# INSURANCE

## CHAPTER 230

## HOUSE BILL NO. 1138

(Representatives Keiser, O'Brien)

AN ACT to amend and reenact subsection 2 of section 26.1-02-27 of the North Dakota Century Code, relating to annual privacy notices.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1. AMENDMENT.** Subsection 2 of section 26.1-02-27 of the North Dakota Century Code is amended and reenacted as follows:

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

~~b.~~a. 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.~~b. Notwithstanding subdivision ~~b~~a and subject to the exceptions, including the affiliate sharing exception provided for in the national association of insurance commissioners' 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.

c. The rules may not require an insurance company, nonprofit health service corporation, or health maintenance organization to provide an annual privacy notice if the insurance company, nonprofit health service corporation, or health maintenance organization:

(1) Complies with nonaffiliated third party sharing rules adopted by the commissioner; and

(2) Has not changed the insurance company's, nonprofit health service corporation's, or health maintenance organization's policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent notice sent to consumers.

Approved March 20, 2019

Filed March 21, 2019

# CHAPTER 231

# HOUSE BILL NO. 1139

(Representative Keiser)
(Senator Klein)

AN ACT to create and enact section 26.1-02-31 of the North Dakota Century Code, relating to confidentiality of insurance department records; and to amend and reenact section 26.1-02-30 of the North Dakota Century Code, relating to confidentiality of consumer assistance records.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1. AMENDMENT.** Section 26.1-02-30 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-02-30. Consumer assistance records - ~~Exempt~~Confidential.**

1. Personal, financial, or health information related to requests for consumer assistance received by the commissioner is ~~an exempt~~a confidential record as defined in section 44-04-17.1.

2. As used in this section, "personal, financial, or health information" means information that would reveal:

   a. An individual's personal health condition, disease, or injury;

   b. The existence, nature, source, or amount of an individual's personal income;

   c. The existence, nature, source, or amount of an individual's personal expenses;

   d. Records of or relating to an individual's personal financial transactions of any kind;

   e. The existence, identification, nature, or value of an individual's personal assets, liabilities, or net worth;

   f. A history of an individual's personal medical diagnosis or treatment;

   g. The existence, identification, nature, value, or content of an individual's coverage or status under any insurance policy;

   h. An individual's personal contractual rights or obligations; or

   i. Any social security number, date of birth, file number, bank account number, or other number used for identification of an individual or any account in which an 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.

**SECTION 2.** Section 26.1-02-31 of the North Dakota Century Code is created and enacted as follows:

**26.1-02-31. Confidentiality of complaint information - Exceptions.**

1. A document, material, or other information, including the contents of a claim file, which is provided to, obtained by, created by, or disclosed to the commissioner in response to a consumer assistance request or a complaint is confidential and not subject to section 44-04-18, a subpoena to the department, or discovery request or admissible as evidence in a private civil action. However, the commissioner may disclose the subject matter of the assistance request or complaint, provide a general description of the disposition of the request or complaint, and use the document, material, or other information for a regulatory or legal action brought as a part of the official duties of the commissioner.

2. A privilege or claim of confidentiality in the document, material, or information is not waived as a result of disclosure to the commissioner under this section or as a result of providing or disclosing information to the commissioner.

Approved March 20, 2019

Filed March 21, 2019

# CHAPTER 232

# HOUSE BILL NO. 1137

(Representatives Keiser, Bosch, O'Brien)
(Senator Burckhard)

AN ACT to create and enact two new sections to chapter 26.1-02 of the North Dakota Century Code, relating to electronic delivery of insurance notices and documents; and to repeal section 26.1-39-26 of the North Dakota Century Code, relating to electronic delivery of property and casualty insurance notices and documents.

**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:

**Electronic notices and documents.**

1. As used in this section:

   a. "Delivered by electronic means" includes:

      (1) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

      (2) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet, or other electronic device, together with separate notice to a party directed to the electronic mail address at which the party has consented to receive notice of the posting.

   b. "Party" means a recipient of a notice or document required as part of an insurance transaction, including an applicant, insured, or policyholder.

2. Subject to the requirements of this section, any notice to a party or any other document required under applicable law in an insurance transaction or any other document that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if the notice or document meets the requirements of chapter 9-16.

3. Delivery of a notice or document in accordance with this section is equivalent to any delivery method required under applicable law, including delivery by first class mail; first class mail, postage prepaid; or registered mail.

4. A notice or document may be delivered by electronic means by an insurer to a party under this section if the following requirements are met:

   a. The party has affirmatively consented to the electronic method of delivery and has not withdrawn the consent.

   b. The party, before giving consent, is provided with a clear and conspicuous statement informing the party of the following:

(1) The right of the party at any time to withdraw consent to have a notice or document delivered by electronic means and any conditions or consequences imposed if consent is withdrawn.

(2) The means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means.

(3) The procedure a party shall follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address.

c. The party:

(1) Before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(2) Consents electronically, or confirms consent electronically, in a manner that demonstrates the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent.

d. After the party has given consent, if a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies, the insurer shall provide the party with a statement of the revised hardware and software requirements which complies with subdivision b.

e. The insurer has provided a copy of the notice or document to the party's insurance producer by electronic means or regular mail.

5. This section does not affect requirements related to content or timing of any notice or document required under applicable law.

6. If a provision of this title or applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the electronic method used provides for verification or acknowledgment of receipt.

7. The legal effectiveness, validity, or enforceability of any insurance contract or policy executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with paragraph 2 of subdivision c of subsection 4.

8. A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

9. A withdrawal of consent by a party is effective within a reasonable time, not to exceed five days, after receipt of the withdrawal by the insurer.

10. This section does not apply to a notice or document delivered before August 1, 2019, by an insurer in an electronic form to a party that, before that

date, has consented to receive notices or documents in an electronic form otherwise allowed by law.

11. If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before August 1, 2019, and pursuant to this section, an insurer intends to deliver additional notices or documents to the party in an electronic form, then before delivering those additional notices or documents electronically, the insurer shall provide the insured with a statement describing:

    a. The notices or documents that must be delivered by electronic means under this section which were not previously delivered electronically; and

    b. The party's right to withdraw consent to have notices or documents delivered by electronic means.

12. Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may qualify as a notice or document delivered by electronic means for purposes of this section.

13. If a provision of this title or applicable law requires a signature, notice, or document to be notarized, acknowledged, verified, or made under oath, the requirement is satisfied if the electronic signature of the individual authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice, or document.

14. This section may not be construed to modify, limit, or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act [15 U.S.C. ch. 7001 et seq.].

**SECTION 2.** A new section to chapter 26.1-02 of the North Dakota Century Code is created and enacted as follows:

**Posting policy on internet.**

1. An insurance policy and an endorsement that does not contain personally identifiable information may be mailed, delivered, or posted on the insurer's website. If the insurer elects to post an insurance policy and an endorsement on the insurer's website in lieu of mailing or delivering the policy and endorsement to the insured, the insurer shall comply with the following conditions:

    a. The policy and an endorsement must be accessible to the insured and producer of record and remain that way while the policy is in force;

    b. After the expiration of the policy, the insurer shall archive the expired policy and endorsement for a period of five years or other period required by law, and make the policy and endorsement available upon request;

    c. The policy and endorsement must be posted in a manner that enables the insured and producer of record to print and save the policy and endorsement using a program or application that is widely available on the internet and free to use;

d. The insurer shall provide the following information in, or simultaneous with, each declaration page provided at the time of issuance of the initial policy and any renewals of the policy:

(1) A description of the exact policy and endorsement form purchased by the insured;

(2) A description of the insured's right to receive, upon request and without charge, a paper copy of the policy and endorsement by mail; and

(3) The internet address at which the policy and endorsement are posted;

e. The insurer, upon an insured's request and without charge, shall mail a paper copy of the policy and endorsement to the insured; and

f. The insurer shall provide notice, in the format preferred by the insured, of any change to the forms or endorsement; the insured's right to obtain, upon request and without charge, a paper copy of the forms or endorsement; and the internet address at which the forms or endorsement are posted.

2. This section does not affect the timing or content of any disclosure or document required to be provided or made available to any insured under applicable law.

**SECTION 3. REPEAL.** Section 26.1-39-26 of the North Dakota Century Code is repealed.

Approved March 20, 2019

Filed March 21, 2019

# CHAPTER 233

# HOUSE BILL NO. 1142

(Representative Keiser)
(Senator Klein)

AN ACT to create and enact a new section to chapter 26.1-02 of the North Dakota Century Code, relating to interpretation of the state's insurance laws.

**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:

**Rules of interpretation.**

In addition to the rules of interpretation under chapters 1-01 and 1-02, in interpreting this title, a person, including the courts of this state, shall apply the Constitution of the United States of America and the Constitution of North Dakota, this code, and the common law of this state. A person may not apply, give weight to, or afford recognition to, the American Law Institute's "Restatement of the Law, Liability Insurance" as an authoritative reference regarding interpretation of North Dakota laws, rules, and principles of insurance law.

Approved March 20, 2019

Filed March 21, 2019

# CHAPTER 234

# SENATE BILL NO. 2077

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

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

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1. 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 - Restitution.**

1. a. A violation of section 26.1-02.1-02.1 is:

   (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~~the act associated with the fraud or directly related to the fraud 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~~the act associated with the fraud or directly related to the fraud 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 one thousand dollars but does not exceed ten thousand dollars; and

   (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 section 12.1-23-05.

2. ~~In the event that~~If a practitioner is adjudicated guilty of a violation of section 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. In addition to any other punishment, a person ~~who~~that violates section 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 26.1-02.1-02.1. The court shall determine the extent and method of restitution.

4. A prosecution for any felony offense under chapter 26.1-02.1 must be commenced within three years after the date of discovery of the fraud.

5. A prosecution for any misdemeanor or infraction offense under chapter 26.1-02.1 must be commenced within two years after the date of discovery of the fraud.

Approved March 14, 2019

Filed March 14, 2019

# CHAPTER 235

# SENATE BILL NO. 2076

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

AN ACT to create and enact chapter 26.1-10.3 of the North Dakota Century Code, relating to corporate governance; and to provide a penalty.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Chapter 26.1-10.3 of the North Dakota Century Code is created and enacted as follows:

**26.1-10.3-01. Definitions.**

As used in this chapter:

1. "Corporate governance annual disclosure" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this chapter.

2. "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in chapter 26.1-10.

3. "Insurer" has the meaning provided in section 26.1-10-01.

4. "Own risk and solvency assessment summary report" means the report filed in accordance with chapter 26.1-10.2.

**26.1-10.3-02. Disclosure requirement.**

1. An insurer, or the insurance group of which the insurer is a member, no later than June first of each calendar year, shall submit to the commissioner a corporate governance annual disclosure that contains the information described in subsection 2 of section 26.1-10.3-04. Notwithstanding any request from the commissioner made pursuant to subsection 3, if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent financial analysis handbook adopted by the national association of insurance commissioners.

2. The corporate governance annual disclosure must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee of the board of directors.

3. An insurer not required to submit a corporate governance annual disclosure under this section shall do so upon the commissioner's request.

4. For purposes of completing the corporate governance annual disclosure, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured the system of corporate governance of the insurer or insurance group. The insurer or insurance group is encouraged to make the corporate governance annual disclosure disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, the insurer or insurance group shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

5. The review of the corporate governance annual disclosure and any additional requests for information must be made through the lead state as determined by the procedures within the most recent financial analysis handbook referenced in subsection 1.

6. An insurer providing information substantially similar to the information required by this chapter in other documents provided to the commissioner, including proxy statements filed in conjunction with form b requirements, or other state or federal filings provided to the commissioner are not required to duplicate that information in the corporate governance annual disclosure, but shall cross-reference the document in which the information is included.

**26.1-10.3-03. Rules and regulations.**

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

**26.1-10.3-04. Contents of corporate governance annual disclosure.**

1. The insurer or insurance group has discretion over the responses to the corporate governance annual disclosure inquiries, if the corporate governance annual disclosure contains the material information necessary to permit the commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The commissioner may request additional information the commissioner deems material and necessary to provide the commissioner with a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

2. Notwithstanding subsection 1, the corporate governance annual disclosure must be prepared according to rules adopted by the commissioner. Documentation and supporting information must be maintained and made available upon examination or upon request of the commissioner.

**26.1-10.3-05. Confidentiality.**

1. Documents, materials, or other information, including the corporate governance annual disclosure, in the possession or control of the insurance department which are obtained by, created by, or disclosed to the

commissioner or any other person under this chapter, are recognized by this state as being proprietary and to contain trade secrets. All documents, materials, or other information is confidential by law and privileged, is not subject to section 44-04-18, is not subject to subpoena, and is not subject to discovery or admissible in evidence in any private civil action. However, the commissioner may 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. The commissioner may not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. This section may not be construed to require written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other corporate governance annual disclosure-related information pursuant to subsection 3 to assist in the performance of the commissioner's regular duties.

2. Neither the commissioner nor any person that received documents, materials, or other corporate governance annual disclosure-related information, through examination or otherwise, while acting under the authority of the commissioner, or with which documents, materials, or other information are shared pursuant to this chapter 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 regulatory duties, the commissioner:

   a. May, upon request, share documents, materials, or other corporate governance annual disclosure-related information, including the confidential and privileged documents, materials, or information subject to subsection 1, including proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in section 26.1-10-06.1, with the national association of insurance commissioners, and with third-party consultants pursuant to section 26.1-10.3-06, if the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality; and

   b. May receive documents, materials, or other corporate governance annual disclosure-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as defined in chapter 26.1-10, and from the national association of insurance commissioners, and shall maintain as confidential or privileged any documents, materials, 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.

4. The sharing of information and documents by the commissioner pursuant to this chapter does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this chapter.

5. A waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other corporate governance annual disclosure-related information does not occur as a result of disclosure of corporate governance annual disclosure-related information or documents to the commissioner under this section or as a result of sharing as authorized in this chapter.

**26.1-10.3-06. National association of insurance commissioners and third-party consultants.**

1. The commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the corporate governance annual disclosure and related information or the insurer's compliance with this chapter.

2. Any persons retained under subsection 1 are under the direction and control of the commissioner and shall act in a purely advisory capacity.

3. The national association of insurance commissioners and third-party consultants are subject to the same confidentiality standards and requirements as the commissioner.

4. As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that the consultant is free of a conflict of interest and has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this chapter.

5. A written agreement with the national association of insurance commissioners or a third-party consultant, or both, governing sharing and use of information provided pursuant to this chapter must contain the following provisions and expressly require the written consent of the insurer before making public information provided under this chapter:

   a. Specific procedures and protocols for maintaining the confidentiality and security of corporate governance annual disclosure-related information shared with the national association of insurance commissioners or a third-party consultant pursuant to this chapter.

   b. Procedures and protocols for sharing by the national association of insurance commissioners only with other state regulators from states in which the insurance group has domiciled insurers. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

   c. A provision specifying that ownership of the corporate governance annual disclosure-related information shared with the national association of insurance commissioners or a third-party consultant remains with the insurance department and the national association of insurance commissioner's or third-party consultant's use of the information is subject to the direction of the commissioner.

d. A provision that prohibits the national association of insurance commissioners or a third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed.

e. A provision requiring the national association of insurance commissioners or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's corporate governance annual disclosure-related information.

f. A requirement that the national association of insurance commissioners or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the national association of insurance commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the national association of insurance commissioners or a third-party consultant pursuant to this chapter.

**26.1-10.3-07. Sanctions.**

Any insurer failing, without just cause, to timely file the corporate governance annual disclosure as required in this chapter is required, after notice and hearing, to pay a penalty of five hundred dollars for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the general fund. The maximum penalty under this section is one hundred thousand dollars. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

Approved April 8, 2019

Filed April 9, 2019

# CHAPTER 236

# HOUSE BILL NO. 1176

(Representatives Monson, Kreidt, Vigesaa)
(Senators Klein, Luick, Rust)

AN ACT to amend and reenact sections 26.1-13-01, 26.1-13-05, 26.1-13-07, 26.1-13-10, 26.1-13-11, 26.1-13-12, 26.1-13-14, 26.1-13-15, 26.1-13-19, 26.1-13-21, 26.1-13-23, 26.1-13-28, 26.1-13-29, and 26.1-13-34 and subsection 7 of section 26.1-42.1-02 of the North Dakota Century Code, relating to county mutual insurance companies; and to repeal sections 26.1-13-20, 26.1-13-22, 26.1-13-24, 26.1-13-25, 26.1-13-26, 26.1-13-27, 26.1-13-31, 26.1-13-32, and 26.1-13-33 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 26.1-13-01 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-01. County mutual insurance company - Organization.**

A corporation for mutual insurance may be formed in accordance with this chapter by any number of persons, not less than fifty, residing in not more than ~~thirty~~forty counties in this state, ~~who~~which collectively own property of not less than ~~one~~four hundred thousand dollars in value which ~~they~~the persons desire to insure; or any number of persons, not less than twenty-five, residing in any one county in this state, ~~who~~which collectively own property of not less than ~~twenty-five~~one hundred thousand dollars in value which ~~they~~the persons desire to insure. A county mutual insurance company organized under this chapter shall maintain a surplus of at least ~~fifty~~two hundred thousand dollars.

**SECTION 2. AMENDMENT.** Section 26.1-13-05 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-05. Bylaws - Contents.**

A county mutual insurance company may make bylaws, not inconsistent with the constitution or laws of this state, necessary to provide for the management of ~~its~~the company's affairs in accordance with this chapter and to prescribe the duties of ~~its~~the company's officers ~~and fix their compensation~~. Bylaws may be repealed or amended in the manner provided in this chapter.

**SECTION 3. AMENDMENT.** Section 26.1-13-07 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-07. Directors - Number - Election - Powers and duties.**

The general management of the business of a county mutual insurance company must be vested in a board of directors consisting of ~~not less~~no fewer than five members nor more than fifteen members. The members of the board must be elected by the members of the company at the annual meeting in the manner provided by the bylaws of the company ~~and, if it is not otherwise provided, by ballot~~. As nearly as may

be, one-third of the members of the first board must be elected for one year, one-third for two years, and one-third for three years, and in all future elections ~~subsequent thereto~~, except in the case of elections to fill vacancies on the board, members must be elected for terms of three years. Each director holds office until a successor is elected and qualified. In the election of the members of the first board, each incorporator is entitled to one vote, and at every subsequent election each member of the company is entitled to one vote per policy. The board may exercise the usual powers and shall perform the usual duties of a board of directors of a corporation generally.

**SECTION 4. AMENDMENT.** Section 26.1-13-10 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-10. Members of county mutual company - Policyholders - Notice of meetings.**

Every person insured by a county mutual insurance company is a member while the policy is in force. The member is entitled to one vote per policy only and must be notified of the time and place of the holding of the meetings of the company by written notice ~~thereof~~ or by an imprint on the face of each policy, receipt, or certificate of renewal, as follows:

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

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

**SECTION 5. AMENDMENT.** Section 26.1-13-11 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-11. Annual meeting - Quorum.**

The annual meeting of a county mutual insurance company must be held ~~on the second Thursday in March in each year~~following notice of a prescribed date, time, and place unless ~~it~~notice is provided otherwise in the bylaws of the company. Twenty members constitute a quorum for the transaction of business at an annual meeting.

