INSURANCE

CHAPTER 299

HOUSE BILL NO. 1439
(Whalen, Aarsvold, Wald, Skjerven)

PETROLEUM RELEASE REMEDIATION

AN ACT to provide for cleanup of petroleum spills through the establishment of a petroleum release compensation fund; to repeal sections 1 through 31 and section 33 of chapter 341 of the 1989 Session Laws of North Dakota; to provide a penalty; to provide a continuing appropriation; to provide an appropriation; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Declaration of purpose. The purpose of this Act is to establish:

1. A petroleum tank release compensation fund; and

2. A petroleum tank release compensation advisory board authorized to review claims against the fund.

SECTION 2. Definitions. As used in this Act, unless the context otherwise requires:

1. "Actually incurred" means in the case of corrective action expenditures, that the owner, the operator, an insurer of the owner or operator, or a contractor hired by the owner, operator, or insurer has made a payment or that a contractor has expended time and materials and that only that person is receiving reimbursement from the fund.

2. "Administrator" means the manager of the state fire and tornado fund.

3. "Board" means the petroleum release compensation advisory board.

4. "Corrective action" means an action taken to minimize, contain, eliminate, remediate, mitigate, or clean up a release, including any remedial emergency measures. The term also includes compensation paid to third parties for bodily injury or property damage which is determined by the board to be eligible for reimbursement. The term does not include the repair or replacement of equipment or preconstructed property.

5. "Dealer" means any person licensed by the tax commissioner to sell motor vehicle fuel or special fuels within the state.

6. "Department" means the state department of health and consolidated laboratories.

7. "Fund" means the petroleum release compensation fund.

8. "Operator" means any person in control of, or having responsibility for, the daily operation of a tank under this Act.

9. "Owner" means any person who holds title to, controls, or possesses an interest in the tank before the discontinuation of its use.

10. "Person" means an individual, trust, firm, joint stock company, federal agency, corporation, state, municipality, commission, political subdivision of a state, or any interstate body. The term also includes a consortium, a joint venture, a commercial entity, and the United States government.

11. "Petroleum" means any of the following:

    a. Gasoline and petroleum products as defined in chapter 19-10.

    b. Constituents of gasoline and fuel oil under subdivision a.

    c. Oil sludge and oil refuse.

12. "Release" means any unintentional spilling, leaking, emitting, discharging, escaping, leaching, or disposing of petroleum from a tank into the environment whether occurring before or after the effective date of this Act, but does not include discharges or designed venting allowed under federal or state law or under adopted rules.

13. "Tank" means any one or a combination of containers, vessels, and enclosures, whether aboveground or underground, including associated piping or appurtenances used to contain an accumulation of petroleum. The term does not include:

    a. Tanks owned by the federal government;

    b. Tanks used for the transportation of petroleum; and

    c. A pipeline facility, including gathering lines, regulated under:

        (1) The Natural Gas Pipeline Safety Act of 1968.

        (2) The Hazardous Liquid Pipeline Safety Act of 1979.

        (3) An interstate pipeline facility regulated under state laws comparable to the provisions of law in paragraph 1 or 2 of this subdivision.

    d. A farm or residential tank with a capacity of one thousand one hundred gallons [4163.94 liters] or less used for storing motor fuel for noncommercial purposes.

    e. A tank used for storing heating oil for consumptive use on the premises where stored.

    f. A surface impoundment, pit, pond, or lagoon.

g. A flowthrough process tank.

h. A liquid trap or associated gathering lines directly related to oil or gas production or gathering operations.

i. A storage tank situated in an underground area such as a basement, cellar, mine working, drift, shaft, or tunnel if the storage tank is situated upon or above the surface of the floor.

j. A tank used for the storage of propane.

k. A tank used to fuel rail locomotives or surface coal mining equipment.

SECTION 3. **Petroleum release compensation advisory board.** The petroleum release compensation advisory board consists of three members, two of whom are active in petroleum marketing, appointed by the governor. Members must be appointed to terms of three years with the terms arranged so that the term of one member expires June thirtieth of each year. A member shall hold office until a successor is duly appointed and qualified. Each member of the board shall receive sixty-two dollars and fifty cents per diem for each day actually spent in the performance of official duties, plus mileage and expenses as are allowed to other state officers.

SECTION 4. **Administration of fund - Staff.** The administrator shall administer the fund according to this Act. The administrator shall convene the board as is necessary to keep the board apprised of the fund's general operations and to discuss all claims against the fund. The administrator may employ any assistance and staff necessary to administer the fund within the limits of legislative appropriation.

SECTION 5. **Adoption of rules.** The administrator shall adopt rules regarding its practices and procedures, the form and procedure for applications for compensation from the fund, procedures for investigation of claims, procedures for determining the amount and type of costs that are eligible for reimbursement from the fund, and procedures for persons to perform services for the fund.

SECTION 6. **Release discovery.** If the department has reason to believe a release has occurred, it shall notify the administrator. The department shall direct the owner or operator to take reasonable and necessary corrective actions as provided under federal or state law or under adopted rules.

SECTION 7. **Owner or operator not identified.** The department may cause legal action to be brought to compel performance of a corrective action if an identified owner or operator fails or refuses to comply with an order of the department, or the department may engage the services of qualified contractors for performance of a corrective action if an owner or operator cannot be identified.

SECTION 8. **Imminent hazard.** Upon receipt of information that a petroleum release has occurred which may present an imminent or substantial endangerment of health or the environment, the department may take such emergency action as it determines necessary to protect health or the environment.

SECTION 9. Duty to notify. Nothing in this Act limits any person's duty to notify the department and to take action related to a release. However, payment for corrective actions required as a result of a petroleum release is governed by this Act.

SECTION 10. Providing of information. Any person whom the administrator or the department has reason to believe is an owner or operator, or the owner of real property where corrective action is ordered to be taken, or any person who may have information concerning a release, shall, if requested by the administrator or the department, or any member, employee, or agent of the administrator or the department, furnish to the administrator or the department any information that person has or may reasonably obtain that is relevant to the release.

SECTION 11. Examination of records. Any employee of the administrator or the department may, upon presentation of official credentials:

1. Examine and copy books, papers, records, memoranda, or data of any person who has a duty to provide information to the administrator or the department under section 10 of this Act; and

2. Enter upon public or private property for the purpose of taking action authorized by this section, including obtaining information from any person who has a duty to provide the information under section 10 of this Act, conducting surveys and investigations, and taking corrective action.

SECTION 12. Responsibility for cost. The owner or operator is liable for the cost of the corrective action required by the department, including the cost of investigating the releases, and for legal actions of the administrator or the department. This Act does not create any new cause of action for damages on behalf of third parties for release of petroleum products against the fund or licensed dealers.

SECTION 13. Liability avoided. No owner or operator may avoid liability by means of a conveyance of any right, title, or interest in real property or by any indemnification, hold harmless agreement, or similar agreement. However, the provisions of this Act do not:

1. Prohibit a person who may be liable from entering into an agreement by which the person is insured or is a member of a risk retention group, and is thereby indemnified for part or all of the liability;

2. Prohibit the enforcement of an insurance, hold harmless, or indemnification agreement; or

3. Bar a cause of action brought by a person who may be liable or by an insurer or guarantor, whether by right of subrogation or otherwise.

SECTION 14. Other remedies. Nothing in this Act limits the powers of the administrator or department, or precludes the pursuit of any other administrative, civil, injunctive, or criminal remedies by the administrator or department or any other person. Administrative remedies need not be exhausted in order to proceed under this Act. The remedies provided by this Act are in addition to those provided under existing statutory or common law.

SECTION 15. **Revenue to the fund.** Revenue from the following sources must be deposited in the state treasury and credited to the fund:

1. Any registration fees collected under section 17 of this Act;

2. Any money recovered by the fund under section 23 of this Act, and any money paid under an agreement, stipulation, or settlement;

3. Any interest attributable to investment of money in the fund; and

4. Any money received by the administrator in the form of gifts, grants, reimbursements, or appropriations from any source intended to be used for the purposes of the fund.

SECTION 16. **Penalty.** A tank owner violating section 17 of this Act is guilty of a class B misdemeanor, unless another penalty is specifically provided.

SECTION 17. **Registration fee.** An owner or operator of a tank shall pay an annual registration fee of seventy-five dollars for each aboveground tank and one hundred twenty-five dollars for each underground tank owned or operated by that person. The registration fees collected under this section must be paid to the administrator for deposit in the state treasury for credit to the petroleum release compensation fund.

SECTION 18. **Reimbursement for corrective action.** The administrator shall reimburse an eligible owner or operator for ninety percent of the costs of corrective action, including the investigation, which are greater than five thousand dollars and less than one million dollars per occurrence and two million dollars in the aggregate. An eligible tank owner or operator may not be liable for more than twenty thousand dollars out-of-pocket expenses for any one release. A reimbursement may not be made unless the administrator determines that:

1. At the time the release was discovered the owner or operator and the tank were in compliance with state and federal rules and rules applicable to the tank, including rules relating to financial responsibility which were in effect at the time of the release;

2. The department was given notice of the release as required by federal and state law;

3. The owner or operator has paid the first five thousand dollars of the cost of corrective action; and

4. The owner or operator, to the extent possible, fully cooperated with the department and the administrator in responding to the release.

SECTION 19. **Application for reimbursement.** Any owner or operator who proposes to take corrective action or has undertaken corrective action in response to a release, the time of such release being unknown, may apply to the administrator for partial or full reimbursement under section 18 of this Act. An owner or operator may be reimbursed only for releases discovered and reported after the effective date of this Act.

SECTION 20. Administrator to determine costs. A reimbursement may not be made from the fund until the administrator has determined that the costs for which reimbursement is requested were actually incurred and were reasonable.

SECTION 21. Liability of responsible person. The right to apply for reimbursement and the receipt of reimbursement does not limit the liability of an owner or operator for damages or costs incurred as the result of a release.

SECTION 22. Reimbursement not subject to attachment. The amount of reimbursement to be paid for corrective action that was done by a third party is not subject to legal process or attachment if actually paid to a third party who performed the corrective action.

SECTION 23. Recovery of expenses. Any reasonable and necessary expenses incurred by the fund, which exceed the amount allowed by section 18 of this Act, in taking a corrective action, including costs of investigating a release, and in taking legal actions may be recovered in a civil action in district court brought by the administrator against an owner or operator. The certification of expenses by an approved agent of the fund is prima facie evidence that the expenses are reasonable and necessary. Any expenses that are recovered under this section must be deposited in the fund.

