death master file or revised death master file match, the insurer may disclose minimum necessary personal information about the insured or beneficiary to:
 - a. A person the insurer reasonably believes may be able to assist the insurer locate the beneficiary; or
 - b. A person otherwise entitled to payment of the claims proceeds.
 6. An insurer or an insurer's service provider may not charge an insured, accountholder, or beneficiary for any fees or costs associated with a comparison, search, or verification conducted pursuant to this section.
 7. The benefits from a life insurance policy or a retained asset account, plus any applicable accrued interest must be first payable to the designated beneficiaries or owners and if the beneficiaries or owners cannot be found, escheat to the state as unclaimed property as provided under this chapter.
 8. Within twelve months following a potential match identified as a result of a death master file or revised death master file match, an insurer shall:
 - a. Notify the state abandoned property office that a life insurance policy beneficiary or retained asset accountholder has not submitted and completed a claim with the insurer and that the insurer has complied with subsections 2 and 3 and has been unable, after good-faith efforts documented by the insurer, to contact the retained asset accountholder, beneficiary, or beneficiaries and unable to complete the necessary payment; and
 - b. Submit any unclaimed life insurance benefits or unclaimed retained asset accounts, plus any applicable accrued interest, to the state abandoned property office under chapter 47-30.1.
 9. Except as otherwise provided under this chapter, chapter 47-30.1 applies to the escheatment of unclaimed life insurance benefits or unclaimed retained asset accounts.

Rulemaking.

The commissioner may adopt rules to limit an insurer's death master file comparisons and revised death master file comparisons required under this chapter to the insurer's electronic searchable files, to allow the commissioner to approve an

insurer's plan and timeline for conversion of the insurer's files to electronic searchable files, and to allow for phasing-in compliance with this chapter according to an insurer's plan and timeline approved by the commissioner.

Application.

Section 47-30.1-07 and chapter 47-30.1, relating to unclaimed property, apply to a contract or policy to the extent the laws do not conflict with this chapter.

Unfair trade practices - Liability limitation.

Failure to meet any requirement of this chapter is a violation of chapter 26.1-04. This chapter does not create a private cause of action for violation of this chapter. Once an insurer submits unclaimed life insurance benefits or unclaimed retained asset accounts, plus any applicable accrued interests, to the state abandoned property office in compliance with this chapter, the insurer is relieved and indemnified from additional liability to any person relating to the proceeds submitted. This indemnification from liability is in addition to any other protections provided by law.

SECTION 2. AMENDMENT. Section 47-30.1-07 of the North Dakota Century Code is amended and reenacted as follows:

47-30.1-07. Funds owing under life insurance policies.

1. ~~Funds~~Except as otherwise provided under this section, funds held or owing under any life or endowment insurance policy or annuity contract that has matured or terminated are presumed abandoned if unclaimed for ~~more than three years~~one year after the funds became due and payable as established from the records of the insurance company holding or owing the funds, ~~but property described in subdivision b of subsection 3 is presumed abandoned if unclaimed for more than three years. If the policy or annuity contract provides for death benefits and is a policy covered under section 1 of this Act, the insurance company shall comply with section 1 of this Act.~~
2. If a person other than the insured or annuitant is entitled to the funds and an address of the person is not known to the company or it is not definite and certain from the records of the company who is entitled to the funds, it is presumed that the last known address of the person entitled to the funds is the same as the last known address of the insured or annuitant according to the records of the company.
3. For purposes of this chapter, a life or endowment insurance policy or annuity contract not matured by actual proof of the death of the insured or annuitant according to the records of the insurance company is matured and the proceeds due and payable if:
 - a. The company knows ~~that~~of the potential death of the insured or annuitant ~~has died~~, in which case the company shall comply with subsection 6; or
 - b. (1) The insured has attained, or would have attained if the insured were living, the limiting age under the mortality table on which the reserve is based;
 - (2) The policy was in force at the time the insured attained, or would have attained, the limiting age specified in paragraph 1; and

- (3) Neither the insured nor any other person appearing to have an interest in the policy within the preceding three years, according to the records of the company, has assigned, readjusted, or paid premiums on the policy, subjected the policy to a loan, corresponded in writing with the company concerning the policy, or otherwise indicated an interest as evidenced by a memorandum or other record on file prepared by an employee of the company.
4. For purposes of this chapter, the application of an automatic premium loan provision or other nonforfeiture provision contained in an insurance policy does not prevent a policy from being matured or terminated under subsection 1 if the insured has died or the insured or the beneficiary of the policy otherwise has become entitled to the proceeds thereof before the depletion of the cash surrender value of a policy by the application of those provisions.
 5. If the laws of this state or the terms of the life insurance policy require the company to give notice to the insured or owner that an automatic premium loan provision or other nonforfeiture provision has been exercised and the notice, given to an insured or owner whose last known address according to the records of the company is in this state, is undeliverable, the company shall make a reasonable search to ascertain the policyholder's correct address to which the notice must be mailed.
 6. ~~Notwithstanding any other provision of law, if~~ the company learns of the ~~death or potential~~ death of the insured or annuitant ~~and the beneficiary has not communicated with the insurer, within fourtwelve months after following the company learning of the death or potential death, the company shall take reasonable steps to pay the proceeds to the beneficiary:~~
 - a. Complete a good-faith effort, which the company shall document, to confirm the death of the insured or annuitant against other available records and information;
 - b. Review the insurer's records to determine whether the individual who has died purchased any other products with the insurer;
 - c. Determine whether benefits are due in accordance with the applicable insurance policy or annuity contract, and if benefits are due in accordance with the applicable policy or contract the company shall:
 - (1) Use good-faith efforts, which the company shall document, to locate the beneficiary or beneficiaries; and
 - (2) Provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim, including the need to provide an official death certificate, if applicable under the policy or contract; and
 - d. Report and deliver the unclaimed property to the administrator as abandoned property if the benefits are due in accordance with the applicable insurance policy or annuity contract and the beneficiary has not submitted and completed a claim with the insurer.
 7. ~~Commencing two years after July 1, 1985, every~~Every change of beneficiary form issued by an insurance company under any life or endowment insurance

policy or annuity contract to an insured or owner who is a resident of this state must request the following information:

- a. The name of each beneficiary, or if a class of beneficiaries is named, the name of each current beneficiary in the class;
- b. The address of each beneficiary; and
- c. The relationship of each beneficiary to the insured.

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