**SECTION 6. 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 has the powers and is subject to the liabilities and duties of other insurance companies, except:

1. ~~The principal office of the company must be located within the company's approved territory of operation.~~

~~2.~~ 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.~~2. 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 any covered hazard to a seasonal dwelling if the primary residence is insured by the company in an authorized county.

b. Protection against loss or damage by tornadoes;

~~b.~~c. Protection against loss or damage by windstorms;

~~c.~~d. Protection against loss or damage by cyclones;

~~d.~~e. Protection against loss or damage by hail, except upon growing crops; and

~~e.~~f. 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 7. AMENDMENT.** Section 26.1-13-14 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-14. County mutual company - Insurance authority.**

A county mutual insurance company may insure against loss or damage by fire~~,~~; lightning~~,~~; cyclone~~,~~; windstorm~~,~~; tornado~~,~~; hail, except upon growing crops~~,~~; any insured hazard ~~upon any risk~~ upon livestock~~,~~; explosion, except the explosion of steam boilers and flywheels~~,~~; riot~~,~~; riot attending a strike~~,~~; civil commotion~~,~~; aircraft~~,~~; vehicles~~,~~; smoke to the property of the insured~~,~~; theft~~,~~; vandalism~~,~~; malicious mischief~~,~~; water damage and freezing~~,~~; collision and overturn of farm machinery~~,~~; collapse of buildings~~,~~; glass breakage~~,~~; the additional living expenses incurred over and above normal living costs in cases of damage~~,~~; the removal of debris~~,~~; the cost of repairing or replacing homes or living residences~~,~~; or all such forms of insurance.

**SECTION 8. 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~~2 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 an incorporated city in this state, except the policy may provide coverage as specified under sections 26.1-13-14 and 26.1-13-16 within the platted limits of the incorporated city on:

   a. The place of residence;

b. A rental property that is no larger than a four residential rental unit;

c. A nonresidential property that is not used by the general public; or

d. A nonresidential property that is part of an existing policy.

4. The company may insure all property located outside of incorporated cities within the limits of the company's territory, as provided under section 26.1-13-02.

5. Policies issued under subsection 3 on property located within the platted limits of an incorporated city with a population over ten thousand must conform to rules adopted by the commissioner establishing requirements for underwriting risks and safeguarding financial solvency. A company's net written premiums of the current year in cities with a population over ten thousand may not exceed thirty-five percent of the gross written premiums of the previous year.

6. A policy issued by the company, if ~~it~~the policy 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.

**SECTION 9. AMENDMENT.** Section 26.1-13-19 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-19. Reinsurance of excessive losses.**

~~Except as otherwise provided in sections 26.1-02-20 and 26.1-02-22, any county mutual insurance company may reinsure in a single contract, with other county mutual insurance companies, against excessive losses on all insurance contracts written. The reinsurance contracts may provide:~~

~~1. That whenever the total losses per dollar of insurance in force of any county mutual insurance company joining the contract exceeds the average total losses per dollar of insurance in force of all county mutual insurance companies joining the contract, the excessive loss or a portion thereof must be paid to the county mutual insurance company or companies suffering the excessive loss by the companies having a lower than average loss ratio; and~~

~~2. That the payments by individual companies suffering a lower than average loss ratio must be prorated according to a formula based upon the total dollars of insurance in force of any participating company as compared to the total dollars of insurance in force of all participating companies suffering a lower than average loss ratio.~~

~~The payments by any single company may not be greater than that sum which would bring the loss ratio per dollar of insurance in force of the company up to the average loss per dollar of insurance in force of all participating companies~~Upon approval by the commissioner, any county mutual insurance company may reinsure in a single contract, with other county mutual insurance companies, against excessive losses on all insurance contracts written.

**SECTION 10. AMENDMENT.** Section 26.1-13-21 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-21. Supervision by commissioner.**

The commissioner has full power of supervision over all reinsurance contracts executed under ~~sections~~section 26.1-13-19 ~~and 26.1-13-20~~.

**SECTION 11. AMENDMENT.** Section 26.1-13-23 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-23. Loss - Notice - Adjustment - Arbitration - Finality of determination of board of adjustment - Powers of board.**

Every member of a county mutual insurance company ~~who~~which sustains loss ~~or damage by fire, lightning, or cyclone~~ shall notify the ~~secretary of the~~ company~~, or the president in the absence of the secretary,~~ immediately after the loss is sustained. ~~That officer shall ascertain the amount of the loss and shall cause the amount of the loss to be adjusted in the manner provided in the bylaws of the company, or the officer forthwith shall convene the board of directors of the company, and, the board shall appoint a committee of not more than three members of the company to ascertain and adjust the amount of the loss.~~The company shall assign the loss to be adjusted in the manner provided in the insurance policy of the company. If the parties are unable to agree upon the amount of the damage, the claimant and the company each shall choose a disinterested party to constitute a board of arbitration to settle the loss. If the parties cannot agree, ~~they~~the parties shall choose a third party to act with ~~them~~the parties. The board of arbitration may examine witnesses and shall determine all matters in dispute, and the decision of the arbitration board is final. ~~Any officer or member of the company, while acting as an adjuster, and the members of any board of arbitration appointed pursuant to this section may subpoena and examine witnesses, administer oaths, and take acknowledgments while acting in that capacity.~~

**SECTION 12. AMENDMENT.** Section 26.1-13-28 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-28. Borrowing of money authorized ~~- Repayment from assessments~~.**

The board of directors of a county mutual insurance company, in ~~its~~the board's discretion, may borrow money for the payment of unpaid losses. ~~Any money borrowed must be repaid from moneys collected from the next ensuing assessment levied in accordance with this chapter.~~

**SECTION 13. AMENDMENT.** Section 26.1-13-29 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-29. Withdrawal from membership.**

Any member of a county mutual insurance company may withdraw from membership at any time while the company continues to transact the business for which ~~it~~the company was organized if, by withdrawal, the number of members remaining in the company will not be reduced below the original number of incorporators, or the assets of the company will not be reduced below the amount at the time of incorporation. In order to withdraw, a member shall surrender the policy for cancellation~~,~~ and give written notice of withdrawal to the secretary or designated employee of the company~~, and pay the member's share of all claims then existing against the company~~.

**SECTION 14. AMENDMENT.** Section 26.1-13-34 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-13-34. Annual statement to be furnished to members of county mutual company ~~or of mutual reinsurance company~~.**

The secretary of each county mutual insurance company ~~and of each mutual reinsurance company~~ formed under this chapter shall prepare and submit to the members of the company, at each annual meeting, a copy of the annual statement required to be filed with the commissioner under section 26.1-03-07.

**SECTION 15. AMENDMENT.** Subsection 7 of section 26.1-42.1-02 of the North Dakota Century Code is amended and reenacted as follows:

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

**SECTION 16. REPEAL.** Sections 26.1-13-20, 26.1-13-22, 26.1-13-24, 26.1-13-25, 26.1-13-26, 26.1-13-27, 26.1-13-31, 26.1-13-32, and 26.1-13-33 of the North Dakota Century Code are repealed.

Approved March 20, 2019

Filed March 21, 2019

# CHAPTER 237

# SENATE BILL NO. 2167

(Senators Burckhard, Vedaa)
(Representatives Kasper, Louser, Schobinger)

AN ACT to create and enact section 26.1-26-31.9 of the North Dakota Century Code, relating to insurance producer and consultant continuing education; and to amend and reenact sections 26.1-26-02 and 26.1-26-35 of the North Dakota Century Code, relating to definitions relating to insurance producers and consultants.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1. AMENDMENT.** Section 26.1-26-02 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-26-02. Definitions.**

As used in this chapter, unless the context requires otherwise:

1. "Active participation" means:

   a. Attendance at a formal meeting of a professional insurance association at which a formal business program is presented;

   b. Service on the board of directors or a formal committee of a professional insurance association and involvement in the activities of the board or committee; or

   c. Participation in industry, regulatory, or legislative meetings held by or on behalf of a professional insurance association.

2. "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

~~2.~~3. "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains the producer's principal place of residence or principal place of business and is licensed to act as an insurance producer.

~~3.~~4. "Insurance" means any of the lines of authority in section 26.1-26-11.

~~4.~~5. "Insurance consultant" means a person that, for a fee, holds oneself or itself out to the public as engaged in the business of offering any advice, counsel, opinion, or service with respect to the benefits, advantages, or disadvantages promised under any insurance policy that could be issued in this state.

~~5.~~6. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

~~6.~~7. "Insurer" means all types of insurance companies as well as prepaid legal services organizations and health maintenance organizations.

~~7.~~8. "License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurance carrier.

~~8.~~9. "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

~~9.~~10. "Person" means an individual or a business entity.

~~10.~~11. "Professional insurance association" means a state or national membership organization that offers courses, lectures, seminars, or other instructional programs certified by the commissioner as approved continuing education activities pursuant to section 26.1-26-31.3; is organized as an association or corporation for the express purpose of promoting the interests of insurance licensees in this state or nationally; and is based on paid membership renewable annually or biennially for a membership fee.

12. "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

~~11.~~13. "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

~~12.~~14. "Surplus lines insurance producer" means a person that sells, solicits, negotiates, or procures an insurance policy from an insurer not licensed to transact business in this state which cannot be procured from an insurer licensed to do business in this state.

~~13.~~15. "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

~~14.~~16. "Uniform application" means the current version of the national association of insurance commissioners uniform application for resident and nonresident insurance producer licensing.

~~15.~~17. "Uniform business entity application" means the current version of the national association of insurance commissioners uniform business entity application for resident and nonresident business entities.

**SECTION 2.** Section 26.1-26-31.9 of the North Dakota Century Code is created and enacted as follows:

**26.1-26-31.9. Credit for active participation.**

1. For each two-year reporting period, the commissioner may approve up to four hours of continuing education credit earned through active participation, with no more than two hours accepted for each calendar year. One hour of active participation equates to one hour of continuing education credit. A licensee may not use continuing education granted for active participation to satisfy

other continuing education requirements or ethics hours required under section 26.1-26-31.1.

2. If an insurance producer or consultant claims continuing education hours through active participation, the professional insurance association shall verify the claimed active participation. The professional insurance association shall inform the commissioner of participation by the insurance producer or consultant. Upon receipt of participation confirmation the commissioner may accept the claimed continuing education hours.

**SECTION 3. AMENDMENT.** Section 26.1-26-35 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-26-35. Duties of consultant - Agreements.**

An insurance consultant shall serve with objectivity and complete loyalty the interests of the consultant's client alone and to render the client such information, counsel, and service as within the knowledge, understanding, and opinion, in good faith of the licensee, best serves the client's insurance needs and interests. Before rendering ~~any service set forth in subsection 4 of section 26.1-26-02~~services as an insurance consultant, an insurance consultant shall prepare a written agreement on a form approved by the commissioner. The agreement must outline the nature of the work to be performed by the consultant and must state the fee for the work. The consultant and the client shall sign the agreement. The consultant shall retain a copy of the agreement for not less than two years after completion of the services. This copy must be available to the commissioner.

Approved March 6, 2019

Filed March 7, 2019

# CHAPTER 238

# HOUSE BILL NO. 1144

(Representatives Keiser, Kasper)

AN ACT to create and enact section 26.1-26-04.1 of the North Dakota Century Code, relating to fees for insurance services.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Section 26.1-26-04.1 of the North Dakota Century Code is created and enacted as follows:

**26.1-26-04.1. Fees for services - Rules.**

1. Notwithstanding any other provision of this title, an insurance producer may charge a fee for any services rendered in connection with the sale, solicitation, negotiation, placement, or servicing of an insurance contract, if the following conditions are met:

   a. The fees may not be charged on a personal lines account, such as personal homeowners and automobile, personal life, and health insurance.

   b. Before rendering the services and accepting any payment, a written disclosure must be provided to the party to be charged on a form approved by the commissioner disclosing:

      (1) The nature of the services for which the fees will be charged along with a separate itemization of the amount of the fees;

      (2) That the fees are charged in addition to any premiums paid;

      (3) That if the insurance producer is also an appointed agent of an insurer with which coverage is being considered for placement, a statement that the insurance producer also represents the insurer in the transaction and owes a duty of loyalty to the insurer; and

      (4) That if the insurance producer is to receive a commission from the sale of an insurance policy related to the services rendered, a statement clearly and completely disclosing that the:

         (a) Insurance producer will receive a commission from the insurer which is paid from the premiums owed for the insurance; and

         (b) Amount of commission received by the insurance producer may differ depending on the product sold and the insurer.

   c. The disclosure required by this section must be signed and dated by both the producer and the party to be charged.

   d. The producer shall retain the signed disclosure required by this section for not less than five years following the completion of the service. A copy of

the signed disclosure must be available to the commissioner for inspection upon request.

e. The insurance producer may not pay or return, or offer to pay or return, all or part of a fee charged as an inducement to purchase a specific policy, or coverage within a policy, or coverage from a particular insurer.

f. Any fee charged under this section must bear a reasonable relationship to the services provided and may not be discriminatory.

2. An insurance producer charging a fee for services rendered for risk management services under this section owes the person to be charged a higher standard of care than the ordinary standard of care otherwise owed by an insurance producer to fully advise the party to be charged as to the party's insurance needs, including the duty to inform the person to be charged as to a potential source of risk and to recommend, if available, insurance coverage for that risk.

3. An insurance producer may charge an individual, for personal or commercial lines, a fee for paying agency-billed premiums and fees by credit card or other electronic means, if the fee is disclosed to the client in writing and agreed to by the client in writing.

4. The commissioner may adopt rules determined necessary by the commissioner for the administration of this section.

Approved March 28, 2019

Filed March 29, 2019

# CHAPTER 239

# HOUSE BILL NO. 1219

(Representative Keiser)

AN ACT to create and enact chapter 26.1-26.8 and chapter 26.1-39.2 of the North Dakota Century Code, relating to public adjuster licensing and to contracts between insured homeowners and residential contractors; to amend and reenact subdivision mm of subsection 2 of section 12-60-24 of the North Dakota Century Code, relating to criminal history record checks; and to provide a penalty.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

[103] **SECTION 1. AMENDMENT.** Subdivision mm of subsection 2 of section 12-60-24 of the North Dakota Century Code is amended and reenacted as follows:

mm. The insurance department for criminal history record checks authorized under ~~chapter~~chapters 26.1-26 and 26.1-26.8.

**SECTION 2.** Chapter 26.1-26.8 of the North Dakota Century Code is created and enacted as follows:

**26.1-26.8-01. Scope.**

This chapter governs the qualifications and procedures for licensing public adjusters in this state and specifies the duties of and restrictions on public adjusters, including limitation of licensure to assisting only insureds with first-party claims.

**26.1-26.8-02. Definitions.**

As used in this chapter:

1. "Business entity" has the same meaning as provided in section 26.1-26-02.
2. "Department" means the insurance department.
3. "Home state" means the state in which the principal place of residence or principal place of business of the public adjuster is located.
4. "Insured" means a person insured under the insurance policy against which the claim is made.
5. "Public adjuster" means a person that, for compensation, does the following:
   a. Acts for or aids an insured in negotiating for or effecting the settlement of a first-party claim for loss or damage to real or personal property of the insured;

[103] Section 12-60-24 was also amended by section 1 of House Bill No. 1074, chapter 102, section 1 of House Bill No. 1084, chapter 100, section 1 of House Bill No. 1102, chapter 404, section 2 of House Bill No. 1349, chapter 61, and section 1 of House Bill No. 1376, chapter 101.

b. Advertises for employment as a public adjuster of first-party claims or otherwise solicits business or represents to the public the person is a public adjuster of first-party claims for loss or damage to real or personal property of an insured; or

c. Solicits the business of investigating or adjusting losses or of advising an insured about first-party claims for loss or damage to real or personal property of the insured.

6. "Uniform business entity application" means the uniform business entity application prescribed by the commissioner which conforms substantially to the uniform business entity application for resident and nonresident business entities adopted by the national association of insurance commissioners.

7. "Uniform individual application" means the uniform individual application prescribed by the commissioner which conforms substantially to the uniform application for individual adjuster licensing adopted by the national association of insurance commissioners.

**26.1-26.8-03. License required - Penalty.**

1. A person may not operate as or represent that the person is a public adjuster in this state unless the person is licensed as a public adjuster in accordance with this chapter.

2. A public adjuster may not misrepresent to an insured the public adjuster is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster.

3. A public adjuster may not solicit or enter an agreement for the repair or replacement of damaged property on which the public adjuster has engaged to adjust or settle claims for losses or damages of the insured.

4. Except as provided in subsection 1, licensure as a public adjuster is not required for:

a. An attorney admitted to practice in this state, in the course of acting in the attorney's professional capacity as an attorney;

b. A person that negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

c. An individual employed for the limited purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including a photographer, estimator, private investigator, engineer, or handwriting expert;

d. A licensed health care provider, or an employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient; or

e. A person that settles subrogation claims between insurers.

5. A person willfully violating subsection 1 or 2 is guilty of a class C felony.

**26.1-26.8-04. Application for resident license.**

An individual applying for a resident public adjuster license shall submit to the commissioner a completed uniform individual application and declare under penalty of denial, 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. The commissioner shall approve the application if the commissioner determines the individual:

1. Is at least eighteen years of age;

2. Has a principal place of residence or principal place of business in this state;

3. Has not committed an act that is a ground for denial, suspension, or revocation set forth in section 26.1-26.8-10;

4. Has paid the resident licensing fee, not to exceed one hundred dollars, prescribed by the commissioner;

5. Except as otherwise provided in this chapter, has passed the examinations required by section 26.1-26.8-07;

6. Is trustworthy, reliable, and of good reputation;

7. Is financially responsible to exercise the license and has provided proof of financial responsibility, as required in section 26.1-26.8-11;

8. Maintains an office in this state, with public access to the office by reasonable appointment or regular business hours; and

9. Has completed a criminal history record check as provided in section 12-60-24.

   a. All costs associated with the criminal history record check under this section are the responsibility of the applicant.

   b. This subsection does not apply to license continuation under section 26.1-26.8-09 or to an individual who applies for a public adjuster license within twelve months following the cancellation or expiration of a valid resident public adjuster license issued by the department, unless the license was suspended or revoked.

   c. The commissioner may make arrangements, including contracting with an outside service, for the collection and transmission of fingerprints for conducting criminal history record checks.

**26.1-26.8-05. Nonresident license reciprocity.**

1. An individual applying for a nonresident public adjuster license shall apply to the commissioner in the manner prescribed by the commissioner and declare under penalty of denial, 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. The commissioner shall approve the application if the commissioner determines the applicant:

   a. Is licensed as a resident public adjuster and in good standing in the individual's home state and the home state awards nonresident public

adjuster licenses to residents of this state on the same basis as provided for in this chapter; and

b. Has paid the nonresident licensing fee, not to exceed one hundred dollars, prescribed by the commissioner.

2. The commissioner may verify the licensing status of a nonresident public adjuster through the producer database maintained by the national association of insurance commissioners, or the association's affiliates or subsidiaries.

3. As a condition to continuation of a nonresident public adjuster license, a nonresident public adjuster shall maintain a resident public adjuster license in good standing in the individual's home state.