SECTION 24. Costs exceeding reimbursement. If the cost of any extraordinary authorized action under this Act exceeds amounts awarded to the administrator or the department from the federal government, the administrator may pay the department the cost of the corrective actions, including the cost of investigating a release, if the board finds that the cause was a petroleum substance, that an adequate amount exists in the fund to pay for the corrective action, that the occurrence was extraordinary in scope and size, and that a danger to the health and safety of citizens exists.

SECTION 25. Coordination of benefits. If an owner or operator has an insurance policy that provides the same coverage as the fund, the administrator of the fund shall pay the share of the covered loss or damage for which the fund is responsible. The share that must be paid from the fund is equal to the proportion that the applicable limit of coverage under the fund bears to the limits of insurance of all insurance coverage on the same basis.

SECTION 26. Third-party damages - Participation in actions and review of settlements.

1. An owner or operator who is sued for damages resulting from a release shall notify the administrator within forty-eight hours of being served with a summons and complaint. The owner or operator shall also advise the administrator if any insurer is defending the owner or operator and provide to the administrator the name of that insurer.

2. An owner or operator who, before litigation, enters into negotiations with a third party who claims to have been damaged by a release, or who receives a demand for payment of damages to a third party who claims to have been damaged by a release, shall

notify the administrator within forty-eight hours of the demand or the negotiations.

3. The administrator and the board shall review the conduct of any litigation or negotiation. The administrator may not assume any legal costs incurred by the defendant or plaintiff, but may participate in discovery, trial proceedings, or settlement negotiations that bear on the determination of a plaintiff's damages.

4. The administrator and the board shall review any settlement negotiations to determine the dollar amount of bodily injury or property damage actually, necessarily, and reasonably incurred by third parties which, if paid by the defendant, would be considered eligible costs.

SECTION 27. Third-party damages - Documentation.

1. An applicant's payments for third-party damages pursuant to a judgment entered in a court must include copies of the notice of entry of judgment, abstract of costs, and a declaration of the fees paid by the defendant to each attorney who appeared in the proceeding.

2. An applicant's payments for third-party damages made by agreement in settlement of litigation must include copies of the settlement agreement and such supporting documents as may be required by the administrator.

3. An applicant's payments for third-party damages made by agreement without reference to litigation must include copies of the settlement and such supporting documents as may be required by the administrator.

4. The administrator and the board may require a third party who claims bodily injury to be examined by a physician and require that the physician's report be submitted to the administrator. The administrator may require a third party who claims property damage to permit a property appraiser or claims adjuster retained by the administrator to inspect the property and report to the administrator.

SECTION 28. Matching federal funds. The administrator and the board may annually allow the department a ten percent matching grant for federal leaking underground storage tank funds to be paid out of the fund if the moneys are available and the administrator and the board determine the allowance appropriate.

SECTION 29. Report to legislative assembly and governor. The administrator and the board shall prepare by December 1, 1992, a report to the legislative assembly and the governor explaining the status of the government's and business' ability to respond to and clean up all past and future petroleum spills.

SECTION 30. Fund appropriations. Money in the fund is continuously appropriated to the administrator for the purpose of making reimbursements under this Act.

SECTION 31. REPEAL. Sections 1 through 31 and section 33 of chapter 341 of the 1989 Session Laws of North Dakota are repealed.

SECTION 32. APPROPRIATION. There is hereby appropriated out of any moneys in the petroleum release compensation fund in the state treasury generated from the registration fees collected under section 17, not otherwise appropriated, the sum of $130,000, or so much thereof as may be necessary, to the administrator for the purpose of administering the fund for the period beginning with the effective date of this Act and ending June 30, 1993.

SECTION 33. EXPIRATION DATE. This Act is effective through June 30, 1999, and after that date is ineffective.

SECTION 34. EMERGENCY. This Act is declared to be an emergency measure.

Approved April 16, 1991
Filed April 18, 1991

CHAPTER 300

SENATE BILL NO. 2383
(Senator Marks)
(Representatives Brokaw, Dalrymple, Gerntholz)

PETROLEUM RELEASE VERIFICATION

AN ACT to amend and reenact section 23 of chapter 341 of the 1989 Session Laws of North Dakota, relating to reimbursement under the petroleum release compensation fund; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23 of chapter 341 of the 1989 Session Laws of North Dakota is amended and reenacted as follows:

SECTION 23. Application for reimbursement. Any owner or operator who proposes to take corrective action or has undertaken corrective action in response to a release, the time of such release being unknown, may apply to the administrator for partial or full reimbursement under section 22 of this Act. An owner or operator may be reimbursed only for releases ~~discovered and~~ reported in writing and verified by the department after ~~the effective date of this Act~~ July 1, 1989.

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

Approved March 14, 1991
Filed March 15, 1991

CHAPTER 301

SENATE BILL NO. 2266
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

INSURANCE LAW REVISIONS

AN ACT to create and enact a new subsection to section 26.1-01-07, a new subsection to section 26.1-03-17, and a new section to chapter 26.1-08 of the North Dakota Century Code, relating to fees chargeable by the commissioner of insurance, collection of insurance premium taxes, and the comprehensive health association; to amend and reenact subsections 15 and 16 of section 26.1-01-07, subsection 2 of section 26.1-03-17, sections 26.1-04-11, 26.1-07-04, subdivision c of subsection 2 of section 26.1-10-02, sections 26.1-16-24, 26.1-17-23, 26.1-17-31, 26.1-19-10, 26.1-26-03, subdivision b of subsection 4 of section 26.1-31.2-01 of the North Dakota Century Code as created by section 12 of House Bill No. 1242, as approved by the fifty-second legislative assembly, section 26.1-33-02, subsections 9 and 13 of section 26.1-33-05, sections 26.1-33-12, 26.1-33-37, subdivisions e and o of subsection 1 of section 26.1-36-04, sections 26.1-36-29, 26.1-36-36.2, subsections 1 and 2 of section 26.1-38.1-01, subsections 2, 3, and 4 of section 26.1-38.1-05, subsection 2 of section 26.1-38.1-16, sections 26.1-42-01, 32-12.1-05, and subsection 1 of section 32-12.1-15 of the North Dakota Century Code, relating to fees chargeable by the commissioner of insurance, collection of insurance premium taxes, immunity from prosecution, investments of domestic insurance companies, insurance company annual statement filing date, licensing of sales representatives of nonprofit health service corporations, filing date for annual statements of nonprofit health service corporations, licensing of sales representatives of prepaid legal service organizations, penalty for selling insurance without a license, credit allowed a domestic ceding insurer, solicitation of life insurance, interest on death claims, group life policy conversion privileges, suicide defense to life policy or certificates, accident and health insurance policy provisions, coordination of benefits in individual and group accident and health policies, noncustodial care coverage, life and health insurance guaranty association, property and casualty insurance guaranty association, and purchase of liability insurance and participation in self-insurance pools by political subdivisions and state agencies; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subsection to section 26.1-01-07 of the North Dakota Century Code is created and enacted as follows:

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

SECTION 2. AMENDMENT. Subsections 15 and 16 of section 26.1-01-07 of the North Dakota Century Code are amended and reenacted as follows:

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

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

SECTION 3. A new subsection to section 26.1-03-17 of the North Dakota Century Code is created and enacted as follows:

An annual filing fee in the amount of two hundred dollars must be collected by the commissioner from each entity subject to this section. This fee must be reduced by an amount equal to the net tax due under subsections 1 and 2.

* SECTION 4. AMENDMENT. Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 4 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit as provided under ~~subsection 1 of~~ section ~~26.1-38-08~~ 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 through 26.1-03-22, 26.1-17-32, and 26.1-18-27, 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 5. AMENDMENT. Section 26.1-04-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-04-11. Immunity from prosecution. If any person asks to be excused from attending and testifying or from producing any evidence at any trial or hearing on the ground that the testimony or evidence required may tend to incriminate that person or subject that person to a penalty or forfeiture, but is directed to give the testimony or produce the evidence, that person shall comply with the direction; but no testimony or evidence compelled from an individual after a valid claim of the privilege against self-incrimination has been made may be used against the individual in any criminal proceeding, or in any proceeding to subject the individual to a penalty or forfeiture. ~~That person may not thereafter be prosecuted or~~

* NOTE: Section 26.1-03-17 was also amended by section 11 of Senate Bill No. 2068, chapter 54.

~~subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which that person may testify or produce evidence pursuant thereto, and no testimony given or evidence produced may be received against that person upon any criminal action, investigation, or proceeding.~~ However, no individual so testifying is exempt from prosecution or punishment for any perjury or false statements committed while testifying and the testimony or evidence given or produced is admissible upon any criminal action, investigation, or proceeding concerning the perjury or false statements, nor is the individual exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance laws of this state. ~~The individual may execute, acknowledge, and file in the office of the commissioner a statement expressly waiving such immunity or privilege in respect to any transaction, matter, or thing specified in the statement and thereupon the testimony of the individual or such evidence in relation to the transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise, and if received or produced the individual is not entitled to any immunity or privilege on account of any testimony given or evidence produced.~~

SECTION 6. AMENDMENT. Section 26.1-07-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-07-04. Notice of petition for consolidation or reinsurance. When a petition is filed, the commissioner shall issue an order requiring notice by mail to each policyholder of the petitioning company, of the pendency of the petition and of the time when and place where a hearing on the petition will be held. The commissioner shall publish the order of notice and the petition in five newspapers, one of which must be a daily newspaper published at the state capital, ~~for~~ at least two weeks before the hearing upon the petition.

SECTION 7. A new section to chapter 26.1-08 of the North Dakota Century Code is created and enacted as follows:

Termination of coverage. Coverage pursuant to this chapter terminates:

1. Upon request of the covered person.

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

3. When the lifetime maximum benefit amount has been reached under subsection 2 of section 26.1-08-05 or subsection 2 of section 26.1-08-06.