4. A licensed nonresident public adjuster shall surrender immediately to the commissioner the individual's nonresident public adjuster license and the commissioner shall terminate the individual's nonresident public adjuster license if the home state public adjuster license terminates for any reason, unless the individual has been issued a license as a resident public adjuster in a new home state and the new home state has reciprocity with this state. A licensed nonresident public adjuster shall notify the commissioner of a change to a new home state as soon as possible, but no later than thirty days after receiving a license as a resident public adjuster from the new home state. The licensed nonresident public adjuster shall include both the new and the old addresses in the notice to the commissioner.

**26.1-26.8-06. License required for business entity.**

1. A business entity acting as a public adjuster in this state must be licensed as a public adjuster. A business entity applying for a public adjuster license shall submit to the commissioner a completed uniform business entity application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the knowledge and belief of the entity. The commissioner shall approve the application if the commissioner determines the applicant:

   a. Has paid the business entity licensing fee, not to exceed one hundred fifty dollars, prescribed by the commissioner; and

   b. Has designated a resident public adjuster or a nonresident public adjuster licensed pursuant to this chapter to be responsible for compliance with the insurance laws, rules, and regulations of this state for the business entity.

2. The commissioner may require additional documents be submitted that are reasonably necessary to verify the information contained in an application pursuant to this section.

**26.1-26.8-07. Examination.**

1. An individual applying for a resident public adjuster license shall pass a written examination, unless exempt pursuant to section 26.1-26.8-08. The examination must test the individual's knowledge concerning the duties and responsibilities of a public adjuster and the insurance laws and regulations of this state and be conducted as prescribed by the commissioner.

2. The commissioner may make arrangements, including contracting with an outside testing service, for administering the written examination required pursuant to subsection 1 and collecting the nonrefundable fee as prescribed by the commissioner as set forth in section 26.1-01-07.

3. An individual applying for examination shall remit a nonrefundable fee as prescribed by the commissioner as set forth in section 26.1-01-07.

4. An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination if the individual remits all required fees and forms before being rescheduled for another examination.

**26.1-26.8-08. Exemptions from examination.**

1. An individual who applies for a resident public adjuster license in this state who was previously licensed as a public adjuster in another state is not required to complete an examination. This exemption is available only if:

   a. The applicant is currently licensed in another state; or

   b. The commissioner receives the application within ninety days of the cancellation of the applicant's previous license and the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in the state or the state's public adjuster database records, maintained by the national association of insurance commissioners or the association's affiliates or subsidiaries, indicate the applicant is or was licensed in good standing.

2. To become a resident licensee pursuant to section 26.1-26.8-04, an individual licensed as a public adjuster in another state who moves to this state shall apply within ninety days of establishing legal residence in this state. An examination may not be required of that individual to obtain a resident public adjuster license unless the commissioner determines otherwise by rule.

3. If an individual who applies for a resident public adjuster license previously was licensed as either a resident public adjuster or a nonresident public adjuster in this state, the commissioner may not require the individual to complete an examination if:

   a. The application is received within twelve months of the termination of the previous license in this state; and

   b. At the time of the termination, the applicant was in good standing in this state.

**26.1-26.8-09. License - Renewal - Reinstatement.**

1. The commissioner shall issue a resident public adjuster license or nonresident public adjuster license to an individual who meets the necessary requirements of this chapter.

   a. A resident public adjuster license and a nonresident public adjuster license expire on the last day of the month of the licensed public adjuster's birthday following the two-year anniversary of issuance of a license by the commissioner.

b. To renew a license, a licensed resident public adjuster and a licensed nonresident public adjuster shall file a biennial license continuation in the form and manner prescribed by the commissioner and pay a fee of twenty-five dollars. The commissioner shall give a licensee at least sixty days' notice of the biennial license continuation filing deadline. A resident public adjuster or a nonresident public adjuster who allows the license to lapse may, within the twelve-month period immediately following the expiration date, reinstate the same license without the necessity of passing a written examination, upon payment of a reinstatement fee, not to exceed one hundred twenty-five dollars, prescribed by the commissioner in addition to the renewal fee.

c. The commissioner may grant an individual licensee who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, including a long-term medical disability, a waiver of an examination requirement or a fine, fee, or sanction imposed for failure to comply with renewal procedures.

2. The commissioner shall issue a business entity public adjuster license to a business entity that meets the necessary requirements of this chapter.

a. A business entity public adjuster license expires on the two-year anniversary of issuance of a license by the commissioner.

b. To renew a license, a licensed business entity public adjuster shall file a biennial license continuation in the form and manner prescribed by the commissioner.

c. A business entity public adjuster license may be renewed within the ninety-day period immediately preceding the expiration date upon payment of the renewal fee, not to exceed one hundred fifty dollars, prescribed by the commissioner. A business entity public adjuster that allows the license to lapse may, within the thirty-day period immediately following the expiration date, renew the same license upon payment of a late renewal fee, not to exceed one hundred twenty-five dollars, prescribed by the commissioner in addition to the renewal fee.

d. A business entity public adjuster license renewed within the thirty-day period immediately following the expiration date pursuant to this section is deemed to have been renewed before the expiration date.

3. A license issued pursuant to this chapter must contain the licensee's name, address, and license number; the date of issuance; the lines of authority; the expiration date; and any information the commissioner deems necessary.

4. Within thirty days after the change, a licensee shall inform the commissioner, by any means acceptable to the commissioner, of a change of legal name, address, or other information submitted on the application.

a. A licensee who fails to provide this notification of change is subject to a fine by the commissioner of not more than five hundred dollars per violation, suspension of the license until the change is reported to the commissioner, or both.

b. A licensee doing business under a name other than the licensee's legal name shall notify the commissioner before using the assumed name.

5. A licensee is subject to the provisions of chapter 26.1-04.

6. A licensee shall report to the commissioner any administrative action taken against the licensee in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. The report must include a copy of the order, consent to order, or other relevant legal documents.

7. Within thirty days after a criminal conviction, a licensee shall report to the commissioner any criminal conviction of the licensee taken in any jurisdiction. The report must include a copy of the initial complaint, the order issued by the court, and any other relevant legal documents.

8. The commissioner may contract with nongovernmental entities, including the national association of insurance commissioners, or affiliates or subsidiaries the national association oversees, to perform ministerial functions, including the collection of fees, related to the administration of this chapter.

9. The commissioner may adopt rules establishing license renewal procedures.

**26.1-26.8-10. License denial, nonrenewal, or revocation - Penalty.**

1. The commissioner may suspend, revoke, or refuse to issue or renew a resident public adjuster license, nonresident public adjuster license, or business entity public adjuster license or may levy an administrative fine in accordance with subsection 4, or a combination of those actions, for the following causes:

   a. Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

   b. Violating any provision of this title or violating a rule, regulation, subpoena, or order of the commissioner or another state's insurance commissioner;

   c. Obtaining or attempting to obtain a license through misrepresentation or fraud;

   d. Improperly withholding, misappropriating, or converting money or property received in the course of doing business;

   e. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

   f. Having been convicted of a felony or a class A or B misdemeanor;

   g. Having admitted or been found to have committed an insurance unfair trade practice, an unfair claims settlement practice, or fraud;

   h. Using fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere or failing to comply with section 26.1-26.8-15;

i. Having an insurance or public adjuster license, or its equivalent, denied, suspended, placed on probation, or revoked in this state or in another state, province, district, or territory;

j. Forging another person's name to an application for insurance or to a document related to an insurance transaction;

k. Improperly using notes or other reference materials to complete an examination for an insurance license;

l. Knowingly accepting insurance business from a person that is not licensed;

m. Failing to comply with an administrative or court order imposing a child support obligation;

n. Failing to pay state income tax or comply with an administrative or court order directing payment of state income tax; or

o. Failing to maintain in good standing a resident license in the public adjuster's home state.

2. If the commissioner does not renew or denies an application for a public adjuster license, the commissioner shall notify the applicant or licensee and advise, in writing, the reason for the denial or nonrenewal of the license. Within thirty days of nonrenewal or denial, the applicant or licensee may make written demand upon the commissioner for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing must be held pursuant to chapter 28-32.

3. A business entity public adjuster license may be suspended, revoked, or denied if the commissioner finds, after notice and hearing, that a violation committed by an individual licensee providing services through the business entity was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the business entity and the violation neither was reported to the commissioner nor was corrective action taken in relation to the violation.

4. In addition to or in lieu of an applicable denial, suspension, or revocation of a license, a person violating this chapter may, after notice and hearing, be subject to an administrative fine of not more than ten thousand dollars per violation. A fine may be enforced in the same manner as civil judgments. A person charged with a violation of this chapter may waive the right to a hearing and consent to the discipline the commissioner determines is appropriate. Chapter 28-32 governs all hearings held pursuant to this subsection.

5. The commissioner may enforce this chapter and impose a penalty or remedy authorized by this chapter against a person under investigation for or charged with a violation of this chapter even if the person's license has been surrendered or lapsed by operation of law. A disciplinary proceeding may not be instituted against a person after three years from the termination of the person's license.

**26.1-26.8-11. Proof of bond or insurance.**

1. At the time of issuance of a resident public adjuster license or a nonresident public adjuster license and for the duration of the license, an applicant shall maintain a surety bond or proof of insurance satisfactory to the commissioner for the use and benefit of the commissioner for insureds that have remitted fees, retainers, compensation, deposits, or other things of value to the public adjuster in the course of the public adjuster's business. The bond:

   a. Must be a minimum of twenty thousand dollars; and

   b. May not be terminated by the surety company or public adjuster unless written notice has been filed with the commissioner and submitted to the public adjuster at least sixty days before the termination.

2. The commissioner may request the evidence of financial responsibility at any time the commissioner deems relevant.

3. A public adjuster immediately shall notify the commissioner if evidence of financial responsibility terminates or becomes impaired. The authority to act as a public adjuster automatically terminates if the evidence of financial responsibility terminates or becomes impaired.

**26.1-26.8-12. Continuing education.**

1. Except as otherwise provided in this section, an individual who holds a resident public adjuster license or a nonresident public adjuster license shall satisfactorily complete a minimum of twenty-four credits of continuing education, including three credits of ethics, reported on a biennial basis in conjunction with the license renewal cycle. Credits for continuing education courses attended in any one year over the minimum number of hours of education required, not to exceed twelve hours, may be credited to the year next preceding the year in which the credits were earned or to the year next following the year in which the credits were earned. Report of continuing education must be made at the end of a two-year period. The commissioner may provide a one-time extension of the two-year reporting requirement, not to exceed thirty-six months, if additional time is necessary to implement the transition to reporting continuing education by birth month.

2. The requirements of subsection 1 do not apply to a nonresident public adjuster who has met the continuing education requirements of the adjuster's home state and whose home state gives credit to residents of this state on the same basis.

3. The commissioner shall provide by rule for reporting by birth month of compliance with the continuing education requirements of this section.

4. The commissioner shall adopt by rule criteria for the accreditation of courses for continuing education. Applications for accreditation of a continuing education course offered in this state must be submitted to the commissioner within the time provided by rule and on forms established by rule and with a fee of fifty dollars. The commissioner shall make a final determination as to accreditation and assignment of credit-hours for continuing education courses.

**26.1-26.8-13. Contract between public adjuster and insured.**

1. A contract for a public adjuster's services must be in writing and contain the following terms:

a. Legible full name of the public adjuster signing the contract, as specified in commissioner records;

b. Home state, business address, and telephone number;

c. Public adjuster license number;

d. Title of "Public Adjuster Contract";

e. Insured's full name and street address, insurer name, and insurance policy number, if known or upon notification;

f. Description of the loss and the location of the loss, if applicable;

g. Description of services to be provided to the insured;

h. Signatures of the public adjuster and the insured;

i. The date the contract was signed by the public adjuster and the date the contract was signed by the insured;

j. Attestation language stating the public adjuster is fully bonded pursuant to state law; and

k. The specific amount of compensation, including the full salary, fee, commission, or other consideration the public adjuster is to receive for services.

2. The contract may specify the public adjuster must be named as a copayee on an insurer's payment of a claim.

3. If the compensation is based on a share of the insurance settlement, the exact percentage must be specified in the contract.

4. Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment must be specified by type and the dollar estimates must be set forth in the contract. Additional expenses must be approved in writing by the insured.

5. Compensation provisions in a public adjuster contract may not be redacted in a copy of the contract provided to the commissioner.

6. If the insurer, not later than three days after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster:

a. May not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim;

b. Shall inform the insured the loss recovery amount might not be increased by the insurer; and

c. Is entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the

claim is paid or the insured receives a written commitment to pay from the insurer.

7. A public adjuster contract may not contain a contract term that:

   a. Allows for balance billing of the insured;

   b. Allows a percentage fee to be collected by the public adjuster if money is due from an insurer, but not paid, or allows a public adjuster to collect the entire fee from the first check issued by an insurer, rather than a percentage of each check issued by an insurer;

   c. Requires the insured to authorize an insurer to issue a check only in the name of the public adjuster;

   d. Imposes collection costs or late fees; or

   e. Precludes a public adjuster from pursuing civil remedies.

8. Before the signing of the contract the public adjuster shall provide the insured with a separate disclosure document regarding the claim process which states:

   a. Property insurance policies obligate the insured to present a claim to the insurer for consideration.

   b. The following three types of adjusters could be involved in the claim process:

      (1) "Company adjuster" means an insurance adjuster who is an employee of an insurer. A company adjuster represents the interest of the insurer, is paid by the insurer, and will not charge the insured a fee.

      (2) "Independent adjuster" means an insurance adjuster who is hired on a contract basis by an insurer to represent the interest of the insurer in the settlement of the claim. An independent adjuster is paid by the insurer and will not charge the insured a fee.

      (3) "Public adjuster" means an insurance adjuster who does not work for an insurer. A public adjuster works for the insured to assist in the preparation, presentation, and settlement of the claim. The insured hires a public adjuster by signing a contract agreeing to pay a fee or commission based on a percentage of the settlement or other method of compensation.

   c. The insured is not required to hire a public adjuster to help the insured meet the insured's obligations under the policy, but has the right to do so.

   d. The insured has the right to initiate direct communications with the insured's attorney, the insurer, the company adjuster, and the insurer's attorney, or any person regarding the settlement of the insured's claim.

   e. The public adjuster is not a representative or employee of the insurer.

f. The salary, fee, commission, or other consideration to be paid to a public adjuster is the obligation of the insured, not the insurer.

9. The contract must be executed in duplicate to provide an original contract to the public adjuster and to the insured. The original contract retained by the public adjuster must be available at all times for inspection without notice by the department.

10. The public adjuster shall provide the insurer a notification letter signed by the insured, authorizing the public adjuster to represent the insured's interest. The notification letter must include a copy of the signed contract.

11. The public adjuster shall give the insured written notice of the insured's rights as provided in this section.

12. Within three days after the claim is submitted to the insurer, the insured has the right to rescind the contract. The rescission must be in writing and mailed or delivered to the public adjuster at the address in the contract within the three business-day period.

13. If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract must be returned to the insured within fifteen days following the receipt by the public adjuster of the rescission notice.

14. The commissioner may require a public adjuster to file a contract with the department in a manner prescribed by the commissioner.

**26.1-26.8-14. Record retention.**

1. A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this section include:

   a. The name of the insured;

   b. The date, location, and amount of the loss;

   c. A copy of the contract between the public adjuster and the insured;

   d. The name of the insurer, amount, expiration date, and policy number for each policy carried with respect to the loss;

   e. An itemized statement of the amount recovered for the insured;

   f. An itemized statement of all compensation received by the public adjuster, from any source, in connection with the loss;

   g. A register of all money received, deposited, disbursed, or withdrawn in connection with a transaction with an insured, including fees, transfers, and disbursements from a trust account and all transactions concerning all interest-bearing accounts;

   h. The name of the public adjuster who executed the contract;

   i. The name of the attorney representing the insured, if applicable, and the name of the claims representative of the insurer; and

j. Evidence of financial responsibility in a format prescribed by the commissioner.

2. A public adjuster shall maintain the records for at least six years after the termination of the transaction with an insured and shall open the records to examination by the department at all times.

**26.1-26.8-15. Standards of conduct of public adjuster.**

1. A public adjuster shall serve with objectivity and complete loyalty to the interest of the insured and in good faith shall render to the insured such information, counsel, and service, as within the knowledge, understanding, and opinion of the public adjuster will best serve the insurance claim needs and interest of the insured.

2. A public adjuster may not solicit or attempt to solicit an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

3. A public adjuster may not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under this chapter.

4. A public adjuster may not have a financial interest in any aspect of the claim, other than the salary, fee, commission, or other consideration established in the written contract with the insured. A financial interest includes ownership of, employment by, or other consideration received from an individual or business entity that performs work pertaining to damage related to the insured loss.

5. A public adjuster may not acquire an interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer.

6. A public adjuster may not refer or direct the insured to obtain needed repairs or services in connection with a loss from a person:

   a. With which the public adjuster has a financial interest; or

   b. From which the public adjuster may receive compensation or other consideration for the referral.

7. A public adjuster may not undertake the adjustment of a claim if the public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage or if the loss or coverage otherwise exceeds the current expertise of the public adjuster.

8. A public adjuster may not knowingly make a false oral or written material statement regarding a person engaged in the business of insurance to an insured client or potential insured client.

9. A public adjuster, while licensed pursuant to this chapter, may not represent or act as a company adjuster or independent adjuster in any circumstance.

10. A public adjuster may not enter a contract or accept a power of attorney that vests in the public adjuster the effective authority to choose the person that will perform repair work.

11. A public adjuster may not agree to a loss settlement without the insured's knowledge and consent.

**26.1-26.8-16. Public adjuster fees.**

1. A public adjuster may charge the insured a reasonable fee for public adjuster services.

2. A person may not accept a commission, service fee, or other valuable consideration for investigating or settling claims in this state if the person is required to be licensed under this chapter and is not licensed.

3. A public adjuster may not charge, agree to, or accept as compensation or reimbursement a payment, commission, fee, or other thing of value equal to or more than ten percent of an insurance settlement or proceeds resulting from a catastrophic disaster.

4. A public adjuster may not require, demand, or accept a fee, retainer, compensation, deposit, or other thing of value before settlement of a claim, unless the loss is being handled by the public adjuster on a time-plus-expense basis.

**26.1-26.8-17. Rulemaking authority.**

The commissioner may adopt rules to carry out this chapter.

**26.1-26.8-18. Investigation by commissioner.**

Within a reasonable time after receipt of a properly completed application for a license under this chapter, the commissioner may conduct an investigation and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter the commissioner believes necessary or advisable to determine compliance with this chapter or for the protection of the public.

**26.1-26.8-19. Approval of examination by commissioner - Contents.**

Each examination must be approved for use by the commissioner and must reasonably test the applicant's knowledge as to the policies and transactions to be handled under the license applied for, the duties and responsibilities of the licensee, and the pertinent insurance laws of this state.

**26.1-26.8-20. Vendor authority.**

The commissioner may contract with nongovernmental entities, including the national association of insurance commissioners or any affiliate or subsidiary the national association of insurance commissioners oversees, to perform any ministerial functions, including the collection of fees, related to public adjuster licensing.

**26.1-26.8-21. Commissioner may make examinations and investigations.**

Whenever the commissioner believes this chapter has been violated, the commissioner, at the expense of the public adjuster involved, may examine, at the offices of the public adjuster, whether located within or outside this state, all books, records, and papers of the public adjuster or the company with which the public adjuster is affiliated and any books, records, and papers of any insured within this state, and may examine under oath, the officers, managers, and public adjusters or the insured as to the violation.