4. If the covered person qualifies for health benefits under other plans or policies.

5. When the covered person ceases to be a resident of this state.

* SECTION 8. AMENDMENT. Subdivision c of subsection 2 of section 26.1-10-02 of the North Dakota Century Code is amended and reenacted as follows:

c. Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries;

* NOTE: Section 26.1-10-02 was also amended by section 2 of House Bill No. 1242, chapter 305.

provided, that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurance company to exceed any of the investment limitations specified in ~~subsection 1~~ subdivisions a and b of subsection 2. "The total investment of the insurance company" includes:

(1) Any direct investment by the company in an asset.

(2) The company's proportionate share of any investment in an asset by any subsidiary of the company, which must be calculated by multiplying the amount of the subsidiary's investment by the percentage of the company's ownership of such subsidiary.

SECTION 9. AMENDMENT. Section 26.1-16-24 of the North Dakota Century Code is amended and reenacted as follows:

26.1-16-24. Annual statement required - Renewal of certificate of authority. ~~Before February second of each year, a~~ Every benevolent society shall ~~file with the commissioner~~ transmit to the commissioner, not later than March first of each year, an annual statement as of the previous December thirty-first. The statement must be on any forms required by the commissioner and must show:

1. All income of the society by sources.

2. All disbursements of the society detailed as to nature.

3. A listing of the assets of the society.

4. The liabilities of the society.

5. The number of members in the society.

6. Any other information required by the commissioner.

If it appears from the statement that the society has a membership at least equal in number to that required as a condition precedent to authorization and that it is otherwise qualified under the requirements of this chapter, a renewal certificate of authority must be issued on the succeeding April thirtieth. The fees for the filing of the statement and the issuance of the certificate are those specified in section 26.1-01-07.

SECTION 10. AMENDMENT. Section 26.1-17-23 of the North Dakota Century Code is amended and reenacted as follows:

26.1-17-23. Licensing of sales representatives. The sales representatives of any health service corporation are subject to the laws pertaining to insurance agents as defined in chapter 26.1-26. ~~The commissioner shall prescribe the form for the license or certificate. The fee for a license or certificate is three dollars.~~ The license for a sales representative must be issued on a form prescribed by the commissioner, and the fee for a license or renewal is prescribed in section 26.1-01-07.

~~Sales representatives licensed to sell hospital service contracts may also sell all other health service contracts without further licensure.~~

SECTION 11. AMENDMENT. Section 26.1-17-31 of the North Dakota Century Code is amended and reenacted as follows:

26.1-17-31. Annual statement. Every health service corporation shall ~~annually before April second file in the office of the commissioner, a verified statement signed by at least two of its principal officers, showing the condition of its affairs~~ transmit to the commissioner, not later than March first of each year, a statement of its condition and business for the year ending on the preceding December thirty-first. The statement must be in the form and must contain the information prescribed by the commissioner.

SECTION 12. AMENDMENT. Section 26.1-19-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-19-10. Licensing of sales representatives. The sales representatives of a prepaid legal services organization are subject to the laws pertaining to insurance agents as defined in chapter 26.1-26. The license for ~~the~~ a sales ~~representatives~~ representative must be issued on a form prescribed by the commissioner, and the fee for a license ~~is three dollars~~ or renewal thereof shall be prescribed in section 26.1-01-07.

SECTION 13. AMENDMENT. Section 26.1-26-03 of the North Dakota Century Code is amended and reenacted as follows:

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

SECTION 14. AMENDMENT. Subdivision b of subsection 4 of section 26.1-31.2-01 of the North Dakota Century Code as created by section 12 of House Bill No. 1242, as approved by the fifty-second legislative assembly, is amended and reenacted as follows:

b. In the case of a group of incorporated insurers under common administration which complies with the filing requirements contained in subdivision a, and which is under the supervision of the department of trade and industry of the United Kingdom and submits to this state's authority to examine its books and records and bears the expense of the examination, and which has aggregate policyholders' surplus of ten ~~million~~ billion dollars; the trust shall be in an amount equal to the group's several liabilities attributable to business written in the United States plus the group shall maintain a joint trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any member of the group, and each member of the group shall make available to the commissioner an annual certification of the

member's solvency by the member's domiciliary regulator and its independent public accountant.

SECTION 15. AMENDMENT. Section 26.1-33-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-33-02. Solicitation of life insurance regulated by rule of the commissioner. Insurers shall deliver to purchasers of life insurance information which will improve the purchaser's ability to select the most appropriate plan of life insurance for the purchaser's needs, which will improve the purchaser's understanding of the basic features of the policy which has been purchased or which is under consideration, and which will improve the ability of the purchaser to evaluate the relative costs of similar plans of life insurance. The commissioner ~~shall~~ may adopt ~~by rule the national association of insurance commissioners life insurance disclosure model regulation of December 9, 1983~~ reasonable rules to implement this section.

SECTION 16. AMENDMENT. Subsections 9 and 13 of section 26.1-33-05 of the North Dakota Century Code are amended and reenacted as follows:

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

13. A provision that in the event of the death of an insured, the insurer will refund within thirty days after notice to the insurer of the insured's death the ~~proportion~~ portion of the premium, fee, or other sum ~~as corresponds with the unexpired time upon the amount of policy remaining~~ paid beyond the month of death. This provision does not apply to term life insurance, flexible premium life insurance, or to any policy where the insurer has a valid defense to the payment of benefits under the policy.

SECTION 17. AMENDMENT. Section 26.1-33-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-33-12. Group life policy conversion privileges. If any individual insured under a group life insurance policy delivered in this state after July 1, 1983, becomes entitled under the terms of the policy to have an individual life insurance policy issued without evidence of insurability, subject to making of application and payment of the first premium within the period specified in the policy, and if the individual is not given notice of the existence of the right at least fifteen days prior to the expiration date of the period, then the individual has an additional period within which to exercise that right. This additional period expires fifteen days after the individual is given notice. Written notice presented to the individual or mailed ~~to~~ by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder or notice of the right of conversion included in a certificate provided to each employee or notice provided by the attachment of a separate notice to the certificate constitutes notice for the purpose of this section.

SECTION 18. AMENDMENT. Section 26.1-33-37 of the North Dakota Century Code is amended and reenacted as follows:

26.1-33-37. Suicide - Determination - No defense to life policy or certificate after one year. The sanity or insanity of the person is not a factor in determining whether a person committed suicide within the terms of a life insurance policy or certificate regulating the payment of benefits in the event of the insured's suicide. In any suit on a life insurance policy or certificate, it is no defense after the policy or certificate has been in force one year that the insured committed suicide, and any provision or stipulation to the contrary in the policy or certificate is void.

SECTION 19. AMENDMENT. Subdivisions e and o of subsection 1 of section 26.1-36-04 of the North Dakota Century Code are amended and reenacted as follows:

e. A provision that the policyholder is entitled to a grace period of ~~fifteen days for monthly premiums and~~ thirty-one days ~~for all others~~ for the payment of any premium due except the first, during which the policy continues in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

o. A provision that in the event of the death of an insured, the insurer will refund within thirty days after notice to the insurer of the insured's death ~~that proportion~~ the portion of the premium, fees, or other sum ~~as corresponds with the unexpired time upon the amount of the policy remaining~~ paid beyond the month of death after deducting any claim for losses during the current term of the policy. This provision does not apply where the insurer has a valid defense to the payment of benefits under the policy.

SECTION 20. AMENDMENT. Section 26.1-36-29 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-29. Coordination of benefits in individual and group accident and health policies - Limitations. An insurer or health service corporation may not issue or renew any individual or group accident and health insurance policy that excludes or reduces the benefits payable or services to be rendered to or on behalf of any insured because benefits have been paid or are also payable under any individually underwritten and individually issued contract or plan of insurance which provides exclusively for accident and health benefits, irrespective of the mode or channel of premium payment, with or without payroll deduction, to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of the insured's status as an employee. This section does not affect the practice of coordination of benefits between group policies as provided in ~~sections 26.1-17-17 and~~ section 26.1-36-10.

SECTION 21. AMENDMENT. Section 26.1-36-36.2 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-36.2. Noncustodial care coverage. An insurer offering convalescent nursing home, extended care facility, or skilled nursing facility coverage ~~in excess of the one hundred fifty day medicare benefit~~ under chapter 26.1-36.1 or 26.1-45 shall ~~also~~ cover intermediate care confinements in the same manner as skilled care confinements.

SECTION 22. AMENDMENT. Subsections 1 and 2 of section 26.1-38.1-01 of the North Dakota Century Code are amended and reenacted as follows:

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

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

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

      (1) Are residents; or

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

         (a) The insurers that issued such policies or contracts are domiciled in this state;

         (b) Such insurers never held a license or certificate of authority in the states in which such persons reside;

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

         (d) Such persons are not eligible for coverage by such associations.

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

SECTION 23. AMENDMENT. Subsections 2, 3, and 4 of section 26.1-38.1-05 of the North Dakota Century Code are amended and reenacted as follows:

2. a. If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then, subject to the preconditions specified in ~~subsection 3~~

subdivision b, the association shall, in its discretion, either:

~~a.~~ (1) Take any of the actions specified in subsection 1, subject to the conditions therein; or

~~b.~~ (2) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

~~3.~~ b. The association is subject to the requirements of ~~subsection 2~~ subdivision a only if:

~~a.~~ (1) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

~~(1)~~ (a) The delinquency proceeding shall not be dismissed;

~~(2)~~ (b) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management; and

~~(3)~~ (c) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

~~b.~~ (2) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

~~c.~~ (3) If the impaired insurer is a foreign or alien insurer,

~~(1)~~ (a) It has been prohibited from soliciting or accepting new business in this state;

~~(2)~~ (b) Its certificate of authority has been suspended or revoked in this state;

~~(3)~~ (c) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state~~, and~~.

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

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

(2) Assure payment of the contractual obligations of the insolvent insurer; and

(3) Provide such moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

~~d.~~ b. With respect only to life and health insurance policies, provide benefits and coverage in accordance with subsection 4.

4. When proceeding under ~~subdivision b~~ paragraph 2 of subdivision a of subsection 2 or subdivision ~~d~~ b of subsection 3, the association shall, with respect to only life and health insurance policies:

a. 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 of the insolvent insurer, for claims incurred:

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

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

b. Make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty days notice of the termination of the benefits provided.

c. With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision d, if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

d. In providing the substitute coverage required under subdivision c, the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(1) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide

for any waiting period or exclusion that would not have applied under the terminated policy.

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

e. Alternative policies adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies of various types of future issuance without regard to any particular impairment or insolvency.