**26.1-26.8-22. Statute of limitations.**

After the effective date of this Act, a civil action for the recovery of damages resulting from negligence or breach of contract brought against any person licensed under this chapter by any person claiming to have been injured as a result of the providing of public adjusting services or the failure to provide public adjusting services of a licensee may not be commenced in this state unless the action is commenced on or before the earlier of:

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

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

**SECTION 3.** Chapter 26.1-39.2 of the North Dakota Century Code is created and enacted as follows:

**26.1-39.2-01. Definitions.**

As used in this chapter:

1. "Residential contractor" means a person in the business of contracting or offering to contract with an owner or possessor of residential real estate to:

   a. Repair or replace a roof system or perform other exterior repair, replacement, construction, or reconstruction work on residential real estate;

   b. Perform interior or exterior cleanup services on residential real estate; or

   c. Arrange for, manage, or process the work referred to in subdivision a or b.

2. "Residential real estate" means a new or existing building, including a detached garage, constructed for habitation by at least one but no more than four families.

3. "Roof system" includes roof coverings, roof sheathing, roof weatherproofing, and insulation.

**26.1-39.2-02. Contract to be paid from proceeds of property and casualty insurance policy - Right to cancel - Duties.**

1. A person that enters a written contract with a residential contractor to provide goods or services to be paid from the proceeds of a property and casualty insurance policy may cancel the contract before midnight on the later of the fifth business day after the person has:

   a. Entered the written contract; or

   b. Received written notice from the person's insurer that all or part of the claim or contract is not a covered loss under the insurance policy.

2. The written contract must include a statement that the insured homeowner has the right to cancel the contract in accordance with subsection 1.

3. The person seeking to cancel the contract shall evidence the cancellation by giving the residential contractor a signed and dated copy of written notice of the cancellation.

   a. The notice of cancellation may be delivered or mailed to the address of the residential contractor's place of business as stated in the contract.

   b. The notice of cancellation must include a copy of the written notice from the person's insurer, if applicable, to the effect that all or part of the claim or contract is not a covered loss under the insurance policy.

   c. Notice of cancellation given by mail is effective upon deposit in the United States mail, postage prepaid, if properly addressed to the residential contractor.

   d. Notice of cancellation is not required to be in a particular form and is sufficient if the notice indicates the intent of the insured not to be bound by the contract.

4. Within ten days after a contract to provide goods or services to be paid from the proceeds of a property and casualty insurance policy has been canceled by notification pursuant to this section, the residential contractor shall tender to the person canceling the contract any payments, partial payments, or deposits made by the person and any note or other evidence of indebtedness, except if the residential contractor has provided goods or services agreed to by the person in writing to be necessary to prevent damage to the premises, the residential contractor is entitled to be paid the reasonable value of those goods or services. A contract provision to provide goods or services to be paid from the proceeds of a property and casualty insurance policy requiring the payment of a fee that is not for those goods or services is not enforceable against a person that has canceled a contract pursuant to this section.

**26.1-39.2-03. Prohibited acts.**

A residential contractor may not promise to rebate a portion of an insurance deductible as an inducement to the sale of goods or services. A promise to rebate a portion of an insurance deductible includes granting an allowance or offering a discount against the fees to be charged or paying an insured or a person associated with the residential real estate a form of compensation, except for an item of nominal value.

**26.1-39.2-04. Post-loss assignment of rights or benefits.**

A post-loss assignment of rights or benefits to a residential contractor under a property and casualty insurance policy insuring residential real estate is subject to each of the following:

1. The assignment may authorize a residential contractor to be named as a copayee for the payment of benefits under a property and casualty insurance policy covering residential real estate.

2. The assignment must be provided to the insurer of the residential real estate within five business days after execution.

3. The assignment must include a statement that the residential contractor made no assurances the claimed loss will be fully covered by an insurance contract and must include the following notice in capitalized fourteen-point type:

   "YOU ARE AGREEING TO ASSIGN CERTAIN RIGHTS YOU HAVE UNDER YOUR INSURANCE POLICY. THE ITEMIZED DESCRIPTION OF THE WORK TO BE DONE SHOWN IN THIS ASSIGNMENT FORM HAS NOT BEEN AGREED TO BY THE INSURER. PLEASE READ AND UNDERSTAND THIS DOCUMENT BEFORE SIGNING.

   THE INSURER MAY ONLY PAY FOR THE COST TO REPAIR OR REPLACE DAMAGED PROPERTY CAUSED BY A COVERED PERIL, SUBJECT TO THE TERMS OF THE POLICY."

4. The assignment may not impair the interest of a mortgagee listed on the declarations page of the property and casualty insurance policy that is the subject of the assignment.

5. The assignment may not prevent or inhibit an insurer from communicating with the named insured or mortgagee listed on the declarations page of the property and casualty insurance policy that is the subject of the assignment.

6. The assignment must include a statement that the insured homeowner has the right to cancel the assignment in accordance with subsection 1 of section 26.1-39.2-02.

**26.1-39.2-05. Itemized description of work.**

Before commencement of repair or replacement work, a residential contractor shall furnish the insured and insurer with an itemized description of the work to be done and the materials, labor, and fees for repair or replacement of the damaged residential real estate and the total itemized amount agreed to be paid for the work to be performed, except the description may not limit the insured or residential contractor from identifying other goods and services necessary to complete repairs or replacement associated with a covered loss.

**26.1-39.2-06. Notice required.**

A written contract, repair estimate, or work order prepared by a residential contractor to provide goods or services to be paid from the proceeds of a property and casualty insurance policy must include the following notice of the prohibition contained in section 26.1-39.2-03 in capitalized fourteen-point type which must be signed by the named insured and sent to the named insured's insurer before payment of proceeds under the applicable insurance policy:

"IT IS A VIOLATION OF THE INSURANCE LAWS OF NORTH DAKOTA TO REBATE ANY PORTION OF AN INSURANCE DEDUCTIBLE AS AN INDUCEMENT TO THE INSURED TO ACCEPT A RESIDENTIAL CONTRACTOR'S PROPOSAL TO REPAIR DAMAGED PROPERTY. REBATE OF A DEDUCTIBLE INCLUDES GRANTING AN ALLOWANCE OR OFFERING A DISCOUNT AGAINST THE FEES TO BE CHARGED FOR WORK TO BE PERFORMED OR PAYING THE INSURED HOMEOWNER THE DEDUCTIBLE AMOUNT SET FORTH IN THE INSURANCE POLICY.

THE INSURED HOMEOWNER IS PERSONALLY RESPONSIBLE FOR PAYMENT OF THE DEDUCTIBLE. THE INSURANCE FRAUD STATUTES AND

NORTH DAKOTA CRIMINAL STATUTES PROHIBIT THE INSURED HOMEOWNER FROM ACCEPTING FROM A RESIDENTIAL CONTRACTOR A REBATE OF THE DEDUCTIBLE OR OTHERWISE ACCEPTING AN ALLOWANCE OR DISCOUNT FROM THE RESIDENTIAL CONTRACTOR TO COVER THE COST OF THE DEDUCTIBLE. VIOLATIONS MAY BE PUNISHABLE BY CIVIL OR CRIMINAL PENALTIES."

**26.1-39.2-07. Violation of the chapter.**

A contract entered with a residential contractor is void if the residential contractor violates this chapter.

**26.1-39.2-08. Rulemaking authority.**

The commissioner may adopt rules to carry out this chapter.

Approved April 8, 2019

Filed April 9, 2019

# CHAPTER 240

# HOUSE BILL NO. 1391

(Representatives Keiser, Bosch, Dockter, Lefor, Louser, Nathe)
(Senators Burckhard, Klein, Meyer)

AN ACT to create and enact chapter 26.1-26.9 of the North Dakota Century Code, relating to regulation of self-service storage insurance.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Chapter 26.1-26.9 of the North Dakota Century Code is created and enacted as follows:

**26.1-26.9-01. Definitions.**

For purposes of this chapter, unless the context otherwise requires:

1. "Location" means any physical location in this state or any website, call center site, or similar location directed to residents of this state.

2. "Occupant" means the person who rents a space at a self-service storage facility under a rental agreement, or a sublessee, successor, or assignee of the renter.

3. "Owner" means any person who owns, leases, subleases, manages, or operates a self-service storage facility and receives rent from an occupant under a rental agreement.

4. "Personal property" means movable property not affixed to land, including merchandise and household goods.

5. "Rental agreement" means a written agreement between the owner and the occupant which establishes or modifies the terms and conditions of the occupant's use of a space at a self-service storage facility.

6. "Self-service storage facility" means any real property used for renting or leasing individual spaces in which occupants customarily store and remove their personal property. The term does not include a garage used principally for parking motor vehicles; any property of a financial institution which contains vaults, safe deposit boxes, or other receptacles for the purpose and benefit of the financial institution's customers; or a warehouse where warehouse receipts, bills of lading, or other documents of title are issued for the personal property stored.

7. "Self-service storage insurance" means personal property insurance offered in connection with and incidental to the rental of a space at a self-service storage facility and which provides coverage to occupants at the self-service storage facility where the insurance is transacted for the loss of or damage to personal property occurring at the facility or when the property is in transit to or from the facility during the period of the rental agreement.

8. "Supervising entity" means a person that is a licensed insurer or insurance producer appointed by an insurer to supervise the administration of a self-service storage insurance program.

**26.1-26.9-02. Licensure of owners.**

1. An owner shall obtain from the insurance commissioner and hold a limited lines license under this section if the owner sells, solicits, or offers coverage for self-service storage insurance. This section does not require an owner to be licensed solely to display and make available to occupants and prospective occupants brochures and other promotional materials created by or on behalf of an authorized insurer or surplus lines insurer.

2. A limited lines license issued under this section is limited to authorizing an owner and the owner's employees and authorized representatives to sell, solicit, and offer coverage for self-service storage insurance to occupants.

3. A limited lines license issued under this section authorizes an owner and the owner's employees and authorized representatives to sell, solicit, and offer self-service storage insurance coverage at each location at which the owner conducts business.

4. The owner or supervising entity shall maintain a registry of owner locations authorized to sell, solicit, or offer self-service storage insurance coverage in this state. Upon request by the commissioner, and with five days' notice, the owner or supervising entity shall provide the registry to the commissioner for inspection and examination.

5. Notwithstanding any other provision of law, a license issued under this section authorizes the licensee and the licensee's employees and authorized representatives to engage only in activities permitted by this chapter in connection with the business of insurance unless authorized to do so under another license issued by the commissioner.

**26.1-26.9-03. Sale of self-service storage insurance - Requirements.**

1. At every location where self-service storage insurance is offered to occupants, the owner shall make available to occupants brochures or other written or electronic materials that:

   a. Disclose that self-service storage insurance may provide a duplication of coverage already provided by an occupant's homeowner's insurance policy, renter's insurance policy, or other source of coverage.

   b. State the purchase by the occupant of the self-service storage insurance offered by the owner is not required to lease a space at the self-service storage facility.

   c. Provide the actual terms of the self-service storage insurance coverage, or summarize the material terms of the insurance coverage, including:

      (1) The identity of the insurer;

      (2) The identity of the supervising entity, if any;

(3) The amount of any applicable deductible and how the deductible is to be paid;

(4) Benefits of the coverage; and

(5) Key terms and conditions of the coverage.

d. Summarize the process for filing a claim.

e. State an occupant that purchases self-service storage insurance may cancel enrollment for the occupant's coverage at any time, and the person paying the premium shall receive a refund of any applicable unearned premium.

2. The written materials required by this section are not subject to filing or approval requirements with the commissioner.

3. Self-service storage insurance may be provided under an individual policy or a commercial, corporate, group, or master policy. Form, policy, and rate filings for self-service storage insurance must be made with the commissioner in accordance with this chapter and section 26.1-30-19.

4. Eligibility and underwriting standards for occupants electing to purchase self-service storage insurance coverage must be established for the self-service storage insurance program.

5. The owner is exempt from the examination and education requirements in chapter 26.1-26.

**26.1-26.9-04. Authority of owners.**

1. Employees and authorized representatives of an owner may sell, solicit, and offer self-service storage insurance to occupants and are not subject to licensure as an insurance producer under this chapter if:

a. The owner obtains a limited lines license to authorize the owner's employees and authorized representatives to sell, solicit, and offer self-service storage insurance under this chapter.

b. The owner files an acknowledgment with the commissioner in a form and manner directed by the commissioner that the owner's counter sales employees and authorized representatives act on the owner's behalf and the owner is responsible for any representations made by the counter sales employees or authorized representatives relating to the self-service storage insurance offered through the owner. The acknowledgment must state the commissioner may take any administrative action included in this title.

c. The insurer issuing the self-service storage insurance or a supervising entity supervises the development of a training program for employees and authorized representatives of the owner. The training required by this subdivision:

(1) Must be delivered to employees and authorized representatives of the owner who are engaged directly in the activity of selling, soliciting, or offering self-service storage insurance, and the training materials must

be maintained by the owner and made available to the commissioner for inspection upon request.

(2) Must include providing each employee and authorized representative with basic instruction about the self-service storage insurance offered to customers and the disclosures required under section 26.1-26.9-03; and

(3) May be provided in electronic form, provided the owner or supervising entity implements a supplemental education program regarding the self-service storage insurance conducted and overseen by a licensed producer.

d. An employee or authorized representative of an owner may not advertise, represent, or otherwise be held out to the public as a nonlimited lines-licensed insurance producer, unless otherwise licensed.

2. An owner's employees and authorized representatives may not be paid directly by an insurance company, or be paid a commission or any other compensation for the sale of self-service storage insurance. This section does not prevent an owner from including the results of selling, soliciting, or offering self-service storage insurance in an overall performance compensation incentive program for employees and authorized representatives.

3. The owner may bill and collect charges for self-service storage insurance coverage. Any charge to the occupant for coverage not included in the cost of the rental of a space must be separately itemized on the occupant's bill. If the self-service storage insurance coverage is included with the lease of a space, the owner clearly and conspicuously shall disclose to the occupant, on the rental invoice or elsewhere, any self-service storage insurance coverage included with the rental of a space. An owner billing and collecting the charges is not required to maintain the funds in a segregated account if the owner is authorized by the insurer to hold the funds in an alternative manner. All premiums received by an owner from an occupant for the sale of self-service storage insurance must be considered funds held by the owner in a fiduciary capacity for the benefit of the insurer. An owner may receive compensation for billing and collection services.

**26.1-26.9-05. Application for license and fees.**

1. An owner selling, soliciting, or offering self-service storage insurance shall apply to the commissioner.

2. In lieu of providing the information for all officers, directors, and shareholders owning more than ten percent of the applicant, the applicant shall provide the name, residential address, and other information required by the commissioner for an employee or officer of the owner or supervising entity designated by the applicant as the person responsible for the owner's compliance with the requirements of this chapter. However, if the owner derives more than fifty percent of the owner's revenue from the sale of self-service storage insurance, the information required under this subsection must be provided for all officers, directors, and shareholders of record having beneficial ownership of ten percent or more.

3. Each owner licensed under this chapter shall pay to the commissioner a fee as prescribed by the commissioner.

4. An owner selling, soliciting, or offering self-service storage insurance before the effective date of this Act shall apply for licensure within ninety days of the application being made available by the commissioner. An applicant that begins to sell, solicit, or offer self-service storage insurance after the effective date of this Act shall obtain a license before selling, soliciting, or offering self-service storage insurance.

**26.1-26.9-06. Authority of commissioner to investigate.**

Within a reasonable time after receipt of a properly completed application for a license under this chapter, the commissioner may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter the commissioner believes necessary or advisable to determine compliance with this chapter or for the protection of the public.

**26.1-26.9-07. Examination and investigation by commissioner.**

If the commissioner believes this chapter has been violated, the commissioner, at the expense of the insurer involved, may examine, at the offices of the insurer or insurance producer, whether located within or outside this state, all books, records, and papers of the insurer or insurance producer, and may examine under oath, the officers, managers, and insurance producer of the insurer, or the insured, regarding the violation.

**26.1-26.9-08. License suspension, revocation, or refusal - Grounds.**

The commissioner may suspend, revoke, place on probation, or refuse to continue or issue a license issued under this chapter if, after notice to the licensee or applicant and a hearing, the commissioner finds as to the licensee any of the following conditions:

1. A materially untrue statement in the license application.

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

3. The applicant cheated on an examination for an insurance license.

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

5. The applicant or licensee has been convicted of a felony or convicted of an offense, as defined by section 12.1-01-04, determined by the commissioner to have a direct bearing on a person's ability to serve the public as a licensee, or the commissioner finds, after conviction of an offense, the person is not sufficiently rehabilitated under section 12.1-33-02.1.

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

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

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

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

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

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

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

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

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

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

16. The licensee knowingly accepts insurance business from an individual who is not licensed.

17. The applicant or licensee knowingly fails to comply with a court order imposing child support obligation.

18. The applicant or licensee fails to file the required returns or pay the taxes due under chapter 57-38 or comply with a court order directing payment of any income tax or employer income tax withholding imposed by chapter 57-38.

**26.1-26.9-09. Rulemaking authority.**

The commissioner may adopt reasonable rules for the implementation and administration of this chapter.

Approved March 28, 2019

Filed March 29, 2019

# CHAPTER 241

# HOUSE BILL NO. 1468

(Representatives Mock, Beadle, Kasper, Porter, Roers Jones, D. Ruby)
(Senators D. Larson, J. Lee, Mathern, Myrdal, Oban)

AN ACT to create and enact a new section to chapter 26.1-33 of the North Dakota Century Code, relating to life insurance policy disclosures; and to provide for application.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

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

**Life of a child - Disclosure.**

A group life insurance policy issued in this state which insures the life of a newborn child of the certificate holder may not include a provision delaying coverage on the life of the newborn child for a specified period, unless the existence and length of the waiting period is prominently disclosed in the certificate or rider or otherwise disclosed by the group policyholder to a certificate holder at the time the certificate holder becomes eligible or enrolls for the coverage.

**SECTION 2. APPLICATION - NOTIFICATION.** Section 1 of this Act applies to life insurance policies issued in this state after July 31, 2019. The insurance commissioner shall require an insurer with a life insurance policy issued before the effective date of this Act, which contains a waiting period, notify the certificate holder of the existence of that waiting period or notify the group policyholder, which upon receipt of such notice shall notify the certificate holders of the existence of that waiting period.

Approved April 23, 2019

Filed April 24, 2019

# CHAPTER 242

# SENATE BILL NO. 2118

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

AN ACT to create and enact section 26.1-36-49 of the North Dakota Century Code, relating to short-term limited-duration health insurance plans; and to amend and reenact subsections 2 and 3 of section 26.1-36.4-02 of the North Dakota Century Code, relating to short-term limited-duration health insurance plans.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Section 26.1-36-49 of the North Dakota Century Code is created and enacted as follows:

**26.1-36-49. Short-term limited-duration health insurance plans.**

1. As used in this section, "short-term limited-duration health insurance plan" means health insurance coverage provided pursuant to an insurance policy or group certificate of insurance that has an expiration date specified in the policy which is no longer than six months after the original effective date of the policy and, taking into account any renewals or extensions, has a duration of not more than twelve months in total.

2. To the extent other state laws do not conflict with this section, any policy or rider advertised, marketed, or offered as a short-term limited-duration health insurance plan must comply with this section and all other applicable state insurance laws.