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

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

h. If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium must be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

i. The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

SECTION 24. AMENDMENT. Subsection 2 of section 26.1-38.1-16 of the North Dakota Century Code is amended and reenacted as follows:

2. Within one hundred eighty days after July 1, 1989, the association shall prepare a summary document describing the general purposes and current limitations of the chapter and complying with subsection 3. This document should be submitted to the commissioner for approval. Sixty days after receiving such approval, no insurer may deliver a policy or contract described in ~~subdivision a of~~ subsection 2 of section 26.1-38.1-01 to a policyholder or contractholder unless the document is delivered to the policyholder or contractholder to or at the time of delivery of the policy or contract except if subsection 4 applies. The document should also be available upon request by a policyholder. The distribution, delivery, or contents or interpretation of this document does not mean that either the policy or contract or the holder thereof would be covered in the event of the impairment or

insolvency of a member insurer. The document must be revised by the association as amendments to the chapter may require. Failure to receive this document does not give the policyholder, contractholder, certificate holder, or insured any greater rights than those stated in this chapter.

* SECTION 25. AMENDMENT. Section 26.1-42-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-42-01. Scope. This chapter applies to all kinds of direct insurance policies and contracts except life insurance policies, accident and health insurance policies, health service contracts, annuity contracts, contracts supplemental to life and accident and health insurance policies and annuity contracts, and any other policies and contracts within the application of ~~section 26.1-38-01~~ chapter 26.1-38.1, title insurance policies, surety contracts, credit insurance policies and contracts, mortgage guaranty insurance policies and contracts, and ocean marine insurance policies and contracts. This chapter must be liberally construed.

SECTION 26. AMENDMENT. Section 32-12.1-05 of the 1989 Supplement to the North Dakota Century Code is amended and reenacted as follows:

32-12.1-05. Liability insurance policy coverage. An insurance policy or insurance contract purchased by a political subdivision or state agency or a government self-insurance pool in which a political subdivision or state agency participates pursuant to this chapter may provide coverage for the types of liabilities established by this chapter and may provide such additional coverage as the state agency or the governing body of the political subdivision determines to be appropriate. The insurer may not assert the defense of governmental immunity, but this chapter confers no right upon a claimant to sue an insurer directly. If a dispute exists concerning the amount or nature of the required insurance coverage, the dispute must be tried separately. The insurance coverage authorized by this chapter may be in addition to any insurance coverage purchased by a political subdivision or state agency pursuant to any other provision of law and if premium savings will result therefrom, any insurance policies purchased pursuant to this chapter or any other provision of law may be written for a period which exceeds one year.

SECTION 27. AMENDMENT. Subsection 1 of section 32-12.1-15 of the 1989 Supplement to the North Dakota Century Code is amended and reenacted as follows:

1. After review by the commissioner of insurance and after receiving the commissioner's approval, the state or any state agency may insure either through an approved insurance company or through a government self-insurance pool formed under this chapter ~~against liabilities provided by this chapter~~ for its own protection or for the protection of any state employee. If a premium savings will result therefrom and the commissioner of insurance approves, the insurance policies may be taken out for more than one year, but in no event beyond a period of five years. No purchase of insurance pursuant to this section or participation in a government self-insurance pool may be construed as a waiver of any existing immunity to suit.

Approved April 5, 1991
Filed April 8, 1991

* NOTE: Section 26.1-42-01 was also amended by section 15 of Senate Bill No. 2068, chapter 54.

CHAPTER 302

HOUSE BILL NO. 1229
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

INSURANCE RATEMAKING ORGANIZATIONS

AN ACT to create and enact sections 26.1-25-02.1, 26.1-25-10.1, 26.1-25-10.2, 26.1-25-10.3, 26.1-25-10.4, 26.1-25-10.5, 26.1-25-19, and 26.1-30.1-03.1 of the North Dakota Century Code, relating to the recognition of an advisory organization's ratemaking-related activities; to amend and reenact sections 26.1-03-11, 26.1-25-01, subsections 1 and 2 of section 26.1-25-03, sections 26.1-25-04, 26.1-25-05, 26.1-25-09, 26.1-25-12, 26.1-25-13, 26.1-25-14, 26.1-25-17, 26.1-25-18, 26.1-30.1-02, 26.1-30.1-03, 26.1-30.1-06, subsection 3 of section 26.1-40-01, section 26.1-40-17, and subsection 1 of section 26.1-40-17.1 of the North Dakota Century Code, relating to the recognition of an advisory organization's ratemaking-related activities, cancellation and nonrenewal of commercial insurance, automobile policies, and policies covering rental vehicles; and to repeal sections 26.1-25-06, 26.1-25-07, 26.1-25-08, 26.1-25-10, and 26.1-25-11 of the North Dakota Century Code, relating to property and casualty insurance ratemaking.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-11. Fire companies to report statistical data - Failure to report - Exceptions to reporting requirements. Each insurance company issuing fire insurance policies covering property in this state shall annually report information setting forth the amount of earned premiums in this state for policies covering insured property located in this state and the amount of claims incurred. This information is not to include personal lines or farm property insurance. This information must be reported on a form prescribed by the commissioner. The company shall file the form with the commissioner or shall certify to the commissioner that the information has been reported directly to ~~a rating organization that predicates~~ an advisory organization upon whose filings the majority of the fire insurance rates for North Dakota are based. The form or certification must accompany the annual statement required under section 26.1-03-07. The commissioner shall forward information filed under this section to the ~~rating~~ advisory organization ~~that predicates~~ upon whose filings a majority of the fire insurance rates for North Dakota are based. Each ~~rating~~ advisory organization filing ~~rates~~ pursuant to chapter 26.1-25 shall use this information in ~~making rates~~ its filing. The commissioner shall revoke the certificate of authority of an insurance company failing to file the information required by this section.

SECTION 2. AMENDMENT. Section 26.1-25-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-01. Purpose of chapter - Construction. The purpose of this chapter is to promote the public welfare by regulating insurance rates so that they are not excessive, inadequate, or unfairly discriminatory, and to authorize and regulate limited cooperative action among insurers in ~~ratemaking~~ ratemaking-related activities and in other matters within the scope of this chapter. Nothing in this chapter is intended to prohibit or discourage reasonable competition, or to prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in ~~insurance rates,~~ rating systems, rating plans or practices. This chapter must be liberally interpreted to carry into effect this section.

SECTION 3. Section 26.1-25-02.1 of the North Dakota Century Code is created and enacted as follows:

26.1-25-02.1. Definitions.

1. "Advisory organization" means any entity, including its affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and which assists insurers in ratemaking-related activities as enumerated in this chapter. Two or more insurers having a common ownership or operating in this state under common management or control constitute a single insurer for purposes of this definition.

2. "Commercial risk" means any kind of risk which is not a personal risk.

3. "Developed losses" means losses including loss adjustment expenses, adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss including loss adjustment expense payments.

4. "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees.

5. "Joint underwriting" means a voluntary arrangement established to provide insurance coverage for a commercial risk pursuant to which two or more insurers jointly contract with the insured at a price and under policy terms agreed upon between the insurers.

6. "Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

7. "Personal risk" means homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs.

8. "Pool" means a voluntary arrangement, established on an ongoing basis, pursuant to which two or more insurers participate in the

sharing of risks on a predetermined basis. The pool may operate through an association, syndicate, or other pooling agreement.

9. "Prospective loss costs" means that portion of a rate that does not include provisions for expenses other than loss adjustment expenses, or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

10. "Rate" means that cost of insurance per exposure unit whether expressed as a single member or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premium.

11. "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

12. "Supplementary rating information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule, statistical plan, and any other similar information needed to determine the applicable rate in effect or to be in effect.

13. "Supporting information" means:

    a. The experience and judgment of the filer and the experience or date of other insurers or advisory organizations relied upon by the filer;

    b. The interpretation of any other data relied upon by the filer; and

    c. Descriptions of methods used in making the rates and any other information required by the commissioner to be filed.

SECTION 4. AMENDMENT. Subsections 1 and 2 of section 26.1-25-03 of the North Dakota Century Code are amended and reenacted as follows:

1. Rates must be made in accordance with the following provisions:

    a. Due consideration must be given to past and prospective loss experience within this state and outside this state to the extent that the consideration is given to areas the commissioner determines are representative of this state, to any conflagration and catastrophe hazards, to a reasonable margin for ~~underwriting~~ profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers, to past and prospective expenses both countrywide, as determined by the commissioner, and those specially applicable to this state, and to all other relevant factors within and outside

this state. In the case of fire insurance rates, consideration must be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which the experience is available. In determining the reasonableness of the profit, consideration may be given to investment income.

b. ~~In the case of casualty insurance, the~~ The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

c. ~~In the case of casualty insurance, risks~~ Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. The standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expense. No risk classification, however, may be based upon race, creed, national origin, or the religion of the insured.

d. ~~In the case of property insurance, manual, minimum, class rates, rating schedules, or rating plans must be made and adopted, except in the case of specified inland marine rates on risks specially rated.~~

~~e.~~ Rates may not be excessive, inadequate, or unfairly discriminatory.

2. Except to the extent necessary to meet subdivision ~~e~~ d of subsection 1, uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

SECTION 5. AMENDMENT. Section 26.1-25-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-04. Rate filings.

1. Every insurer shall file with the commissioner, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual, minimum class rate, rating schedule or rating plan, and every other rating rule, and every modification of any of the foregoing which it proposes to use. Every filing must state the proposed effective date thereof and must indicate the character and extent of the coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports the filing, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, the commissioner shall require the insurer to furnish the information upon which it supports the filing and the waiting period commences

as of the date the information is furnished. Every insurer shall file or incorporate by reference to material which has been approved by the commissioner, at the same time as the filing of the rate, all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The information furnished in support of a filing may include:

a. The experience or judgment of the insurer or ~~rating~~ advisory organization making the filing.

b. Its interpretation of any statistical data upon which it relies.

c. The experience of other insurers or ~~rating~~ advisory organizations.

d. Any other relevant factors.

A filing and any supporting information is open to public inspection after the filing becomes effective. Specific inland marine rates on risks specially rated, made by ~~a rating~~ an advisory organization, must be filed with the commissioner.