3. An insurer issuing a policy or certificate under this chapter shall provide, at the insured's option, for renewal or continuation of coverage. The renewal or continuation of coverage period may not extend for more than twelve months from the original effective date of the policy.

4. An insured may not be subject to additional underwriting at renewal or continuation of coverage and shall remain within the same risk class as of the original effective date of the policy.

5. An insurer shall provide a notice of termination of the policy or certificate to the insured at least fifteen days before renewal or end of the policy term.

6. All marketing materials related to the offering or sale of a short-term limited-duration health insurance plan must be filed with and approved by the commissioner before the plan is offered for sale in this state.

7. Sale of a policy for short-term limited-duration health insurance plan is only allowed through a licensed and properly appointed insurance producer. An insurance producer's signature and identification number must be included on the prospective insured's application.

8. A phone call made to a prospective insured relating to the marketing or sale of a short-term limited-duration health insurance plan must be recorded and maintained by the producer or the insurer for a period of no less than one year after the termination date of the policy.

**SECTION 2. AMENDMENT.** Subsections 2 and 3 of section 26.1-36.4-02 of the North Dakota Century Code is amended and reenacted as follows:

2. "Policy" means any health benefit plan as defined in section 26.1-36.3-01, whether offered on a group or individual basis. The term does not include short-term ~~major medical policies~~limited-duration health insurance plans offered in the individual market.

3. "Short-term limited-duration health insurance plan", except as required by the Health Insurance Portability and Accountability Act of 1996, ~~means a policy or plan providing coverage for one hundred eighty-five days or less~~is defined by section 26.1-36-49.

Approved March 14, 2019

Filed March 14, 2019

# CHAPTER 243

# HOUSE BILL NO. 1106

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

AN ACT to create and enact chapter 26.1-36.7 of the North Dakota Century Code, relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study; to provide an expiration date; and to declare an emergency.

**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 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 against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is 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.

**SECTION 2.** Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

**26.1-36.7-01. Definitions.**

For purposes of this chapter, unless the context otherwise requires:

1. "Association" means the reinsurance association of North Dakota.

2. "Board" means the board of directors of the reinsurance association of North Dakota.

3. "Earned group health benefit plan premiums" means premium owed to an insurer for a period of time during which the insurer has been liable to cover

claims for an insured pursuant to the terms of a group health benefit plan issued by the insurer.

4. "Future losses" means reserves for claims incurred but not reported.

5. "Group health benefit plan" means a health benefit plan offered through an employer, or an association of employers, to more than one individual employee.

6. "Health benefit plan" means any hospital and medical expense-incurred policy or certificate, 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 that pay the costs of or provide medical, surgical, or hospital care.

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

      (1) Coverage only for accident or disability income insurance, or any combination of the two;

      (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 workers' compensation insurance;

      (5) Automobile medical payment insurance;

      (6) Credit-only insurance;

      (7) Coverage for onsite medical clinics;

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

      (9) Self-funded plans.

   b. "Health benefit plan" does not include the following benefits if the benefits 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, or community-based care, or any combination of this care; and

      (3) Other similar limited benefits specified under federal regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

   c. "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 insurance coverage 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 sponsor:

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

(2) Hospital indemnity or other fixed indemnity insurance.

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

(1) Medicare supplement health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 13295ss(g)(1)];

(2) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

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

7. "Individual health benefit plan" means a health benefit plan offered to individuals, other than in connection with a group health benefit plan. The term does not include short-term limited-duration health insurance as defined by section 26.1-36-49.

8. "Insured" means an individual who is insured by a health benefit plan.

9. "Insurer" means an entity authorized to write health benefit plans or that provides health benefit plans in the state. The term includes an insurance company as defined in section 26.1-02-01, a nonprofit health service organization, a fraternal benefit society, and a health maintenance organization.

10. "Member insurer" means an insurer that offers individual health benefit plans and is actively marketing individual health benefit plans in this state.

**26.1-36.7-02. Waiver proposal and application.**

1. The commissioner may develop a proposal for an innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.].

2. On behalf of the state, in accordance with the proposal developed under subsection 1, the commissioner may submit an application to the United States department of health and human services and to the United States secretary of the treasury. The commissioner may implement any federally approved waiver.

**26.1-36.7-03. Reinsurance association of North Dakota.**

1. The reinsurance association of North Dakota is established as a nonprofit legal entity. As a condition of writing health insurance business in this state, an insurer that has issued or administered a group health benefit plan within the

previous twelve months or is actively marketing or administering a group health benefit plan in this state shall participate in the association.

2. The association may begin operation on either:

   a. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the state's innovation waiver application has been approved by the federal government pursuant to section 1332 of the federal Patient Protection and Affordable Care Act [Pub L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.]; or

   b. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the Patient Protection and Affordable Care Act [Pub. L. 111-148] has been repealed, amended, or finally adjudicated by a court of law with jurisdiction over North Dakota as invalid or in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.

3. If the federal funding associated with an approved innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.] is terminated or otherwise discontinued, the commissioner may cease or suspend operations of the reinsurance association of North Dakota beginning on the January first following the date the commissioner notifies the board that federal funding has been terminated or otherwise discontinued.

**26.1-36.7-04. Board of directors.**

1. The association is governed by the board of directors of the reinsurance association of North Dakota.

2. The board consists of the state health officer, 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, one individual from each of the four insurers of the association with the highest annual market share as determined by annual market share reports of health benefit plans provided by the commissioner annually, and two nonvoting members from the insurance department appointed by the commissioner.

3. 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.

4. The costs of conducting the meetings of the association and the board are borne by the association.

5. For cause, the commissioner may remove any board member representing one of the four insurers.

**26.1-36.7-05. Powers and duties of commissioner and board.**

1. The commissioner shall:

   a. Perform all functions necessary for the association to carry out the purposes of this chapter; and

b. Approve any assessments to the insurers writing or otherwise issuing group health benefit plans. A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment.

2. The board shall:

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

b. Schedule and approve independent biennial audits in order to:

(1) Ensure claims are being processed appropriately and only include services covered by the individual health benefit plan for the contracted rates; and

(2) Verify that the assessment base is accurate and that the appropriate percentage was used to calculate the assessment;

c. Approve bylaws and operating rules; and

d. 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 and the members of the board are not liable for any obligations of the association.

**26.1-36.7-06. Assessments against insurers.**

1. For the purpose of providing the funds necessary to carry out the purposes of the association under this chapter, the commissioner shall assess insurers writing or otherwise issuing group health benefit plans based on the insurer's group health benefit plan premium written in this state. The assessment must be paid quarterly within forty-five days of the end of the previous quarter on all earned group health benefit plan premiums for the previous calendar quarter. An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due.

2. The commissioner may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the commissioner. The commissioner may use any reasonable method of estimating an insurer's group health benefit plan premium if the specific number is not reported to the commissioner.

3. Any federal funding obtained by the association must be used to reduce the assessments of insurers writing or otherwise issuing group health benefit plans pursuant to this section.

4. Before April second of each year, the association shall determine and report to the board the association's net gains or net losses for the previous calendar year.

5. Before April sixteenth of each year, the association shall provide an estimate to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

6. Before May second of each year, the board may provide a recommendation to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

7. An insurer may apply to the commissioner for a deferral of all or part of an assessment imposed by the association under this section. The commissioner may defer all or part of the assessment if the commissioner determines the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited from reinsuring any person through the association until such time as the insurer pays the assessments.

8. The board shall use any surplus, including any interest earned on the surplus, to:

   a. Offset future losses;

   b. Reduce future assessments to insurers writing or otherwise issuing group health benefit plans; or

   c. Pay off a line of credit issued pursuant to section 26.1-36.7-07.

9. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the commissioner may use any power granted to the commissioner by this title to collect any unpaid assessment.

**26.1-36.7-07. Bank of North Dakota line of credit.**

The Bank of North Dakota shall extend to the association a line of credit not to exceed twenty-five million dollars. The association shall repay the line of credit from assessments against insurers writing or otherwise issuing group health benefit plans in this state or from other funds appropriated by the legislative assembly. The association may access the line of credit to the extent necessary to provide reimbursements to member insurers as required by this chapter.

**26.1-36.7-08. Reinsurance.**

For claims of an insured which total one hundred thousand dollars to one million dollars incurred per plan year, a member insurer must be reinsured by the association at seventy-five percent of the member insurer's responsibility for claims incurred by the insured pursuant to the terms of an individual's nongrandfathered individual health benefit plan.

**26.1-36.7-09. Reimbursement of member insurer.**

For nongrandfathered individual health benefit plans issued or renewed after the November second preceding to the date the association begins operation, a member insurer may seek reimbursement from the association and the association shall reimburse the member insurer pursuant to the provisions of section 26.1-36.7-08 to

the extent the claims incurred by the insured and submitted by the member insurer to the association are eligible for coverage and reimbursement according to the terms of insured's individual health benefit plan.

**26.1-36.7-10. Rulemaking.**

The commissioner may adopt rules for the implementation and administration of this chapter.

**SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PREMIUM TREND.** During the 2019-20 interim, the legislative management shall study ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution based to reduce costs and may include consideration of whether a strict managed care model might be effective. The legislative management shall report its findings and recommendations, together with any legislation necessary to implement the recommendations, to the sixty-seventh legislative assembly.

**SECTION 4. EXPIRATION DATE.** This Act is effective through December 31, 2021, and after that date is ineffective.

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

Approved April 18, 2019

Filed April 19, 2019

# CHAPTER 244

# HOUSE BILL NO. 1116

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

AN ACT to amend and reenact sections 26.1-38.1-01, 26.1-38.1-02, 26.1-38.1-03, 26.1-38.1-04, 26.1-38.1-05, 26.1-38.1-06, 26.1-38.1-08, 26.1-38.1-09, 26.1-38.1-10, 26.1-38.1-11, 26.1-38.1-13, 26.1-38.1-14, and 26.1-38.1-16 of the North Dakota Century Code, relating to the North Dakota life and health insurance guaranty association; to repeal section 26.1-38.1-17 of the North Dakota Century Code, relating to application of laws to an insolvent insurer; and to provide for application.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

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

**26.1-38.1-01. ~~Scope~~Coverage and limitations.**

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

   a. To persons, except for nonresident certificate holders under group policies or contracts, who, regardless of where they reside, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subdivision b.

   b. To persons who are owners of or certificate holders or enrollees under such policies or contracts other than unallocated annuity contracts and structured settlement annuities, and in each case who:

      (1) Are residents; or

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

         (a) The member insurer that issued such policies or contracts is domiciled in this state;

         (b) The states in which the persons reside have associations similar to the association created under this chapter; and

         (c) The persons are not eligible for coverage by an association in any other state ~~due to the fact that~~because the insurer or the health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

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

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

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

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

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

(2) Is not a resident, and:

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

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

e. This chapter does not provide coverage to:

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

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

(3) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in section 5891(c)(3)(A) of title 26 of the United States Code, regardless of whether the transaction occurred before or after this federal law became effective.

f. This chapter provides coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person may not be provided coverage under this chapter. In determining the application of the provisions of this subdivision in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter must be construed in conjunction with other state laws to result in coverage by only one association.

2. This chapter provides coverage to the persons specified in subsection 1 for policies or contracts of direct, nongroup life insurance, health insurance, which

for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates, or ~~annuity policies or contracts~~annuities, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and supplemental contracts to any of these and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

3. ~~This~~Except for the portion of a policy or contract, including a rider, which provides long-term care or any other health insurance benefits, this chapter does not provide coverage for:

   a. Any portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy owner or contract owner;

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

   c. Any portion of a policy or contract to the extent that the rate of interest on which the portion of the policy or contract is based or to the extent that the rate of interest, crediting of a rate of interest, or similar factor determined by using an index or other external reference stated in the policy or contract which is employed in calculating returns or changes in value:

      (1) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

      (2) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

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

      (1) A multiple employer welfare arrangement as defined in ~~29 U.S.C. 1144~~section 1144 of title 29 of the United States Code;

      (2) A minimum premium group insurance plan;

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

(4) An administrative services only contract;

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

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

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

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

i. A portion of a policy or contract to the extent that the assessments required by section 26.1-38.1-06 with respect to the policy or contract are preempted or otherwise not permitted by federal or state law;

j. An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including:

(1) Claims based on marketing materials;

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

(3) Misrepresentations of or regarding policy or contract benefits;

(4) Extracontractual claims; or

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

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

l. A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which has not been credited to the policy or contract, or as to which the policy owner's or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values

that have been credited and are not subject to forfeiture under this subdivision, the interest or changes in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and is not subject to forfeiture; ~~and~~

m. A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to part C or part D of subchapter XVIII~~,~~ of chapter 7 of title 42 of the United States Code ~~(~~, commonly known as Medicare part C and part D~~)~~, or subchapter XIX of chapter 7 of title 42 of the United States Code; commonly known as Medicaid, or any regulations issued pursuant thereto; and

n. Structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transactions, as defined in section 5891(c)(3)(A) of title 26 of the United States Code, regardless of whether the transaction occurred before or after this federal law became effective.

4. The benefits that the association may become obligated to cover may in no event exceed the lesser of:

a. The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

b. (1) With any respect to one life, regardless of the number of policies, or contracts:

(a) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(b) ~~In~~For health insurance benefits:

[1] One hundred thousand dollars for coverages not defined as disability income insurance or ~~basic hospital, medical, and surgical insurance or major medical insurance~~health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values.

[2] Three hundred thousand dollars for disability income insurance, and three hundred thousand dollars for long-term care insurance.

[3] Five hundred thousand dollars for ~~basic hospital, medical, and surgical insurance or major medical insurance~~health benefit plans.

(c) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(2) With respect to each individual participating in a government retirement benefit plan established under section 401(k), 403(b), or

457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, two hundred fifty thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values.

(3) With respect to each payee of a structured settlement annuity or beneficiary, or beneficiaries of the payee if deceased, two hundred fifty thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

(4) However, in no event shall the association be obligated to cover more than:

(a) An aggregate of three hundred thousand dollars in benefits with respect to any one life under paragraphs 1, 2, and 3 of subdivision b except with respect to the benefits for ~~basic hospital, medical, and surgical insurance and major medical insurance~~health benefit plans under subparagraph b of paragraph 1 of subdivision b, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or

(b) With respect to one owner of multiple nongroup policies of life insurance, whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner.

(5) With respect to either one contract owner provided coverage under ~~subparagraph c of~~ paragraph 2 of subdivision ~~b~~c of subsection 1; or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in paragraph 2 of subdivision b, five million dollars in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case in which one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage must be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event is the association obligated to cover more than five million dollars in benefits with respect to all these unallocated contracts.

(6) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

5. In performing its obligations to provide coverage under this chapter, the association is not required to guarantee, assume, reinsure, reissue, or

perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

6. For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract must be considered the same type of benefits as the related base life insurance policy or annuity contract.

**SECTION 2. AMENDMENT.** Section 26.1-38.1-02 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-02. Definitions.**

As used in this chapter:

1. "Account" means either of the two accounts created under section 26.1-38.1-03.

2. "Association" means the North Dakota life and health insurance guaranty association created under section 26.1-38.1-03.

3. "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed under which an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

4. "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

5. "Called assessment" or "called" when used in the context of assessments means that a notice was issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

6. "Commissioner" means the insurance commissioner of this state.

7. "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 26.1-38.1-01.

8. "Covered contract" or "covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided under this chapter.

9. "Extracontractual claims" include claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney's fees and costs.

10. "Health benefit plan" means any hospital or medical expense policy or certificate, any health maintenance organization subscriber contract, or any other similar health contract. The term does not include:

    a. Accident only insurance;

    b. Credit insurance;

c. Dental only insurance;

d. Vision only insurance;

e. Medicare supplement insurance;

f. Benefits for long-term care, home health care, community-based care, or any combination of these benefits;

g. Disability income insurance;

h. Coverage for onsite medical clinics; or

i. Specified disease, hospital confinement indemnity, or limited health insurance, if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

11. "Impaired insurer" means a member insurer that, after July 1, 1989, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

~~11.~~12. "Insolvent insurer" means a member insurer which, after July 1, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

~~12.~~13. "Member insurer" means any insurer~~, including a nonprofit health service corporation,~~ or health maintenance organization licensed or which holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under section 26.1-38.1-01~~, and~~. The term includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

a. ~~A health maintenance organization;~~

~~b.~~ A fraternal benefit society;

~~c.~~b. A mandatory state pooling plan;

~~d.~~c. A mutual assessment company or other person that operates on an assessment basis;

e. ~~A nonprofit health service corporation that is participating in a reinsurance plan that has been approved by the commissioner as an alternative to participation in the state guaranty association;~~

~~f.~~d. An insurance exchange;

~~g.~~e. An organization that has a certificate or license limited to the issuance of charitable gift annuities under sections 26.1-34.1-01 through 26.1-34.1-07; or

~~h.~~f. Any entity similar to any of the above.

~~13.~~14. "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, incorporated, or any successor thereto.

~~14.~~15. "Owner" of a policy or contract and "policyholder", "policy owner", and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

~~15.~~16. "Person" means any individual, corporation, limited liability company, partnership, association, governmental entity, or voluntary organization.

~~16.~~17. "Plan sponsor" means:

a. The employer in the case of a benefit plan established or maintained by a single employer;

b. The employee organization in the case of a benefit plan established or maintained by an employee organization; or

c. In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

~~17.~~18. "Premiums" means amounts or considerations, by whatever name called, received ~~in any calendar year~~ on covered policies or contracts less returned premiums, considerations, and deposits, and less dividends and experience credits. "Premiums" do not include any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsections 2 and 3 of section 26.1-38.1-01 and except that assessable premium shall not be reduced on account of subdivision c of subsection 3 of section 26.1-38.1-01, relating to interest limitations, and subsection 3 of section 26.1-38.1-01, relating to limitations with respect to any one individual, any one participant, and any one policy or contract owner. "Premiums" do not include:

a. Premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement plan established under section 401(k), 403(b), or 457 of the United States Internal Revenue Code; or

b. With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

~~18.~~19. a. "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors: the state in which the primary executive and administrative headquarters of the entity is located; the state in which the principal office of the chief executive officer of the entity is located; the state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; the state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; the state from which the management of the overall operations of the entity is directed; and in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state is deemed to be the principal place of business of the plan sponsor.

b. The principal place of business of a plan sponsor of a benefit plan described in subdivision c of subsection ~~16~~17 is deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, is deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

~~19.~~20. "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

~~20.~~21. "Resident" means any person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person must be its principal place of business. Citizens of the United States who are residents of foreign countries, or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created under this chapter, are deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

~~21.~~22. "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

~~22.~~23. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

~~23.~~24. "Supplemental contract" means any written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

~~24.~~25. "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

**SECTION 3. AMENDMENT.** Section 26.1-38.1-03 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-03. Creation of the association.**

1. There is created a nonprofit legal entity to be known as the North Dakota life and health insurance guaranty association. All member insurers must be and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under section 26.1-38.1-07 and shall exercise its powers through a board of directors established under section 26.1-38.1-04. For purposes of administration and assessment, the association shall maintain two accounts:

   a. The life insurance and annuity account 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 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.

   b. The health ~~insurance~~ account.