2. ~~An insurer may satisfy its obligation to make the filings by becoming a member of, or a subscriber to, a licensed rating organization which makes the filings, and by authorizing the commissioner to accept the filings on its behalf; provided, that upon the request of the commissioner the insurer shall file information relating to the insurer which supports the filing made by a rating organization prior to the filing becoming effective for the insurer.~~ After reviewing an insurer's filing, the commissioner may require that the insurer's rates be based upon the insurer's own loss and expense information. If the insurer's loss or allocated loss adjustment expense information is not actuarially credible, as determined by the commissioner, the insurer may use or supplement its experience with information filed with the commissioner by an advisory organization. Insurers utilizing the services of an advisory organization must provide with their rate filing, at the request of the commissioner, a description of the rationale for such use, including its own information and method of utilization of the advisory organization's information. This chapter does not require any insurer to become a member of or a subscriber to any ~~rating~~ advisory organization.

3. The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

4. Subject to the exceptions specified in subsection 5, each filing must be on file for a waiting period of sixty days before it becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the insurer or ~~rating~~ advisory organization which made the filing that the commissioner needs the additional time for the consideration of the filing. Upon written application by the insurer or ~~rating~~ advisory organization, the commissioner may authorize a filing

which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing is deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

5. Any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order or rule of a public body, not covered by a previous filing, becomes effective when filed and is deemed to meet the requirements of this chapter until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect. Specific inland marine rates on risks specially rated by ~~a rating~~ an advisory organization become effective when filed and are deemed to meet the requirements of this chapter until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect.

6. Under any rules the commissioner may adopt, the commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision, or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. The orders and rules must be made known to insurers and ~~rating~~ advisory organizations affected thereby. The commissioner may make any examination the commissioner deems advisable to ascertain whether any rates affected by the order meet the standards set forth in subdivision e of subsection 1 of section 26.1-25-03.

7. Upon the written application of the insured, stating the insured's reasons therefor, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

8. No insurer may make or issue a contract or policy except in accordance with the filings that have been approved and are in effect for the insurer as provided in this chapter or in accordance with subsection 6 or 7.

9. Nothing in this chapter may be construed to require an advisory organization or its members or its subscribers to immediately refile final rates or premium charges previously approved by the commissioner. Members or subscribers of an advisory organization are authorized to continue to use insurance rates or premium charges approved before the effective date of this Act or decreases from those rates or premium charges filed by the advisory organization and subsequently approved after the effective date of this Act.

SECTION 6. AMENDMENT. Section 26.1-25-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-05. Disapproval of filings.

1. If within the waiting period or any extension thereof as provided in subsection 4 of section 26.1-25-04 the commissioner finds that a filing does not meet the requirements of this chapter, the

commissioner shall send to the insurer or ~~rating~~ advisory organization which made the filing written notice of disapproval of the filing specifying therein in what respects the commissioner finds the filing fails to meet the requirements of this chapter and stating that the filing will not become effective.

2. If within thirty days after a filing subject to subsection 5 of section 26.1-25-04 has become effective the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall send to the insurer or ~~rating~~ advisory organization that made the filing written notice of disapproval of the filing specifying therein in what respect the commissioner finds that the filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, the filing will be deemed no longer effective. The disapproval may not affect any contract made or issued prior to the expiration of the period set forth in the notice.

3. If at any time subsequent to the applicable review period provided for in subsection 1 or 2 the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall, after a hearing held upon not less than ten days' written notice, specifying the matters to be considered at the hearing, to every insurer and ~~rating~~ advisory organization which made the filing, issue an order specifying in what respects the commissioner finds that the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing will be deemed no longer effective. Copies of the order must be sent to every such insurer and ~~rating~~ advisory organization. The order may not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

4. Any person or organization aggrieved with respect to any filing which is in effect may make written application to the commissioner for a hearing thereon. However, the insurer or ~~rating~~ advisory organization that made the filing may not proceed under this subsection. The application must specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds are established, and that the grounds otherwise justify holding such a hearing, the commissioner shall, within thirty days after receipt of the application, hold a hearing upon not less than ten days' written notice to the applicant and to every insurer and ~~rating~~ advisory organization which made the filing. If, after the hearing, the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing will be deemed no longer effective. Copies of the order must be sent to the applicant and to every such insurer and ~~rating~~ advisory organization. The order may not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

5. A manual, minimum class rate, rating schedule, rating plan, or rating rule, or any modification of any of the foregoing, which has

been filed pursuant to the requirements of section 26.1-25-04, may not be disapproved if the rates thereby produced meet the requirements of this chapter.

SECTION 7. AMENDMENT. Section 26.1-25-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-09. Information to be furnished insureds - Hearings and appeals of insureds. Every ~~rating organization and every~~ insurer which ~~makes its own~~ files rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to the rate. Every ~~rating organization and every~~ insurer which ~~makes its own~~ files rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by an authorized representative, on the person's written request to review the manner in which the rating system has been applied in connection with the insurance afforded the person. If the ~~rating organization or~~ insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of the ~~rating organization or the~~ insurer on the request may, within thirty days after written notice of the action, appeal to the commissioner, who, after a hearing held upon not less than ten days' written notice to the appellant and to the ~~rating organization or~~ insurer, may affirm or reverse the action.

SECTION 8. Section 26.1-25-10.1 of the North Dakota Century Code is created and enacted as follows:

26.1-25-10.1. Licensing advisory organizations.

1. No advisory organization may provide any service relating to the rates of any insurance subject to this chapter, and no insurer may utilize the services of such organization for such purposes unless the organization has obtained a license under subsection 3.

2. No advisory organization may refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

3. a. An advisory organization applying for a license shall include with its application:

   (1) A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation, and any other rules or regulations governing the conduct of its business;

   (2) A list of its members and subscribers;

   (3) The name and address of one or more residents of this state upon whom notices, process affecting it, or orders of the commissioner may be served;

(4) A statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(5) A biography of the ownership and management of the organization; and

(6) Any other relevant information and documents that the commissioner may require.

b. Every organization that has applied for a license shall notify the commissioner of every material change in the facts or in the documents on which its application was based. Any amendment to a document filed under this section must be filed at least thirty days before it becomes effective.

c. If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed, and that all requirements of the law are met, the commissioner shall issue a license specifying the authorized activity of the applicant. The commissioner may not issue a license if the proposed activity would tend to create a monopoly or to substantially lessen the competition in any market.

d. Licenses issued pursuant to this section are perpetual in duration unless the license is suspended or revoked. The fee for the license is fifty dollars per year. The commissioner may at any time, after hearing, revoke or suspend the license of an advisory organization that does not comply with the requirements and standards of this chapter.

SECTION 9. Section 26.1-25-10.2 of the North Dakota Century Code is created and enacted as follows:

26.1-25-10.2. Insurers and advisory organizations - Prohibited activity.

1. No insurer or advisory organization may:

a. Attempt to monopolize or combine or conspire with any other person to monopolize an insurance market.

b. Engage in a boycott, on a concerted basis, of an insurance market.

2. a. No insurer may agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to develop statistical plans permitted by subsection 1. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections, or

similar materials is not sufficient in itself to support a finding that an agreement exists.

b. Two or more insurers having a common ownership or operating in this state under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this chapter as if they constituted a single insurer.

3. No insurer or advisory organization may make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance.

4. In addition to the other prohibitions contained in this chapter, except as specifically permitted under this section, no advisory organization may compile or distribute recommendations relating to rates that include expenses other than loss adjustment expenses, or profit.

SECTION 10. Section 26.1-25-10.3 of the North Dakota Century Code is created and enacted as follows:

26.1-25-10.3. Advisory organizations - Permitted activity. Any advisory organization in addition to other activities not prohibited, is authorized, on behalf of its members and subscribers, to:

1. Develop statistical plans including territorial and class definitions.

2. Collect statistical data from members, subscribers, or any other sources.

3. Prepare and distribute prospective loss costs.

4. Prepare and distribute factors, calculations, or formulas pertaining to classification, territory, increased limits, and other variables.

5. Prepare and distribute manuals of rating rules and rating schedules that do not include final rates, expense provisions, profit provisions, or minimum premiums.

6. Distribute information that is required or directed to be filed with the commissioner.

7. Conduct research and onsite inspections in order to prepare classifications of public fire defenses.

8. Consult with public officials regarding public fire protection as it would affect members, subscribers, and others.

9. Conduct research and collect statistics in order to discover, identify, and classify information relating to causes or prevention of losses.

10. Prepare policy forms and endorsements and consult with members, subscribers, and others relative to their use and application.

11. Conduct research and onsite inspections for the purpose of providing risk information relating to individual structures.

12. Collect, compile, and distribute past and current prices of individual insurers and publish such information.

13. File final rates, at the direction of the commissioner, for residual market mechanisms.

14. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

SECTION 11. Section 26.1-25-10.4 of the North Dakota Century Code is created and enacted as follows:

26.1-25-10.4. Advisory organizations - Filing requirements. Every advisory organization shall file with the commissioner for approval all prospective loss costs and all supplementary rating information and every change or amendment or modification of any of the foregoing proposed for use in this state. The filings are subject to the provisions of this chapter relating to filings made by insurers.

SECTION 12. Section 26.1-25-10.5 of the North Dakota Century Code is created and enacted as follows:

26.1-25-10.5. Joint underwriting, joint reinsurance pool, and residual market activities.

1. Authorization. Notwithstanding subdivision a of subsection 2 of section 26.1-25-10.1, insurers participating in joint underwriting, joint reinsurance pools, or residual market mechanisms may in connection with such activity act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss and expense statistics or other information, or carrying on research. Joint underwriting, joint reinsurance pools, and residual market mechanisms may not be deemed an advisory organization.

2. Regulation.

   a. Except to the extent modified by this section, insurers, joint underwriting, joint reinsurance pool, and residual market mechanism activities are subject to the other provisions of this chapter.

   b. If, after hearing, the commissioner finds that any activity or practice of an insurer participating in joint underwriting or a pool is unfair, is unreasonable, will tend to lessen competition in any market, or is otherwise inconsistent with the provisions or purposes of this chapter, the commissioner may issue a written order and require the discontinuance of such activity or practice.

c. Every pool shall file with the commissioner a copy of its constitution; its articles of incorporation, agreement, or association; its bylaws, rules, and regulations governing its activities; its members; the name and address of a resident of this state upon whom notices or orders of the commissioner or process may be served; and any changes in amendments or changes in the foregoing.

d. Any residual market mechanism, plan, or agreement to implement such a mechanism, and any changes or amendments thereto, must be submitted in writing to the commissioner for consideration and approval, together with such information as may be reasonably required. The commissioner may approve only such agreements as are found to contemplate:

(1) The use of rates that meet the standards prescribed by this chapter; and

(2) Activities and practices that are not unfair, unreasonable, or otherwise inconsistent with the provisions of this chapter.

At any time after such agreements are in effect, the commissioner may review the practices and activities of the adherents to such agreements and if, after a hearing, the commissioner finds that any such practice or activity is unfair or unreasonable, or is otherwise inconsistent with the provisions of this chapter, the commissioner may issue a written order to the parties and either require the discontinuance of such acts or revoke approval of any such agreement.

SECTION 13. AMENDMENT. Section 26.1-25-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-12. Examinations. ~~The commissioner shall, at least once in five years, make or cause to be made an examination of each rating organization licensed in this state.~~ The commissioner may, as often as the commissioner deems expedient, make or cause to be made an examination of each advisory organization referred to in section ~~26.1-25-10~~ 26.1-25-10.1 and of each group, association, or other organization referred to in section ~~26.1-25-11~~ 26.1-25-10.5. The reasonable costs of any examination must be paid by the ~~rating organization.~~ advisory organization, or group, association, or other organization examined upon presentation to it of a detailed account of the costs. The officer, manager, agents, and employees of the ~~rating organization,~~ advisory organization, or group, association, or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation.

The commissioner shall furnish two copies of the examination report to the organization, group, or association examined and shall notify the organization, group, or association that it may, within twenty days thereafter, request a hearing on the report or on any facts or recommendations therein. Before filing any report for public inspection, the commissioner shall grant a hearing to the organization, group, or association examined. The report of any examination, when filed for public inspection,

is admissible in evidence in any action or proceeding brought by the commissioner against the organization, group, or association examined, or its officers or agents, and is prima facie evidence of the facts stated therein. The commissioner may withhold the report of any examination from public inspection for the time as the commissioner deems proper.

In lieu of any such examination the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

SECTION 14. AMENDMENT. Section 26.1-25-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-13. Rate administration.

1. The commissioner shall adopt reasonable rules and statistical plans, reasonably adopted to each of the rating systems on file with the commissioner, which may be modified from time to time and which must be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner in determining whether rating systems comply with the standards set forth in section 26.1-25-03. The rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience. In adopting the rules and plans, the commissioner shall give due consideration to the rating systems on file with the commissioner and, in order that the rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for the rating systems in other states. No insurer may be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The commissioner may designate one or more ~~rating~~ advisory organizations or other agencies to assist the commissioner in gathering such experience and making compilations thereof, and the compilations must be made available, subject to reasonable rules adopted by the commissioner, to insurers and ~~rating~~ advisory organizations.

2. Reasonable rules and plans may be adopted by the commissioner for the interchange of data necessary for the application of rating plans.

3. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and ~~rating~~ advisory organization may exchange information and experience data with insurance supervisory officials, insurers, and ~~rating~~ advisory organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

4. The commissioner may adopt reasonable rules necessary to effect the purposes of this chapter.

SECTION 15. AMENDMENT. Section 26.1-25-14 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-14. False or misleading information. No person or organization may willfully withhold information from, or knowingly give false or misleading information to, the commissioner, any statistical agency designated by the commissioner, any ~~rating~~ advisory organization, or any insurer, which will affect the rates or premiums chargeable under this chapter. A violation of this section subjects the offender to the penalties provided in section 26.1-25-18.

SECTION 16. AMENDMENT. Section 26.1-25-17 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-17. Hearing procedure and judicial review. Any insurer or ~~rating~~ advisory organization aggrieved by any order or decision of the commissioner made without a hearing may, within thirty days after notice of the order to the insurer or organization, make written request to the commissioner for a hearing thereon. The commissioner shall hear the party within twenty days after receipt of the request and shall give not less than ten days' written notice of the time and place of the hearing. Within fifteen days after the hearing, the commissioner shall affirm, reverse, or modify the previous action, specifying the reasons therefor. Pending the hearing and decision thereon the commissioner may suspend or postpone the effective date of the previous action. This chapter does not require the observance at any hearing of formal rules of pleading or evidence.

SECTION 17. AMENDMENT. Section 26.1-25-18 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-18. Penalties. Any person who violates this chapter shall be guilty of a class B misdemeanor.

The commissioner may suspend the license of any ~~rating~~ advisory organization or insurer which fails to comply with the order of the commissioner with the time limited by the order or any extension thereof which the commissioner may grant. However, no right to suspend any license exists until after the time for appeal from the order has expired, or if an appeal has been taken, until the order has been affirmed, and no right of suspension exists if prompt compliance with the order is made following the expiration of the time for appeal or the entry of a final order or judgment of affirmance upon appeal. The commissioner may determine when a suspension becomes effective and it remains in effect for the period fixed by the commissioner, unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

A license may not be suspended or revoked except upon a written order of the commissioner, stating the findings, made after a hearing held upon not less than ten days' written notice to the person or organization specifying the alleged violation.

SECTION 18. Section 26.1-25-19 of the North Dakota Century Code is created and enacted as follows:

26.1-25-19. Exemptions. The commissioner may, by rule, exempt any market from any or all of the provisions of this chapter, if and to the extent that the exemption is necessary to achieve the purposes of this chapter.

SECTION 19. AMENDMENT. Section 26.1-30.1-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-30.1-02. Midterm cancellation of ~~liability~~ commercial insurance. No insurer may cancel a policy of commercial ~~liability~~ insurance during the term of the policy, except for one or more of the following reasons:

1. Nonpayment of premiums;

2. Misrepresentation or fraud made by or with the knowledge of the insured in obtaining the policy or in pursuing a claim under the policy;

3. Actions by the insured that have substantially increased or substantially changed the risk insured;

4. Refusal of the insured to eliminate known conditions that increase the potential for loss after notification by the insurer that the condition must be removed;

5. Substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the contract;

6. Loss of reinsurance by the insurer which provided coverage to the insurer for a significant amount of the underlying risk insured. Any notice of cancellation pursuant to this subsection must advise the policyholder that the policyholder has ten days from the date of receipt of the notice to appeal the cancellation to the insurance commissioner and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within five business days after receipt of the appeal;

7. A determination by the insurance commissioner that the continuation of the policy could place the insurer in violation of the insurance laws of this state; or

8. Nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to obtaining or continuing such insurance; except this provision for cancellation for failure to pay dues does not apply to persons who are retired at sixty-two years of age or older or to any person who is disabled according to social security standards.

9. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against.

SECTION 20. AMENDMENT. Section 26.1-30.1-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-30.1-03. Notice. Cancellation under subsections 2 through ~~8~~ 9 of section 26.1-30.1-02 is not effective prior to thirty days after notice to the policyholder. The notice of cancellation must contain a specific reason for cancellation as provided in section 26.1-30.1-02. A policy may not be

canceled for nonpayment of premium pursuant to subsection 1 of section 26.1-30.1-02 unless the insurer, at least ten days prior to the effective cancellation date, has given notice to the policyholder of the amount of premium due and the due date. The notice must state the effect of nonpayment by the due date. No cancellation for nonpayment of premium is effective if payment of the amount due is made prior to the effective date set forth in the notice.

SECTION 21. Section 26.1-30.1-03.1 of the North Dakota Century Code is created and enacted as follows:

26.1-30.1-03.1. Five-day notice exception for cancellation. Policies subject to this chapter may be canceled upon five days' written notice to the named insureds if one or more of the following conditions exist:

1. Buildings with at least sixty-five percent of the rental units in the building unoccupied.

2. Buildings that have been damaged by a peril insured against and the insured has stated or such time has elapsed as clearly indicates that the damage will not be repaired.

3. Buildings to which, following a fire, permanent repairs have not commenced within sixty days following satisfactory adjustment of loss.

4. Buildings that have been unoccupied sixty consecutive days, except buildings that have a seasonal occupancy, and buildings actually in the course of construction or repair and reconstruction which are properly secured against unauthorized entry.

5. Buildings that are in danger of collapse because of serious structural conditions or those buildings subject to extremely hazardous conditions not contemplated in filed rating plans such as those buildings that are in a state of disrepair as to be dilapidated.

6. Buildings on which, because of their physical condition, there is an outstanding order to vacate or an outstanding demolition order, or which have been declared unsafe in accordance with applicable law.

7. Buildings from which fixed and salvageable items have been or are being removed and the insured can give no reasonable explanation for the removal.

8. Buildings on which there is reasonable knowledge and belief that the property is endangered and is not reasonably protected from possible arson for the purpose of defrauding an insurer.

9. Buildings with any of the following conditions:

   a. Failure to furnish heat, water, sewer service, or public lighting for thirty consecutive days or more.

   b. Failure to correct conditions dangerous to life, health, or safety.

c. Failure to maintain the building in accordance with applicable law.

d. Failure to pay property taxes for more than one year.

10. Buildings that have characteristics of ownership condition, occupancy, or maintenance which are violative of law or public policy.

SECTION 22. AMENDMENT. Section 26.1-30.1-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-30.1-06. Nonrenewal of commercial ~~liability~~ insurance policies - Notice required - Exceptions.

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

2. This section does not apply if the policyholder has insured elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal.

SECTION 23. AMENDMENT. Subsection 3 of section 26.1-40-01 of the North Dakota Century Code is amended and reenacted as follows:

3. "Policy" means any automobile policy which includes automobile liability coverage, uninsured motorist coverage, underinsured motorist coverage, automobile medical payments coverage, basic or optional excess no-fault benefits, or automobile physical damage coverage, delivered or issued for delivery in this state, insuring as the named insured an individual residing in this state, and under which the insured vehicles designated in the policy are of the following types only:

   a. A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance, nor rented to others.

   b. Any four-wheel motor vehicle with a load capacity of one thousand five hundred pounds [680.39 kilograms] or less which is not used in the occupation, profession, or business of the insured, nor used as a public or livery conveyance, nor rented to others.

   c. Any motorcycle as that term is defined in section 39-01-01 that is not used as a public or livery conveyance, nor rented to others.