2. The association shall come under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

**SECTION 4. AMENDMENT.** Section 26.1-38.1-04 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-04. Board of directors.**

1. The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The insurer members of the board must be selected by member insurers, subject to the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term by a majority vote of the

remaining board members, for member insurers, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights of the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

2. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

3. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board may not otherwise be compensated by the association for their services.

**SECTION 5. AMENDMENT.** Section 26.1-38.1-05 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-05. Powers and duties of the association.**

1. If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner:

   a. Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer; or

   b. Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision a and assure payment of the contractual obligations of the impaired insurer pending action under subdivision a.

2. If a member insurer is an insolvent insurer, the association, in its discretion, ~~either~~ shall:

   a. ~~Provide the moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to:~~

      ~~(1)~~ Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; ~~or~~

   ~~(2)~~b. Assure payment of the contractual obligations of the insolvent insurer; ~~or~~

   ~~b.~~c. Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

   d. Provide benefits and coverage in accordance with the following provisions:

      (1) With respect to ~~life and health insurance policies and annuities,~~policies and contracts, assure payment of benefits ~~for premiums identical to the~~

~~premiums and benefits, except for terms of conversion and renewability,~~ that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(a) With respect to group policies and contracts, not later than the earlier of the next renewal date under ~~such~~those policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to ~~such~~the policies and contracts.

(b) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under such policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to ~~such~~the policies or contracts.

(2) Make diligent efforts to provide all known insureds, enrollees, or annuitants for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty days' notice of the termination pursuant to paragraph 1 of the benefits provided.

(3) With respect to nongroup ~~life and health insurance~~ policies and ~~annuities~~contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or ~~formerly an~~ annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of paragraph 4, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

(a) In providing the substitute coverage required under this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the commissioner.

(b) Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

(c) The association may reinsure any alternative or reissued policy or contract.

(4) Alternative policies or contracts adopted by the association shall be subject to the approval of the ~~domiciliary insurance~~ commissioner ~~and the receivership court~~. The association may adopt alternative policies

or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(5) Alternative policies or contracts must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy or contract was last underwritten.

(6) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(7) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium must be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the ~~domiciliary insurance~~ commissioner ~~and the receivership court~~.

(8) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date ~~such~~the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association.

3. When proceeding under subsection 2 with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subdivision c of subsection 3 of section 26.1-38.1-01.

4. Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract ~~of~~or substitute coverage terminates the association's obligations under ~~such~~the policy, contract, or coverage under this chapter with respect to ~~such~~the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

5. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association~~, and~~. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding the premium collected by the association. The association is liable for unearned premiums due to policy or contract owners arising after the entry of ~~such~~the order.

6. The protection provided by this chapter does not apply when any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

7. In carrying out its duties under subsection 2, the association may:

   a. Subject to approval by a court in this state, impose permanent policy or contract liens in connection with any guarantee assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest.

   b. Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral or cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

8. A deposit in this state, held according to law or as required by the commissioner for the benefits of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of ~~an~~a member insurer domiciled in this state or in a reciprocal state, under section 26.1-06.1-50, must be paid promptly to the association. The association may retain a portion of any amount received equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association ~~and~~, less the amount retained pursuant to this subsection. Any amount paid to the association ~~less the amount~~and retained by it is treated as a distribution of estate assets pursuant to section 26.1-06.1-43 or similar provision of the state of domicile of the impaired or insolvent insurer.

9. If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection 2, the commissioner shall have the powers and duties of the association under this chapter with respect to insolvent insurers.

10. The association may render assistance and advice to the commissioner, upon request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

11. The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer

concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

12. Any person receiving benefits under this chapter must be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of such rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon such person.

13. The subrogation rights of the association under this section have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

14. In addition to subsections 12 and 13, the association shall have all common-law rights of subrogation and other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to such policy or contract, including, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person originally or by succession responsible for the losses arising from ~~or payment for~~ the personal injury relating to the annuity or payment for the personal injury, except any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code.

15. If subsections 12, 13, and 14 are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portion of the policies or contracts covered by the association. If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts or portion of the policies or contracts covered by the association.

16. In addition to any other rights and powers under this chapter, the association may:

a. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

b. Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 26.1-38.1-06 and to settle claims or potential claims against it;

c. Borrow money to effect the purposes of this chapter and any notes or other evidences of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

d. Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

e. Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

f. Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the ~~power~~powers of a domestic life ~~or~~insurer, health insurer, or health maintenance organization, but in no case may the association issue ~~insurance~~ policies or ~~annuity~~ contracts other than those issued to perform its obligations under this chapter;

g. Organize itself as a corporation or in other legal form permitted by the laws of this state;

h. Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person promptly shall comply with the request; ~~and~~

i. Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which the association provides coverage under this chapter; and

~~i.~~j. Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

17. The association may join an organization of one or more state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

18. At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of the member insurer which accrue on or after this coverage date and which relate to contracts covered in whole or in part by the association under any indemnity reinsurance agreement entered by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer previously and expressly has disaffirmed the reinsurance agreement. The election is effected by a notice to the receiver, rehabilitator, or

liquidator and to the affected reinsurers. If the association makes an election, subdivisions a through d apply with respect to the agreements selected by the association.

a. The association is responsible for all unpaid premiums due under the agreements, for periods both before and after the coverage date, and is responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered, in whole or in part, by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association.

b. The association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part, provided that, upon receipt of any of these amounts, the association is obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of the amount received by the association, over the benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event.

c. Within thirty days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to every item paid by the member insurer or its receiver, rehabilitator, or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. The association or indemnity reinsurer shall pay the net balance due the other within five days of the completion of the aforementioned calculation. If the receiver, rehabilitator, or liquidator received any amounts due the association pursuant to subdivision b, the receiver, rehabilitator, or liquidator shall remit the amounts to the association as promptly as practicable.

d. If the association, within sixty days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association, in whole or in part, the reinsurer may not terminate the reinsurance agreements, to the extent the agreements relate to contracts covered by the association, in whole or in part, and may not set off any unpaid premium due for periods before the coverage date against amounts due the association.

19. If the association transfers its obligations to another insurer, and if the association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subsection 18 effective as of the date agreed by the association and the other insurer and regardless of whether the association made the election, provided that:

a. The indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

b. The obligations described in the proviso to subdivision b of subsection 18 no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third-party insurer; and

c. This subsection does not apply if the association previously expressly determined in writing that it will not exercise the election referred to in subsection 18.

20. Subsections 18 and 19 supersede the provisions of any law of this state or of any affected reinsurance ~~agreement~~contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, rehabilitator, or liquidator, of the insolvent member insurer. The receiver, rehabilitator, or liquidator remains entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods before the coverage date, subject to applicable setoff provisions.

21. Except as otherwise expressly provided in this section, this section does not alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. This section does not abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. This section does not give a policy owner, contract owner, enrollee, certificate holder, or beneficiary an independent claim for relief against an indemnity reinsurer which is not otherwise set forth in the indemnity reinsurance agreement.

22. The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

23. If the association arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

24. Burleigh County is the venue in a course of action against the association arising under this chapter. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

25. ~~Subject to approval of the receivership court, the~~The association, in carrying out association duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections ~~2~~1 and ~~3~~2, may issue substitute coverage for a policy or contract that provides a rate of interest, crediting of a rate of interest, or similar factor determined by using an index or other external reference stated in the policy or contract which is employed in calculating returns or changes in value by issuing an alternative policy or contract if:

a. Instead of the index or other external reference provided for in the ~~replaced~~original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or different method for calculating interest or changes in value;

b. There is no requirement for evidence of insurability, a waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

c. The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

**SECTION 6. AMENDMENT.** Section 26.1-38.1-06 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-06. Assessments.**

1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments must be due not less than thirty days after prior written notice to the member insurers and must accrue interest at eighteen percent per annum on and after the due date.

2. There must be two classes of assessment, as follows:

   a. Class A assessments must be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

   b. Class B assessments must be authorized and called to the extent necessary to carry out the powers and duties of the association under section 26.1-38.1-05 with regard to an impaired or insolvent insurer.

3. The amount of any class A assessment must be determined at the discretion of the board of directors and must be authorized and called on a non-pro rata basis.

4. The amount of any class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes ~~among~~between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

5. The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer must be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

6. Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available

preceding the year in which the member insurer became impaired, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

~~6.~~7. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection 2 and computation of assessments under this section must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

~~7.~~8. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral are removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

~~8.~~9. a. Subject to subdivision b, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account may not in any one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

b. If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision a must be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

c. If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon after as permitted under this chapter.

~~9.~~10. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

~~10.~~11. If the maximum assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection ~~7~~4, the board

shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection ~~8~~9.

~~11.~~12. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future claims.

~~12.~~13. It is proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

~~13.~~14. The association shall issue to each member insurer paying an assessment under this chapter, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

~~14.~~15. a. A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made under protest and must set forth a brief statement of the grounds for the protest.

b. Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

c. Within thirty days after a final decision was made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

d. In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

e. If the protest or appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

~~15.~~16. The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall comply promptly with a request.

**SECTION 7. AMENDMENT.** Section 26.1-38.1-08 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-08. Duties and powers of the commissioner.**

In addition to the duties and powers enumerated elsewhere in this chapter:

1. The commissioner shall:

   a. Upon request of the board of directors, provide the association with a statement of premiums in this and any other appropriate states for each member insurer;

   b. When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer constitutes notice to its shareholders, if any; and the failure of the impaired insurer to promptly comply with such demand does not excuse the association from the performance of its powers and duties under this chapter; and

   c. In any liquidation or rehabilitation proceedings involving a domestic insurer, be appointed as the liquidator or rehabilitator.

2. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact ~~insurance~~business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture may be less than one hundred dollars per month.

3. Any final action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the member's receipt of notice of the final action being appealed. Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state which apply to the action or orders of the commissioner.

4. The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify any interested persons of the effect of this chapter.

**SECTION 8. AMENDMENT.** Section 26.1-38.1-09 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-09. Prevention of insolvencies.**

1. To aid in the detection and prevention of member insurer insolvencies or impairments, it is the duty of the commissioner:

a. To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:

(1) Revokes its license;

(2) Suspends its license; or

(3) Makes any formal order that ~~such company~~the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders, or creditors.

(4) Such notice must be mailed to all commissioners within thirty days following the action taken or the date on which such action occurs.

b. To report to the board of directors when the commissioner has taken any of the actions set forth in subdivision a or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors must contain all significant details of the action taken or the report received from another commissioner.

c. To report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that such insurer may be an impaired or insolvent insurer.

d. To furnish to the board of directors the national association of insurance commissioners insurance ~~regulation~~regulatory information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners and the board may use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein must be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

2. The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers ~~and companies~~of insurers or health maintenance organizations seeking admission to transact ~~insurance~~ business in this state.

3. The board of directors, upon majority vote, may make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any ~~company~~insurer or health maintenance organization seeking to do ~~an insurance~~ business in this state. Such reports and recommendations may not be considered public documents.

4. The board of directors, upon majority vote, may notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

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

**SECTION 9. AMENDMENT.** Section 26.1-38.1-10 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-10. Credits for assessments paid - Tax offsets.**

1. A member insurer may offset against its premium tax liability to this state an assessment described in section 26.1-38.1-06 to the extent of twenty percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its ~~premiums~~premium tax liability for the year it ceases doing business.

2. A member insurer that is exempt from taxes referenced in subsection 1 may recoup that member insurer's assessments by a surcharge on that member insurer's premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the commissioner. Amounts recouped may not be considered premiums for any other purpose, including the computation of gross premium tax, the medical loss ratio, or agent commission. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount must be applied to reduce future assessments in the appropriate account.

3. Any sums ~~which~~that are acquired by refund, pursuant to section 26.1-38.1-06, from the association by member insurers, and which have ~~theretofore~~ been offset against premium taxes as provided in subsection 1, must be paid by ~~such~~the member insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

**SECTION 10. AMENDMENT.** Section 26.1-38.1-11 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-11. Miscellaneous provisions.**

1. This chapter does not reduce the liability for unpaid assessments of the insured of an impaired or insolvent insurer operating under a plan with assessment liability.

2. Records must be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 26.1-38.1-05. The records of the association with respect to an impaired or insolvent insurer may not be disclosed before the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except upon the termination of the impairment or solvency of the member insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the association to render a report of its activities under section 26.1-38.1-12.

3. For the purpose of carrying out its obligations under this chapter, the association must be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any

amounts to which the association is entitled as subrogee pursuant to subsections 12, 13, and 14 of section 26.1-38.1-05. Assets of the impaired or insolvent insurer attributable to covered policies must be used to continue as covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

4. As a creditor of the impaired or insolvent insurer as established in subsection 3 and consistent with chapter 26.1-06, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator, within one hundred twenty days of a final determination of insolvency of ~~an~~a member insurer by the receivership court, does not apply to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association is entitled to apply to the receivership court for approval of its own proposal to disburse these assets.

5. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, ~~any~~contract owners, certificate holders, enrollees, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In making such a determination, consideration must be given to the welfare of the policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

6. No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 26.1-38.1-05 with respect to ~~such~~the member insurer have been fully recovered by the association.

7. a. If an order for liquidation or rehabilitation of ~~an~~a member insurer domiciled in this state has been entered, the receiver appointed under the order has the right to recover on behalf of the member insurer, from any affiliate that controlled its capital stock, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subdivisions b, c, and d.

   b. No such distribution is recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

   c. Any person who was an affiliate that controlled the member insurer at the time the distributions were paid is liable up to the amount of distributions

the person received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared is liable up to the amount of distributions the person would have received if payment had been made immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

d. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

e. If any person liable under subdivision c is insolvent, all its affiliates that controlled it at the time the distribution was paid, are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

**SECTION 11. AMENDMENT.** Section 26.1-38.1-13 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-13. Tax exemptions.**

The association is exempt from payment of all fees and all taxes levied by this state ~~on~~or any of its subdivisions, except taxes levied on real property.

**SECTION 12. AMENDMENT.** Section 26.1-38.1-14 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-14. Immunity.**

There is no liability on the part of and no cause of action of any nature may arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this chapter. ~~Such~~This immunity extends to the participation of any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

**SECTION 13. AMENDMENT.** Section 26.1-38.1-16 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-38.1-16. Prohibited advertisement of Insurance Guaranty Association Act in insurance sales - Notice to policy owners.**

1. No person, including ~~an~~a member insurer, insurance producer, or affiliate of ~~an~~a member insurer, may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by chapter 26.1-38.1. ~~Provided, however, that~~However, this section does not apply to the North Dakota life and health insurance guaranty association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

2. Before January 1, 1990, the association shall prepare a summary document describing the general purposes and current limitations of the chapter and complying with subsection 3. This document should be submitted to the commissioner for approval. Sixty days after receiving approval, no member insurer may deliver a policy or contract to a policy ~~or~~owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy ~~or~~owner, contract owner ~~to or~~, certificate holder, or enrollee at the time of delivery of the policy or contract. The document should also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document does not mean that either the policy or contract or the policy owner ~~thereof would be~~, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document must be revised by the association as amendments to the chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

3. The document prepared under subsection 2 must contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer must:

   a. State the name and address of the life and health insurance guaranty association and insurance department;

   b. Prominently warn the policy owner ~~or~~, contract owner, certificate holder, or enrollee that the North Dakota life and health insurance guaranty association may not cover the policy or contract, or, if coverage is available, it will be subject to substantial limitations and exclusions and be conditioned on continued residence in this state;

   c. State the types of policies or contracts for which guaranty funds will provide coverage;

   d. State that the member insurer and its insurance producers are prohibited by law from using the existence of the North Dakota life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

   e. Emphasize that the policy owner ~~or~~, contract owner, certificate holder, or enrollee should not rely on coverage under the North Dakota life and health insurance guaranty association when selecting an insurer or health maintenance organization coverage;

   f. Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and

   g. Provide other information as directed by the commissioner, including sources for information about the financial condition of insurers provided the information is not proprietary and is subject to disclosure under the state's public records law.

4. A member insurer shall retain evidence of compliance with subsection 2 for so long as the policy or contract for which the notice is given remains in effect.

**SECTION 14. REPEAL.** Section 26.1-38.1-17 of the North Dakota Century Code is repealed.

**SECTION 15. APPLICATION.** This Act applies to an insolvent insurer that is placed under an order of liquidation with a finding of insolvency after July 31, 2019.

Approved March 8, 2019

Filed March 8, 2019

# CHAPTER 245

# HOUSE BILL NO. 1123

(Representatives Schobinger, Kasper, Lefor, Mitskog)
(Senators Klein, Krebsbach, Mathern)

AN ACT to create and enact a new section to chapter 26.1-39 of the North Dakota Century Code, relating to property and casualty insurance risk rating; and to provide for application.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** A new section to chapter 26.1-39 of the North Dakota Century Code is created and enacted as follows:

**Fire protection class - Dispute.**

1. This section applies to an insurance policy issued or renewed to insure real property in this state.

2. Within thirty days following quoting, issuing, or renewing of the policy, the insured may assert a fire protection class which differs from the class identified by the insurer and the insurer shall implement this class. The insured shall present to the insurer a credible basis for the assertion supported by factual information.

3. Within ninety days following receipt of the assertion by an insured, the insurer may investigate the assertion and:

   a. Change the fire protection class, effective from the date of issuance or renewal; or

   b. Document the basis for the original class and implement the original class effective from the date of issuance or renewal.

4. After making a determination under subsection 3, the insurer shall inform the insured of the determination.

**SECTION 2. APPLICATION.** This Act applies to quoting, issuing, or renewing of insurance policies on and after the effective date of this Act.

Approved April 23, 2019

Filed April 24, 2019

# CHAPTER 246

# HOUSE BILL NO. 1140

(Representatives Keiser, Lefor)
(Senator Klein)

AN ACT to amend and reenact subsections 3 and 4 of section 26.1-39-11 and subsections 4 and 5 of section 26.1-40-01 of the North Dakota Century Code, relating to the renewal of an insurance policy with altered terms.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1. AMENDMENT.** Subsections 3 and 4 of section 26.1-39-11 of the North Dakota Century Code are amended and reenacted as follows:

3. "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term. The term includes a change or alteration in the amount of a deductible, coverage, or exclusion which results in substantially equivalent coverage if the altered terms are provided to the insured in the notice of renewal.

4. "Termination" means cancellation or nonrenewal of property insurance coverage in whole or in part. Cancellation occurs during the policy term. Nonrenewal occurs at the end of the policy term as set forth in subsection 3. For purposes of sections 26.1-39-10 through 26.1-39-21, the transfer of a policy between companies within the same insurance holding company system is not a termination. ~~Requiring a reasonable deductible, reasonable changes in the amount of insurance, or reasonable reductions in policy limits or coverage is not considered a termination if the requirements are directly related to the hazard involved and are made on the~~A renewal ~~date for the policy~~with altered terms as provided in subsection 3 is not a termination.

**SECTION 2. AMENDMENT.** Subsections 4 and 5 of section 26.1-40-01 of the North Dakota Century Code are amended and reenacted as follows:

4. "Renewal" or "to renew" means~~:~~

   ~~a.~~ ~~The~~ the issuance and delivery by an insurer of a policy replacing, at the end of the previous policy period, a policy previously issued and delivered by the same insurer;

   ~~b.~~ ~~The~~ the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term; or

   ~~c.~~ ~~The~~ the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium. The term includes a change or alteration in the amount of a deductible, coverage, or exclusion which results in substantially equivalent coverage if the altered terms are provided to the insured in the notice of renewal. Any policy with a policy period or term of less than six

months must be considered as if written for a policy period or term of six months except in case of termination under any of the circumstances specified in subsection 2 of section 26.1-40-05. Any policy written for a term longer than one year or any policy with no fixed expiration date must be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of the policy is deemed a failure to renew.