   "Policy" does not include any policy that has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy; any policy issued under the North Dakota assigned risk plan; any policy insuring more than six motor vehicles; any policy covering the operation of a garage, automobile sales agency, repair shop,

service station, or public parking place; any policy providing insurance only on an excess basis; or any other contract providing insurance to a named insured even though the contract may incidentally provide insurance with respect to such motor vehicles.

SECTION 24. AMENDMENT. Section 26.1-40-17 of the North Dakota Century Code is amended and reenacted as follows:

26.1-40-17. Establishment of primary and excess automobile liability coverages in certain instances. When an automobile insurance policy which includes only automobile liability coverage, uninsured motorist coverage, underinsured motorist coverage, automobile medical payments coverage, and basic or optional excess no-fault benefits, is in force for anyone engaged in the business of selling, repairing, servicing, storing, leasing, or parking motor vehicles and the owner of the vehicles loans, rents, or leases a vehicle to any other person or organization and the vehicle is involved in an accident out of which bodily injury or property damage arises, the following is applicable:

1. If no other automobile insurance policy is in force at the time of the accident for the person or organization to whom the vehicle was loaned, rented, or leased, the coverage provided by the motor vehicle owner's automobile policy extends to the borrower, rentee, or lessee in the event the owner's automobile insurance policy extends coverage to the borrower, rentee, or lessee.

2. If another automobile insurance policy is in force for the person or organization to whom the vehicle was loaned, rented, or leased, any coverage provided by the motor vehicle owner's automobile insurance policy is excess coverage only but limited, however, by the terms of the owner's applicable automobile insurance policy. The policy afforded the person or organization to whom the vehicle was loaned, rented, or leased is primary.

Any policy provisions at variance with this section must be interpreted so as to comply with this section.

SECTION 25. AMENDMENT. Subsection 1 of section 26.1-40-17.1 of the North Dakota Century Code is amended and reenacted as follows:

1. Every motor vehicle liability insurance policy, ~~as that term is defined in section 39-16.1-11,~~ as required by section 39-08-20, covering noncommercial private passenger motor vehicles must provide that all of the obligation for damage and loss of use to a rented private passenger vehicle will be covered by the property damage liability portion of the policy and subject to that policy limit. The obligation of the policy must not be contingent on fault or negligence of the insured. For purposes of this section, private passenger motor vehicle includes station wagons, minivans, vans, and pickups, and does not include motor homes, motorcycles, or trucks other than pickups.

SECTION 26. REPEAL. Sections 26.1-25-06, 26.1-25-07, 26.1-25-08, 26.1-25-10, and 26.1-25-11 of the North Dakota Century Code are repealed.

Approved March 20, 1991
Filed March 21, 1991

CHAPTER 303

HOUSE BILL NO. 1077
(Kloubec)

INSURANCE PREMIUM TAX CREDIT

AN ACT to provide a one-time credit against insurance premium tax liability for certain taxpayers; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Insurance premium tax credit for certain 1989 premium tax payments. A taxpayer is entitled to a credit, as provided in this section, against the tax otherwise due under section 26.1-03-17 if all of the following conditions are met:

1. The taxpayer collected premiums, assessments, membership fees, subscriber fees, policy fees, service fees collected by any third party administrator providing administrative services to a group that is self-insured for health care benefits, or finance and service charges in this state for sales of insurance other than life insurance after December 31, 1988, and before April 14, 1989, for which the amount paid by the purchaser was based upon a tax rate of one and one-fourth percent under section 26.1-03-17.

2. The taxpayer paid tax on the sale of insurance described in subsection 1 at a rate of one and three-fourths percent under section 26.1-03-17.

3. The taxpayer has not recouped the difference between the amount collected as determined under subsection 1 and the amount paid as premium tax as determined under subsection 2 through any other method, including a rate increase.

4. The credit under this section is limited to the difference between the amount collected in taxes as determined under subsection 1 and the amount paid in taxes as determined under subsection 2.

SECTION 2. EXPIRATION DATE. This Act is effective through June 30, 1992, and after that date is ineffective.

SECTION 3. EMERGENCY. This Act is declared to be an emergency measure.

Approved March 18, 1991
Filed March 19, 1991

CHAPTER 304

HOUSE BILL NO. 1227
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

MEDICARE SUPPLEMENT AND NURSING HOME INSURANCE

AN ACT to create and enact chapter 26.1-36.1, a new subsection to section 26.1-45-05, and sections 26.1-45-05.2, 26.1-45-11, and 26.1-45-12 of the North Dakota Century Code, relating to the regulation of medicare supplement insurance policies and sales, and provisions of long-term care insurance policies; to amend and reenact subdivision 1 of subsection 9 of section 26.1-04-03, sections 26.1-45-01, 26.1-45-04, subsection 2 of section 26.1-45-05, subsection 4 of section 26.1-45-06, sections 26.1-45-07, 26.1-45-09, and 26.1-45-10 of the North Dakota Century Code, relating to medicare supplement policies and the Prohibited Practices Act, noncustodial care coverage and provisions of long-term care insurance policies; to repeal sections 26.1-36-31, 26.1-36-32, 26.1-36-33, 26.1-36-34, 26.1-36-35, 26.1-36-36, 26.1-36-36.1, and 26.1-36-37 of the North Dakota Century Code, relating to the provisions of medicare supplement insurance policies and sales, and provisions of long-term care insurance policies; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subdivision 1 of subsection 9 of section 26.1-04-03 of the North Dakota Century Code is amended and reenacted as follows:

1. Providing coverage under a policy issued under chapter 26.1-45 or ~~as defined in section 26.1-36-31~~ chapter 26.1-36.1 for confinement to a nursing home and refusing to pay a claim when a person is covered by such a policy and the person's physician ordered confinement pursuant to the terms of the policy for care other than custodial care. Custodial care means care which is primarily for the purpose of meeting personal needs without supervision by a registered nurse or a licensed practical nurse.

SECTION 2. Chapter 26.1-36.1 of the North Dakota Century Code is created and enacted as follows:

26.1-36.1-01. Medicare supplement policies - Definitions. For purposes of this chapter:

1. "Applicant" means:

   a. In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

b. In the case of a group medicare supplement policy or subscriber contract, the proposed certificate holder.

2. "Certificate" means any certificate issued under a group medicare supplement policy which has been delivered or issued for delivery in this state.

3. "Medicare" means the Health Insurance for the Aged and Disabled Act, title XVIII of the Social Security Act of 1935, as amended [Pub. L. 92-603; 86 Stat. 1370].

4. "Medicare supplement policy" means a group or individual accident and health insurance policy or a subscriber contract of a health service corporation or a health care plan of a health maintenance organization, which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare by reason of age. The term does not include:

a. A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations.

b. A policy or contract of any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if the association:

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

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

(3) Has been in existence for at least two years prior to the date of its initial offering of the policy or plan to its members.

26.1-36.1-02. Standards for medicare supplement policies.

1. The commissioner shall adopt reasonable rules to establish specific standards for provisions of medicare supplement policies. The standards are in addition to and in accordance with applicable laws of this state, and may include coverage of:

a. Terms of renewability.

b. Initial and subsequent conditions of eligibility.

c. Nonduplication of coverage.

d. Probationary periods.

e. Benefit limitations, exceptions, and reductions.

f. Elimination periods.

g. Requirements for replacement.

h. Recurrent conditions.

i. Definition of terms.

2. The commissioner may adopt rules that specify prohibited medicare supplement policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.

3. Notwithstanding any other law, a medicare supplement policy may not deny a claim for losses incurred for more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting conditon more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

4. A policy or certificate of insurance providing medicare supplement benefits which is sold to a consumer in addition to another medicare supplement policy or which is sold to a consumer to replace such a policy may not contain any provision limiting payment of benefits due to preexisting conditions of the insured except if there is any time period remaining relating to the exclusion of coverage for preexisting conditions as specified in the underlying policy that remaining waiting period for coverage of preexisting conditions applies to the new policy unless the policy otherwise provides.

5. No medicare supplement insurance policy, contract, or certificate in force in the state may contain benefits that duplicate benefits provided by medicare.

26.1-36.1-03. Rulemaking authority. The commissioner may adopt rules to establish standards for benefits, standard policies and optional benefit riders, claims payments, abusive marketing practices and compensation arrangements, and reporting practices for medicare supplement policies.

26.1-36.1-04. Medicare supplement policy loss ratio standards. Medicare supplement policies must return benefits to individual policyholders in the aggregate of not less than sixty-five percent of premium received. The commissioner shall adopt rules to establish minimum standards for medicare supplement policy loss ratios on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices.

26.1-36.1-05. Medicare supplement policy disclosure standards.

1. To provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy may be delivered or issued for delivery in this state and no certificate may be delivered pursuant to a group medicare supplement policy delivered

or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time application is made.

2. The commissioner shall prescribe the format and content of the outline of coverage required by subsection 1. For purposes of this section, "format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. The outline of coverage must include:

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

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

   c. A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

   d. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

3. The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare concurrently with the delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare by reason of age, but in no event later than the time of policy delivery.

4. The commissioner may adopt rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for medicare, other than:

   a. Medicare supplement policies.

   b. Disability income policies.

   c. Basic, catastrophic, or major medical expense policies.

   d. Single premium, nonrenewable policies.

5. The commissioner may also adopt rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for medicare.

26.1-36.1-06. Medicare supplement policies - Notice of free examination. Medicare supplement policies or certificates must have a notice prominently printed on or attached to the first page of the policy stating in substance that the applicant may return the policy or certificate within thirty days of its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

26.1-36.1-07. Filing requirements for advertising. Every insurer, health care service plan, or other entity providing medicare supplement insurance or benefits in this state shall provide a copy of any medicare supplement advertisement within ten days after its first use in this state whether through written, radio, or television medium for review or approval by the commissioner to the extent required or authorized by state law.

26.1-36.1-08. Effect of policy not conforming to chapter. A policy delivered or issued for delivery to any person in this state in violation of this chapter is valid but must be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary are governed by this chapter.

26.1-36.1-09. General penalty - License suspension or revocation. Any person willfully violating any provision of this chapter or order of the commissioner made in accordance with this chapter is guilty of a class A misdemeanor. The commissioner may also suspend or revoke the license of an insurer or agent for any such willful violation.

SECTION 3. AMENDMENT. Section 26.1-45-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-01. Definitions. In this chapter ~~and section 26.1-36-37~~, unless the context requires otherwise:

1. "Applicant" means:

   a. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

   b. In the case of a group long-term care insurance policy, the proposed certificate holder.