5. "Termination" means cancellation or nonrenewal of automobile insurance coverage in whole or in part. Cancellation occurs during the policy term. Nonrenewal occurs at the end of the policy term. An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage is not a termination. The transfer of a policy between companies within the same insurance holding company system is not a termination. A renewal with altered terms as provided in subsection 4 is not a termination.

Approved March 20, 2019

Filed March 21, 2019

# CHAPTER 247

# HOUSE BILL NO. 1156

(Representatives Howe, Dockter, K. Koppelman, Schauer)
(Senator Wanzek)

AN ACT to create and enact sections 26.1-39-27 and 26.1-39-28 of the North Dakota Century Code, relating to the inception and termination times of specific insurance and rulemaking authority of the insurance commissioner; and to declare an emergency.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Section 26.1-39-27 of the North Dakota Century Code is created and enacted as follows:

**26.1-39-27. Travel, event, and unmanned aircraft insurance.**

1. As used in this section:

   a. "Event cancellation coverage" means insurance covering the cancellation of an organized event, either public or private, described in the policy, which occurs on a specified date and time.

   b. "Unmanned aircraft" means an aircraft operated without the possibility of direct human intervention from within or on the aircraft.

2. Unless otherwise provided under this title, the following insurance coverages are the only coverages that may cover an insured for a period of time other than beginning at 12:01 a.m. on the day on which coverage begins and ending at 12:01 a.m. on the day of expiration of the policy, as required by section 26.1-30-18:

   a. Travel insurance;

   b. Event cancellation coverage insurance; and

   c. Unmanned aircraft liability insurance.

3. Any insurance policy covering insureds for a period of time other than beginning at 12:01 a.m. on the day on which coverage begins and ending at 12:01 a.m. on the day of expiration of the policy is subject to the provisions of sections 26.1-30-19, 26.1-30-20, and 26.1-30-21.

**SECTION 2.** Section 26.1-39-28 of the North Dakota Century Code is created and enacted as follows:

**26.1-39-28. Rulemaking.**

The commissioner may adopt rules for the implementation and administration of this chapter.

**SECTION 3. EMERGENCY.** This Act is declared to be an emergency measure.

Approved March 12, 2019

Filed March 13, 2019

# CHAPTER 248

# HOUSE BILL NO. 1075

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

AN ACT to amend and reenact sections 26.1-44-02, 26.1-44-03.1, 26.1-44-03.2, 26.1-44-06, 26.1-44-06.1, and 26.1-44-08 of the North Dakota Century Code, relating to surplus lines insurance; and to declare an emergency.

**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. Duty to file evidence of insurance and ~~affidavits~~signed statement.**

1. Each surplus lines producer, ~~within sixty days~~ after the placing of any surplus lines insurance ~~where~~if the insured's home state is this state, shall execute and file a ~~written~~ report of placement, no later than March first for the quarter ending the preceding December thirty-first, June first for the quarter ending the preceding March thirty-first, September first for the quarter ending the preceding June thirtieth, and December first for the quarter ending the preceding September thirtieth of each year, regarding the insurance which must be kept confidential by the commissioner. The report of placement must include:

~~1.~~ a. The name and address of the insured;

~~2.~~ b. The identity of the insurer or insurers;

~~3.A description of the subject and location of the risk;~~

~~4.~~ c. The amount of premium charged for the insurance;

~~5.~~ d. AThe amount of premium tax ~~allocation spreadsheet detailing the portion of premium attributable to properties, risks, or exposures located in each state~~;

~~6.~~ e. Any other pertinent information as the commissioner may reasonably require; and

~~7.~~ f. ~~An affidavit on a~~A signed statement certifying under penalty of law in the form prescribed by the commissioner as to the diligent efforts to place the coverage with admitted insurers and the results of that effort. The ~~affidavit~~signed diligent search statement must be open to public inspection. The ~~affidavit~~signed diligent search statement must affirm that the insured was expressly advised in writing ~~prior to~~before placement of the insurance that:

~~a.~~ (1) The surplus lines insurer with ~~whom~~which the insurance was to be placed is not licensed in this state and is not subject to the state's supervision; and

~~b.~~ (2) In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty fund.

2. A surplus lines producer seeking to place nonadmitted insurance for an exempt commercial purchaser is not required to make a due diligence search or to file the ~~affidavit~~signed diligent search statement in subdivision f of subsection ~~7~~1 if the surplus lines producer has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight and the exempt commercial purchaser has subsequently requested in writing the surplus lines producer to procure or place such insurance from a nonadmitted insurer.

**SECTION 2. AMENDMENT.** Section 26.1-44-03.1 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-44-03.1. Surplus lines tax.**

1. If the insured's home state is this state, ~~in addition to the full amount of gross premiums charged by the insurer for the insurance on properties, risks, or exposures located or to be performed in this state or another state,~~ every surplus lines producer shall ~~collect and~~ pay to the commissioner a sum equal to one and three-fourths percent of the gross premiums charged, assessments, membership fees, subscriber fees, policy fees, and service fees, less any return premiums, for surplus lines insurance provided by the surplus lines producer.

2. The tax on any portion of the premium unearned at termination of insurance having been credited or refunded by the state to the surplus lines producer must be returned to the policyholder directly by the surplus lines producer. The surplus lines producer is prohibited from rebating, for any reason, any part of the tax.

3. At the time of filing the annual tax statement as set forth in section 26.1-44-06.1, each surplus lines producer shall pay the premium tax due for the policies written during the period covered by the annual tax statement.

**SECTION 3. AMENDMENT.** Section 26.1-44-03.2 of the North Dakota Century Code is amended and reenacted 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; and

   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.

**SECTION 4. AMENDMENT.** Section 26.1-44-06 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-44-06. Records of surplus lines producer.**

1. If the insured's home state is this state, each surplus lines producer shall keep in this state a full and true record of each surplus lines insurance contract placed by or through the producer, including a copy of the policy, certificate, cover note, or other evidence of insurance showing each of the following applicable items:

~~1.~~ a. Amount of the insurance, risks, and perils insured;

~~2.~~ b. Brief description of the property insured and its location;

~~3.~~ c. Gross premium charged;

~~4.~~ d. Any return premium paid;

~~5.~~ e. Rate of premium charged upon the several items of property;

~~6.~~ f. Effective date and terms of the contract;

~~7.~~ g. Name and address of the insured;

~~8.~~ h. Name and address of the insurer;

~~9.~~ i. Amount of tax and other sums to be collected from the insured;

~~10.Allocation of taxes by state;~~

~~11.~~ j. Identity of the producer of record;

~~12.~~ k. Any confirming correspondence from the insurer or its representative; and

~~13.~~ l. The application.

2. The surplus lines producer shall keep open the record of each contract at all reasonable times to examination by the commissioner without notice for a period not less than five years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines producer shall make available to the commissioner any and all records that the commissioner deems necessary for examination.

**SECTION 5. AMENDMENT.** Section 26.1-44-06.1 of the North Dakota Century Code is amended and reenacted as follows:

**26.1-44-06.1. Reports and policy changes.**

1. If the insured's home state is this state, ~~before~~no later than March ~~second~~first of each year, each surplus lines producer shall file with the commissioner on forms prescribed by the commissioner an annual tax statement of all surplus lines insurance transacted during the preceding calendar year, including:

   a. Aggregate gross premiums written;

   b. Aggregate return premiums; and

   c. Amount of aggregate tax remitted ~~on risks located or to be performed in this state; and~~

   ~~d. Amount of aggregate tax remitted on risks located or to be performed in another state~~.

2. An annual tax statement is not required to be filed ~~when~~if a surplus lines producer has transacted no surplus lines insurance during the preceding calendar year.

3. a. If the insured's home state is this state, each surplus lines producer shall file with the commissioner in the manner prescribed by the commissioner any surplus lines insurance endorsement, audit, or cancellation as follows:

      (1) After any change to the initial surplus lines insurance placement which changes the insurance premium amount; or

      (2) After the producer obtains knowledge of any change to the initial surplus lines insurance placement which changes the insurance premium amount and the producer is able to provide written proof to the commissioner of the date the producer obtained knowledge of the change.

   b. Any endorsement, audit, or cancellation subject to subdivision a must be filed no later than March first for the calendar quarter ending the preceding

December thirty-first, June first for the calendar quarter ending the preceding March thirty-first, September first for the calendar quarter ending the preceding June thirtieth, or December first for the calendar quarter ending the preceding September thirtieth of each year.

**SECTION 6. 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 report of placement and ~~affidavit~~signed statement, endorsement, audit, cancellation, file annual tax statement, and pay tax - Action for recovery - Revocation of license - Conditions prerequisite to reissuance - Hearing procedure and judicial review.**

1. A surplus lines producer is liable for a fine ~~of~~up to twenty-five dollars for each day of delinquency, not to exceed the sum of five hundred dollars for each failure or refusal to file, if the producer:

   a. Fails or refuses to file the report of placement or ~~affidavit within sixty days~~signed diligent search statement as required under section 26.1-44-02;

   b. Fails or refuses to file the endorsement, audit, or cancellation ~~within sixty days after any change to the initial placement which changes the insurance premium amount, except a surplus lines producer that is able to provide written proof of the date the producer obtained knowledge of the change to the initial placement which changes the insurance premium amount has sixty days from the date the producer obtained knowledge of this change~~as required under section 26.1-44-06.1; or

   c. Fails or refuses to make and file the annual tax statement or pay the tax no later than March first as required under section 26.1-44-06.1~~; or~~

   ~~d. Fails or refuses to pay the taxes required to be paid before the second day of March after such tax is due~~.

2. 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 tax statement, report of placement, endorsement, audit cancellation, or ~~affidavit and~~signed diligent search statement or the payment of the tax was excusable, may waive all or any part of the fine. The commissioner may revoke or suspend the surplus lines producer's license if any surplus lines producer fails to make and file the annual tax 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 or provides false information in the ~~affidavit~~signed diligent search statement referred to in section 26.1-44-02.

3. If the license of a surplus lines producer is revoked, whether by the action of the commissioner or by judicial proceedings, another license may not be issued to that surplus lines 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.

**SECTION 7. EMERGENCY.** This Act is declared to be an emergency measure.

Approved March 8, 2019

Filed March 8, 2019

# CHAPTER 249

# SENATE BILL NO. 2102

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

AN ACT to create and enact chapter 26.1-53.1 of the North Dakota Century Code, relating to discount plans; and to repeal chapter 26.1-53 of the North Dakota Century Code, relating to discount medical plans.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Chapter 26.1-53.1 of the North Dakota Century Code is created and enacted as follows:

**26.1-53.1-01. Definitions.**

For purposes of this chapter, unless the context otherwise requires:

1. "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

2. "Ancillary services" includes audiology, dental, vision, mental health, substance abuse, chiropractic, and podiatry services.

3. "Control", "controlled by", or "under control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by section 26.1-10-04, that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

4. "Direct primary care" means any private contract between a provider and consumer for services associated with that provider.

5. "Discount plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, offers members the access to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount plan from those providers. The term includes a discount prescription drug plan. The term does not include:

a. A plan that does not charge a membership, payment, dues, other consideration, or other fee to use the discount plan;

b. Any product otherwise regulated under title 26.1;

c. Direct primary care;

d. A patient access program; or

e. A Medicare prescription drug plan.

6. "Discount plan organization" means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for discount plan members to providers of medical or ancillary services and the right to receive medical or specialty services from those providers at a discount. It is the organization that contracts with providers, provider networks, or other discount plan organizations to offer access to medical or specialty services at a discount and determines the charge to discount plan members.

7. "Discount prescription drug plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides members the access to providers of pharmacy services and the right to receive discounts on pharmacy services provided under the discount prescription drug plan from those providers.

8. "Facility" means an institution providing medical or ancillary services or a health care setting. The term includes:

a. A hospital or other licensed inpatient center;

b. An ambulatory surgical or treatment center;

c. A skilled nursing center;

d. A residential treatment center;

e. A rehabilitation center; and

f. A diagnostic, laboratory, or imaging center.

9. "Health care professional" means a physician, pharmacist, or other health care practitioner who is licensed, accredited, or certified to perform specified medical or ancillary services within the scope of the professional's license, accreditation, certification, or other appropriate authority consistent with state law.

10. "Health insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or medical or ancillary services.

11. "Marketer" means a person that markets, promotes, sells, or distributes a discount plan, including a private label entity that places the entity's name on and markets or distributes a discount plan pursuant to a marketing agreement with a discount plan organization.

12. "Medical services" means any maintenance care of, or preventive care for, the human body, or care, service, or treatment of an illness or dysfunction of, or injury to, the human body. The term includes physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric services, laboratory services, medical equipment and supplies, pharmacy services, and ancillary services.

13. "Medicare prescription drug plan" means a plan that provides Medicare part D prescription drug benefits in accordance with the requirements of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173].

14. "Member" means any individual who pays fees, dues, charges, or other consideration for the right to receive the benefits of a discount plan or discount prescription drug plan.

15. "Patient access program" means a voluntary program sponsored by a pharmaceutical manufacturer, or a consortium of pharmaceutical manufacturers, which provide free or discounted health care products directly to low-income or uninsured individuals either through a discount card or direct shipment.

16. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

17. "Pharmacy services" includes pharmaceutical supplies and prescription drugs.

18. "Provider" means any health care professional or facility that has contracted, directly or indirectly, with a discount plan organization to provide medical or ancillary services to members.

19. "Provider network" means an entity that negotiates, directly or indirectly, with a discount plan organization on behalf of more than one provider to provide medical or ancillary services to members.

**26.1-53.1-02. Application.**

1. This chapter applies to all discount plan organizations conducting business in this state.

2. A discount plan organization that is a health insurer licensed pursuant to title 26.1:

   a. Is not required to be registered as a discount plan organization. However, any of the organization's affiliates that operate as a discount plan organization in this state shall comply with all provisions of this chapter and must be registered as a discount plan organization.

   b. Is required to comply with sections 26.1-53.1-14 through 26.1-53.1-21.

**26.1-53.1-03. Registration requirements for a discount plan organization - Fees.**

1. Before doing business in or from this state as a discount plan organization, a discount plan organization:

   a. Must be authorized to transact business in this state through the secretary of state; and

   b. Must be registered by the commissioner to operate as a discount plan organization.

2. An application for registration under this chapter must be filed with the commissioner on a form prescribed by the commissioner.

3. The application must demonstrate, set forth, or be accompanied by the following:

   a. The five hundred dollar application fee;

   b. A list of the names, addresses, official positions, and biographical information of each individual responsible for conducting the applicant's affairs, including each:

      (1) Member of the board of directors, board of trustees, executive committee, or other governing board or committee; and

      (2) Officer;

   c. A copy of the form of any contract made or arrangement to be made between the applicant and any individual listed in subdivision b;

   d. All marketing materials to be used in connection with marketing a discount plan in this state;

   e. A description of member complaint procedures to be established and maintained by the applicant;

   f. A copy of the applicant's cancellation and refund policy;

   g. The name and address of the applicant's agent for service of process, notice, or demand, or if not domiciled in this state, a duly executed instrument appointing the commissioner and the commissioner's successors, the applicant's attorney upon whom all process in any action or proceeding against the applicant may be served; and

   h. Any other information the commissioner may reasonably require.

4. The department may request a copy of the form of all contracts to be made or sold in this state or to be made between the applicant and any providers or provider networks regarding provision of medical or ancillary services to members.

5. The department may request a copy of the form of any contract between the applicant and any person or other entity for the performance on the applicant's behalf of any function, including marketing, administration, enrollment,

investment management, and contracting for the provision of medical or ancillary services to cardholders.

6. After the receipt of an application filed pursuant to this section, the commissioner shall review the application and notify the applicant of any deficiencies in the application.

7. After receipt of a completed application, the commissioner shall:

   a. Register the applicant as a discount plan if the commissioner is satisfied the applicant has met the following:

      (1) The requirements of this section; and

      (2) The ownership, control, and management of the applicant are competent and trustworthy and possess managerial experience that would make the proposed operation of the discount plan organization beneficial to discount plan members; or

   b. Deny the registration application and state the grounds for denial.

8. Registration is effective for one year, unless before expiration the registration is renewed in accordance with this subsection or suspended or revoked in accordance with section 26.1-53.1-12.

9. Not later than March first of each year, the discount plan organization shall submit:

   a. Updated information to anything provided pursuant to subsections 3, 4, and 5 and section 26.1-53.1-23; and

   b. The renewal fee of two hundred fifty dollars.

10. The commissioner shall renew the registration of each discount plan organization that meets the requirements of this chapter and pays the appropriate renewal fee.

**26.1-53.1-04. Exception to registration for providers giving discounts to own patients.**

A provider that provides discounts to the provider's own patients, without any cost or fee of any kind to the patient, is not required to obtain and maintain registration under this chapter as a discount plan organization.

**26.1-53.1-05. Surety bond.**

Each registered discount plan organization shall maintain in force a surety bond in the organization's own name in an amount not less than thirty-five thousand dollars to be used in the discretion of the commissioner to protect the financial interest of members. The bond must be issued by an insurance company licensed to do business in this state. Initially, a copy of the bond or a statement identifying the depository, trustee, and account number of the surety account, and for renewal proof of annual renewal of the bond or maintenance of the surety account, must be filed with the commissioner.

**26.1-53.1-06. Surety bonds not subject to levy by claimants.**

Except for the commissioner, the assets or securities held in this state as a deposit pursuant to section 26.1-53.1-05 are not subject to levy by a judgment creditor or other claimant of the discount plan organization.

**26.1-53.1-07. Internet website to be established.**

Before registration by the commissioner, each discount plan organization shall establish an internet website. The internet website must have an up-to-date list of names and addresses of the providers with which the organization has contracted directly or through a provider network. The internet website address must be displayed prominently on all of the discount plan organization's advertisements, marketing materials, brochures, and discount plan cards.

**26.1-53.1-08. Investigation by commissioner.**

Within a reasonable time after receipt of a properly completed application for registration under this chapter, the commissioner may conduct investigations and propound interrogatories concerning the applicant's qualifications, residence, business affiliations, and any other matter the commissioner believes necessary or advisable to determine compliance with this chapter or for the protection of the public.

**26.1-53.1-09. Reporting of actions.**

A discount plan organization shall report to the commissioner any administrative action taken against the organization in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report must include a copy of the order, consent to order, or other relevant legal documents.

**26.1-53.1-10. Nonrenewal, suspension, or revocation.**

The commissioner may suspend the authority of a discount plan organization to enroll new members or refuse to renew, suspend, or revoke a discount plan organization's registration if, after notice to the registrant and hearing, the commissioner finds that any of the following conditions exist:

1. The discount plan organization is not operating in compliance with this chapter;

2. The discount plan organization has advertised, merchandised, or attempted to merchandise the organization's services in such a manner as to misrepresent the organization's services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising;

3. The discount plan organization is not fulfilling the organization's obligations as a discount plan organization; or

4. The continued operation of the discount plan organization would be hazardous to the organization's members.

**26.1-53.1-11. Winding up of affairs.**

If the registration of a discount plan organization is surrendered, revoked, or not renewed, the discount plan organization shall proceed, immediately following

surrender, or the effective date of the order of revocation or, in the case of a nonrenewal, the date of expiration of the registration, to wind up the organization's affairs transacted under the registration. The discount plan organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

**26.1-53.1-12. Duration of suspension - Conditions for reinstatement.**

The commissioner shall, in the commissioner's order suspending the authority of the discount plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount plan organization before reinstatement of the organization's registration to enroll members. The commissioner may rescind or modify the order of suspension before the expiration of the suspension period. Registration of a discount plan organization may not be reinstated unless requested by the discount plan organization. The commissioner may not grant the request for reinstatement if the commissioner finds the circumstances for which the suspension occurred still exist or are likely to continue.

**26.1-53.1-13. Examination or investigation of discount plan organization - Expenses.**

The commissioner may examine or investigate the business and affairs of any discount plan organization to protect the interests of the residents of this state for any potential violations of this chapter or as the commissioner deemed necessary. The discount plan organization shall produce any requested information and documentation within twenty days of such request. The discount plan organization that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount plan organization to pay the expenses is grounds for denial of registration or revocation of registration to operate as a discount plan organization. The discount plan organization is subject to the provisions of section 26.1-04-03 and nothing in this chapter may be construed to discharge any requirements imposed by section 26.1-04-03.

**26.1-53.1-14. Charges and fees - Refund requirements.**

1. A discount plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount plan.

2. If a member cancels the member's membership in the discount plan organization within the first thirty days after the date of receipt of the signed consumer contract or agreement, the member shall receive a reimbursement of all periodic charges.

3. If the discount plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount plan organization shall make a pro rata reimbursement of all periodic charges to the member.

**26.1-53.1-15. Bundled products.**

1. If a discount plan is bundled with other products, the bundled product must clearly identify the discount plan component separately from each other component.

2. A discount plan organization that is a health insurer licensed pursuant to title 26.1 which provides a discount plan product that is incidental to the insured product is not subject to this section.

3. If a discount plan is bundled with an insurance product, the discount plan organization or marketer selling such product must be licensed pursuant to chapter 26.1-26.

**26.1-53.1-16. Provider agreements.**

1. A discount plan organization must have a written provider agreement with all providers offering medical or ancillary services to the organization's members. The written provider agreement may be entered directly with the provider or indirectly with a provider network to which the provider belongs.

2. A provider agreement between a discount plan organization and a provider must provide the following:

   a. A list of the medical or ancillary services and products to be provided at a discount;

   b. The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

   c. That the provider will not charge members more than the discounted rates.

3. A provider agreement between a discount plan organization and a provider network must require that the provider network have written agreements with the provider network's providers which:

   a. Contain the provisions described in subsection 2;

   b. Authorize the provider network to contract with the discount plan organization on behalf of the provider; and

   c. Require the provider network to maintain an up-to-date list of the provider network's contracted providers and to provide the list on a monthly basis to the discount plan organization.

4. A provider agreement between a discount plan organization and an entity that contracts with a provider network must require that the entity, in the entity's contract with the provider network, require the provider network to have written agreements with the provider network's providers which comply with subsection 3.

5. The discount plan organization shall maintain a copy of each active provider agreement into which the organization has entered.

**26.1-53.1-17. Marketing requirements.**

1. A discount plan organization may market directly or contract with other marketers for the distribution of the organization's product.

2. The discount plan organization must have an executed written agreement with a marketer before the marketer's marketing, promoting, selling, or distributing the discount plan.

3. The agreement between the discount plan organization and the marketer must prohibit the marketer from using advertising, marketing materials, brochures,

and discount plan cards without the discount plan organization's approval in writing.

4. The discount plan organization must be bound by and responsible for the activities of a marketer which are within the scope of the marketer's agency relationship with the organization, or are otherwise approved by or under the direction and control of the organization.

5. Before use, a discount plan shall approve in writing any advertisements, marketing materials, brochures, and discount cards used by marketers to market, promote, sell, or distribute the discount plan.

**26.1-53.1-18. Advertisements to be truthful and not misleading.**

Any advertisements, marketing materials, brochures, discount plan cards, and any other communications of a discount plan organization provided to prospective members and members must be truthful and not misleading in fact or implication. An advertisement, marketing material, brochure, discount plan card, or other communication is misleading in fact or in implication if the communication has a capacity or tendency to mislead or deceive based on the overall impression the communication is reasonably expected to create within the segment of the public to which the communication is directed.

**26.1-53.1-19. Prohibited conduct.**

A discount plan organization may not:

1. Except as otherwise provided in this chapter, or as a disclaimer of any relationship between discount plan benefits and insurance, or as a description of an insurance product connected with a discount plan, use the term "insurance" in any advertisement, marketing material, brochure, or discount plan cards;

2. Use in any advertisements, marketing materials, brochures, or discount plan cards the terms "health plan", "coverage", "copay", "copayments", "deductible", "preexisting conditions", "guaranteed issue", "premium", "PPO", "preferred provider organization", or other terms in a manner that could reasonably mislead an individual into believing the discount plan is health insurance;

3. Use language in any advertisements, marketing materials, brochures, or discount plan cards with respect to being licensed or registered by the state insurance department in a manner that could reasonably mislead an individual into believing the discount plan is insurance or has been endorsed by the state;

4. Make misleading, deceptive, or fraudulent representations regarding the discount or range of discounts offered by the discount plan;

5. Have restrictions on access to discount plan providers, including, except for hospital services, waiting periods and notifications periods; or

6. Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided, unless the discount plan organization has an active certificate of

authority to act as a third-party administrator in accordance with chapter 26.1-27.

**26.1-53.1-20. Required disclosures.**

1. A discount plan organization or marketer shall disclose clearly and conspicuously in writing to any prospective member and on any advertisements, marketing materials, or brochures relating to a discount plan:

   a. The plan is a discount plan and is not insurance coverage;

   b. The range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;

   c. Unless the discount plan organization has an active certificate of authority to act as a third-party administrator as described in subsection 6 of section 26.1-53.1-19, that the plan does not make payments to providers for the medical or ancillary services received under the discount plan;

   d. The plan member is obligated to pay for all medical or ancillary services, but will receive a discount from those providers that have contracted with the discount plan organization; and

   e. The toll-free telephone number and internet website address for the registered discount plan organization for prospective members and members to obtain additional information about and assistance on the discount plan and up-to-date lists of providers participating in the discount plan.

2. If the initial contact with a prospective member is by telephone, the disclosures required under subsection 1 must be made orally and be included in the initial written materials that describe the benefits under the discount plan provided to the prospective or new member.

3. In addition to the disclosures required under subsection 1, each discount plan organization or marketer shall provide to each prospective member, at the time of enrollment, information that describes the terms and conditions of the discount plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount plan.

**26.1-53.1-21. Written agreement with member.**

Each new member must be provided a written document that contains the terms and conditions of the discount plan that clearly provides:

1. The name of the member;

2. The benefits to be provided under the discount plan;

3. Any processing fees and periodic charges associated with the discount plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

4. The mode of payment of any processing fees and periodic charges, such as monthly or quarterly, and procedures for changing the mode of payment;

5. Any limitations, exclusions, or exceptions regarding the receipt of discount plan benefits;

6. Any waiting periods for certain medical or ancillary services under the discount plan;

7. Procedures for obtaining discounts under the discount plan, such as requiring members to contact the discount plan organization to make an appointment with a provider on the member's behalf;

8. Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;

9. Renewal, termination, and cancellation terms and conditions;

10. Procedures for adding new members to a family discount plan, if applicable;

11. Procedures for filing complaints under the discount plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact the plan member's state insurance department; and

12. The name and mailing address of the registered discount plan organization where the member can make inquiries about the plan, send cancellation notices, and file complaints.

**26.1-53.1-22. Notice of change in name or address.**

Each discount plan organization shall provide the commissioner at least thirty days' advance notice of any change in the discount plan organization's name, principal business address, mailing address, or internet website address.

**26.1-53.1-23. Annual reports.**

1. A discount plan organization shall file an annual report with the commissioner in the form prescribed by the commissioner no later than March first.

2. The report must include:

   a. If different from the initial application for registration or at the time of renewal of registration or the last annual report, as appropriate, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with these persons and the discount plan organization, including any possible conflict of interest;

   b. The number of discount plan members in the state; and

   c. Any other information relating to the performance of the discount plan organization which the commissioner may require.

3. Any discount plan organization that fails to file an annual report in the form and within the time required by this section:

   a. Accrues monetary penalties of:

(1) Up to five hundred dollars each day for the first ten days during which the violation continues; and

(2) Up to one thousand dollars each day after the first ten days during which the violation continues; and

b. Upon notice by the commissioner, lose the organization's authority to enroll new members or do business in this state while the violation continues.

**26.1-53.1-24. Civil penalties for violation of chapter.**

In addition to or in lieu of any applicable denial, suspension, or revocation of registration, any person violating this chapter may, after hearing, be subject to a civil fine not to exceed ten thousand dollars for each violation. The fine may be collected and recovered in an action brought in the name of the state.

**26.1-53.1-25. Designation of compliance officer.**

Each discount plan organization shall designate and provide the commissioner with the name, address, and telephone number of the discount plan organization's compliance officer responsible for ensuring compliance with this chapter.

**26.1-53.1-26. Record filing and retention requirements.**

1. Upon demand by the commissioner, a discount plan organization shall file with the commissioner a list of prospective member fees and charges associated with the discount plan.

2. A copy of every form to be used by a discount plan organization, including the form for the written document demonstrating membership in the plan and all advertising, marketing materials, and brochures, must be retained by such organization and available for inspection by the commissioner for at least five years from the date on which the form was last used.

**26.1-53.1-27. Rulemaking.**

The commissioner may adopt rules for the implementation and administration of this chapter.

**26.1-53.1-28. Application to existing discount plan organizations.**

A person doing business in this state as a discount plan organization on or before the effective date of this chapter has six months following the effective date of this Act to come into compliance with the requirements of this chapter.

**SECTION 2. REPEAL.** Chapter 26.1-53 of the North Dakota Century Code is repealed.

Approved April 23, 2019

Filed April 24, 2019

# CHAPTER 250

# HOUSE BILL NO. 1181

(Representative Keiser)
(Senator Klein)

AN ACT to create and enact chapter 26.1-57 of the North Dakota Century Code, relating to the regulation of guaranteed asset protection waivers; to provide a penalty; and to provide for application.

**BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

**SECTION 1.** Chapter 26.1-57 of the North Dakota Century Code is created and enacted as follows:

**26.1-57-01. Definitions.**

As used in this chapter:

1. "Administrator" means a person, other than an insurer or creditor, which performs administrative or operational functions pursuant to guaranteed asset protection waiver programs.

2. "Borrower" means a debtor, retail buyer, or lessee, under a finance agreement.

3. "Creditor" means the lender in a loan or credit transaction; the lessor in a lease transaction; a dealer that provides credit to a motor vehicle retail buyer; the seller in a commercial retail installment transaction; or an assignee of any of the these persons.

4. "Dealer" has the same meaning as provided under section 39-01-01.

5. "Finance agreement" means a loan, lease, or retail installment sales contract for the purchase or lease of a motor vehicle.

6. "Free-look period" means the period of time from the effective date of the guaranteed asset protection waiver until the date the borrower may cancel the contract without penalty, fees, or costs to the borrower. This period of time may not be shorter than thirty days.

7. "Guaranteed asset protection waiver" means a contractual agreement in which a creditor agrees for a separate charge to cancel or waive all or part of amounts due on a borrower's finance agreement if there is a total physical damage loss or unrecovered theft of the motor vehicle, which agreement must be part of, or a separate addendum to, the finance agreement.

8. "Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

9. "Motor vehicle" has the same meaning as provided under section 39-01-01, except the term includes a snowmobile and a trailer for a snowmobile, motorcycle, boat, camper, or personal watercraft.

**26.1-57-02. Scope.**

1. This chapter does not apply to:

   a. An insurance policy offered by an insurer under the insurance laws of this state;

   b. A debt cancellation or debt suspension contract offered in compliance with title 12, Code of Federal Regulations, part 37 or title 12, Code of Federal Regulations, part 721, or other federal law; or

   c. A debt cancellation or debt suspension contract offered by a bank or credit union chartered under the laws of this state.

2. Guaranteed asset protection waivers are not insurance and, except as provided under this chapter, are exempt from the insurance laws of this state. A person marketing, selling, or offering to sell guaranteed asset protection waivers to borrowers which complies with this chapter is exempt from the insurance requirements of this state.

**26.1-57-03. Requirements for offering guaranteed asset protection waivers.**

1. A guaranteed asset protection waiver may be offered, sold, or provided to a borrower in this state in compliance with this chapter.

2. A guaranteed asset protection waiver may, at the option of the creditor, be sold for a single payment or may be offered with a monthly or periodic payment option.

3. Notwithstanding any contrary provision of law, any cost to the borrower for a guaranteed asset protection waiver entered in compliance with the federal Truth in Lending Act [15 U.S.C. 1601 et seq.], and related implementing regulations, must be separately stated and is not a finance charge or interest.

4. A dealer shall insure the dealer's guaranteed asset protection waiver obligations under a contractual liability or other insurance policy issued by an insurer. A creditor, other than a dealer, may insure the creditor's guaranteed asset protection waiver obligations under a contractual liability policy or other such policy issued by an insurer. Any such insurance policy may be obtained directly by a creditor or dealer, or may be procured by an administrator, to cover a creditor's or dealer's obligations. However, a dealer that is a lessor on a motor vehicle is not required to insure obligations related to guaranteed asset protection waivers on that leased vehicle.

5. The guaranteed asset protection waiver remains a part of the finance agreement upon the assignment, sale, or transfer of that finance agreement by the creditor.

6. Neither the extension of credit, the term of credit, nor the term of the related motor vehicle sale or lease may be conditioned upon the purchase of a guaranteed asset protection waiver.

7. A creditor that offers a guaranteed asset protection waiver shall report the sale of, and forward funds received on all such waivers to the designated party, if any, as prescribed in any applicable administrative services agreement, contractual liability policy, other insurance policy, or other specified program documents.

8. Funds received or held by a creditor or administrator and belonging to an insurer, creditor, or administrator, pursuant to the terms of a written agreement, must be held by the creditor or administrator in a fiduciary capacity.

**26.1-57-04. Contractual liability or other insurance policies.**

1. Contractual liability or other insurance policies insuring guaranteed asset protection waivers must state the obligation of the insurer to reimburse or pay to the creditor any sums the creditor is legally obligated to waive under the guaranteed asset protection waivers issued by the creditor and purchased or held by the borrower.

2. Coverage under a contractual liability or other insurance policy insuring a guaranteed asset protection waiver also must cover any subsequent assignee upon the assignment, sale, or transfer of the finance agreement.

3. Coverage under a contractual liability or other insurance policy insuring a guaranteed asset protection waiver must remain in effect unless canceled or terminated in compliance with applicable insurance laws of this state.

4. The cancellation or termination of a contractual liability or other insurance policy may not reduce the insurer's responsibility for guaranteed asset protection waivers issued by the creditor before the date of cancellation or termination and for which premium has been received by the insurer.

**26.1-57-05. Disclosures.**

A guaranteed asset protection waiver must disclose, as applicable, in writing and in clear, understandable language that is easy to read, the following:

1. Neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease, may be conditioned upon the purchase of the guaranteed asset protection waiver.

2. The name and address of the initial creditor and the borrower at the time of sale, and the identity of any administrator if different from the creditor.

3. The purchase price and the terms of the guaranteed asset protection waiver, including the requirements for protection, conditions, or exclusions associated with the guaranteed asset protection waiver.

4. The borrower may cancel the guaranteed asset protection waiver within a free-look period as specified in the waiver, and is entitled to a full refund of the purchase price, if no benefits have been provided.

5. The procedure the borrower shall follow, if any, to obtain guaranteed asset protection waiver benefits under the terms and conditions of the waiver, including a telephone number and address at which the borrower may apply for waiver benefits.

6. The procedure for canceling the guaranteed asset protection waiver and for requesting any refund due.

7. To receive any refund due in the event of a borrower's cancellation of the guaranteed asset protection waiver agreement or early termination of the finance agreement after the free-look period of the guaranteed asset protection waiver, the borrower, in accordance with terms of the waiver, shall provide a written request to cancel to the creditor, administrator, or such other party. If the request to cancel is a result of the early termination of the finance agreement the borrower shall provide the written request to cancel within ninety days of the occurrence of the event terminating the finance agreement.

8. The methodology for calculating any refund of the unearned purchase price of the guaranteed asset protection waiver due, in the event of cancellation of the guaranteed asset protection waiver or early termination of the finance agreement.

**26.1-57-06. Cancellation.**

1. A guaranteed asset protection waiver agreement is cancellable. A guaranteed asset protection waiver must provide if a borrower cancels a waiver within the free-look period, the borrower is entitled to a full refund of the purchase price, if benefits have not been provided. If a borrower cancels the waiver after the free-look period and no benefits have been provided, the creditor, administrator, or other authorized party shall provide the borrower a refund of the purchase price, calculated in a manner at least as favorable as using the sum-of-the-digits method, less any cancellation fee no greater than fifty dollars.

2. To receive a refund, the borrower, in accordance with any applicable terms of the waiver, shall provide a written request to cancel to the creditor, administrator, or other party. If the request to cancel is a result of the early termination of the finance agreement the borrower shall provide the written request to cancel within ninety days of the occurrence of the event terminating the finance agreement.

3. If the cancellation of a guaranteed asset protection waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, or any other termination of the finance agreement, any refund due may be paid directly to the creditor or administrator and applied as set forth in subsection 4.

4. Any cancellation refund under subsection 1, 2, or 3 may be applied by the creditor as a reduction of the amount owed under the finance agreement, unless the borrower can show that the finance agreement has been paid in full.

**26.1-57-07. Commercial transactions exempted.**

Subsection 3 of section 26.1-57-03, section 26.1-57-05, and section 26.1-57-06, are not applicable to a guaranteed asset protection waiver offered in connection with a lease or retail installment sale associated with a commercial transaction.

**26.1-57-08. Enforcement - Penalty.**

1. The commissioner may take action as necessary or appropriate to enforce this chapter and to protect guaranteed asset protection waiver holders in this state.

2. After proper notice and opportunity for hearing, the commissioner may:

   a. Order the creditor, administrator, or any other person not in compliance with this chapter to cease and desist from further guaranteed asset protection waiver-related operations that are in violation of this chapter.

   b. Impose a penalty of not more than five hundred dollars per violation and no more than ten thousand dollars in the aggregate for all violations of a similar nature. For purposes of this chapter, violations are of a similar nature if the violation consists of the same or similar course of conduct, action, or practice, regardless of the number of times the conduct or practice determined to be a violation of the chapter occurred.

   c. Order the creditor, administrator, or any other person not in compliance with this chapter to pay restitution of the guaranteed asset protection waiver purchase price.

**SECTION 2. APPLICATION.** This Act applies to all guaranteed asset protection waivers that become effective on or after the effective date of this Act.

Approved March 20, 2019

Filed March 21, 2019