2. "Certificate" means any certificate issued under a group long-term care insurance policy that has been delivered or issued for delivery in this state.

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

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

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

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

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

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

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

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

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

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

4. "Long-term care insurance" means any insurance policy or rider primarily advertised, marketed, offered, or designed to provide coverage for not less than one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health service corporations, prepaid health plans, health maintenance organizations, or any similar entity. The term also includes home health care type insurance policies or riders which provide directly or which supplement long-term care insurance; and include a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term does not include any insurance policy that is offered primarily to provide ~~catastrophic coverage and comprehensive coverage,~~ basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expenses coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income ~~protection~~ or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the

benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as a long-term care insurance is subject to the provisions of this chapter.

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

SECTION 4. AMENDMENT. Section 26.1-45-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-04. Disclosure and standards for long-term care insurance. The commissioner of insurance may adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

SECTION 5. AMENDMENT. Subsection 2 of section 26.1-45-05 of the North Dakota Century Code is amended and reenacted as follows:

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group ~~certificate~~ policyholder.

SECTION 6. A new subsection to section 26.1-45-05 of the North Dakota Century Code is created and enacted as follows:

Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

SECTION 7. Section 26.1-45-05.2 of the North Dakota Century Code is created and enacted as follows:

26.1-45-05.2. Nursing home policy - Guaranteed renewable for life - Limitation on preexisting conditions. Any long-term care insurance policy or certificate providing benefits for confinement to a nursing home must be guaranteed renewable for life. For purposes of this section, "guaranteed renewable for life" means the insured has the right to continue the policy in force for life subject to the policy's terms by the timely payment of premiums during which the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. The insurer may, however, in accordance with the provisions of the policy, make changes in premium rates as to all insureds who are placed in the same class for purposes of rate determination in the process of issuance of the policy or making it guaranteed renewable.

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

SECTION 8. AMENDMENT. Subsection 4 of section 26.1-45-06 of the North Dakota Century Code is amended and reenacted as follows:

4. The limitation on defining a preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection 2 expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection 2.

SECTION 9. AMENDMENT. Section 26.1-45-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-07. Prior institutionalization requirement prohibited.

1. ~~Effective one year after July 12, 1989, no~~ No long-term care insurance policy or certificate may be delivered or issued for delivery in this state if such policy:

   a. Conditions eligibility for any benefits on a prior hospitalization requirement~~, or~~.

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

   c. Conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement.

2. ~~Effective one year after July 12, 1989, a long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in subsection 1 must clearly label such limitations or conditions in the manner prescribed by the commissioner.~~

   a. A long-term care insurance policy containing postconfinement, postacute care, or recuperative benefits must clearly label in a separate paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" such

limitations or conditions, including any required number of days of confinement.

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

3. No long-term care insurance policy or rider which provides benefits only following institutionalization may condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

SECTION 10. AMENDMENT. Section 26.1-45-09 of the North Dakota Century Code is amended and reenacted as follows:

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

1. ~~a. Individual long-term care insurance policyholders under sixty-five years of age may return the policy within ten days of its delivery and policyholders at least sixty-five years of age may return the policy within thirty days of its delivery. Any policyholder that returns a policy under this section may have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies must have a notice prominently printed on the first page of the policy or attached to the first page stating that the policyholder has the right to return the policy within ten days of its delivery if the policyholder is under sixty-five years of age and within thirty days after its delivery if the policyholder is at least sixty-five years of age and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.~~

~~b. A person insured under a long-term care insurance policy or certificate issued pursuant to a direct response solicitation may return the policy within thirty days of its delivery and have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies or certificates issued pursuant to a direct response solicitation must have a notice prominently printed on the first page or attached to the first page stating in substance that the insured person may return the policy within thirty days of its delivery and may have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason.~~ Long-term care insurance applicants have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return

the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in subdivision a of subsection 3 of section 26.1-45-01, the applicant is not satisfied for any reason.

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

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

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

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

b. The outline of coverage must include:

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

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

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

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

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

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

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

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

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

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

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

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

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

   c. Any exclusions, reductions, and limitations on benefits of long-term care; and

   d. If applicable to the policy type, the summary shall also include:

      (1) A disclosure of the effects of exercising other rights under the policy;

      (2) A disclosure of guarantees relating to long-term care costs of insurance charges; and

      (3) Current and projected maximum lifetime benefits.

5. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report must be provided to the policyholder. Such report must include:

   a. Any long-term care benefits paid out during the month;

   b. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

   c. The amount of long-term care benefits existing or remaining.

SECTION 11. AMENDMENT. Section 26.1-45-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-45-10. Application. ~~This chapter and section 26.1-36-37 do not supersede the obligations of entities subject to this chapter and section 26.1-36-37 to comply with the substance of other applicable insurance laws insofar as they do not conflict with this chapter and section 26.1-36-37,~~

~~except that laws and rules designed and intended to apply to medicare supplement insurance policies may not be applied to long-term care insurance. A policy that is not advertised, marketed, or offered as long-term care insurance or solely as nursing home insurance need not meet the requirements of this chapter and section 26.1-36-37.~~ Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance must comply with the provisions of this chapter and all other applicable insurance laws insofar as they do not conflict with this chapter.

SECTION 12. Section 26.1-45-11 of the North Dakota Century Code is created and enacted as follows:

26.1-45-11. Rulemaking authority. The commissioner may adopt reasonable rules to establish minimum standards for correcting abusive marketing practices, replacement forms, agent testing, penalties, and reporting practices for long-term care insurance.

SECTION 13. Section 26.1-45-12 of the North Dakota Century Code is created and enacted as follows:

26.1-45-12. Penalties. In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this title relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

SECTION 14. REPEAL. Sections 26.1-36-31, 26.1-36-32, 26.1-36-33, 26.1-36-34, 26.1-36-35, 26.1-36-36, 26.1-36-36.1, and 26.1-36-37 of the North Dakota Century Code are repealed.

Approved March 27, 1991
Filed March 28, 1991

CHAPTER 305

HOUSE BILL NO. 1242
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

INSURANCE COMPANY REGULATION

AN ACT to create and enact chapter 26.1-06.1, sections 26.1-10-03.1 and 26.1-10-10.1, chapters 26.1-26.2, 26.1-26.3, 26.1-31.1, and 26.1-31.2 of the North Dakota Century Code, relating to rehabilitation and liquidation of insurance companies, insurance broker-controlled property and casualty insurance companies, managing general agents, reinsurance intermediaries, and credit for reinsurance; to amend and reenact subsections 2 and 4 of section 26.1-10-02, subsections 4 and 5 of section 26.1-10-03, sections 26.1-10-04, 26.1-10-05, 26.1-10-10, and 26.1-10-11, relating to insurance holding company systems; to repeal sections 26.1-07-08, 26.1-07-09, 26.1-07-10, 26.1-07-11, 26.1-07-12, 26.1-07-13, 26.1-07-14, 26.1-07-15, 26.1-07-16, 26.1-07-17, 26.1-07-18, 26.1-07-19, and 26.1-07-20, relating to rehabilitation and liquidation of insurance companies; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-06.1 of the North Dakota Century Code is created and enacted as follows:

26.1-06.1-01. Construction and purpose.

1. This chapter may not be interpreted to limit the powers granted the commissioner by other provisions of the law.

2. This chapter must be liberally construed to effect the purpose stated in subsection 3.

3. The purpose of this chapter is the protection of the interests of insureds, claimants, creditors, and the public generally; with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

   a. Early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures;

   b. Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

   c. Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

   d. Equitable apportionment of any unavoidable loss;

e. Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this state;

f. Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business; and

g. Providing for a comprehensive scheme for the rehabilitation and liquidation of insurance companies and those subject to this chapter as part of the regulation of the business of insurance, insurance industry, and insurers in this state. Proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

26.1-06.1-02. Persons covered. The proceedings authorized by this chapter may be applied to:

1. All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future.

2. All insurers who purport to do an insurance business in this state.

3. All insurers who have insureds residing in this state.

4. All persons subject to examination by the commissioner.

5. All other persons organized or in the process of organizing with the intent to do an insurance business in this state.

6. All nonprofit health service corporations subject to chapter 26.1-17.

7. All fraternal benefit societies subject to chapter 26.1-15.1.

8. All title insurance companies subject to chapter 26.1-20.

9. All health maintenance organizations subject to chapter 26.1-18.

10. All prepaid legal service companies subject to chapter 26.1-19.

26.1-06.1-03. Definitions. For the purposes of this chapter:

1. "Ancillary state" means any state other than a domiciliary state.

2. "Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

3. "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer, and any summary proceeding under section 26.1-06.1-09. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

4. "Doing business" includes any of the following acts, whether effected by mail or otherwise:

   a. The issuance or delivery of contracts of insurance to residents of this state;

   b. The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

   c. The collection of premiums, membership fees, assessments, or other consideration for such contracts;

   d. The transaction of matters subsequent to execution of such contracts and arising out of them;

   e. Operating under a license or certificate of authority, as an insurer, issued by the commissioner; or

   f. Any other act specified in section 26.1-02-06 as the transaction of an insurance business.

5. "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

6. "Fair consideration" is given for property or obligation:

   a. When in exchange for property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

   b. When property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

7. "Foreign country" means any other jurisdiction not in any state.

8. "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

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

10. "Insolvency" or "insolvent" means:

    a. For an insurer issuing only assessable fire insurance policies:

        (1) The inability to pay any obligation within thirty days after it becomes payable; or

        (2) If an assessment be made within thirty days after such date, the inability to pay the obligation thirty days following the date specified in the first assessment notice issued after the date of loss.

    b. For any other insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

        (1) Any capital and surplus required by law for its organization; or

        (2) The total par or stated value of its authorized and issued capital stock.

    c. As to any insurer licensed to do business in this state as of the effective date of this chapter which does not meet the standard established under subdivision b, the term "insolvency" or "insolvent" means, for a period not to exceed three years from the effective date of this chapter, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the commissioner under provisions of the insurance law.

    d. For purposes of this subsection "liabilities" includes reserves required by statute or by rule, or by specific requirements imposed by the commissioner upon a subject company at the time of admission or a later time.

11. "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by any other state. For purposes of this chapter, any other persons included under section 26.1-06.1-02 shall be deemed to be insurers.

12. "Policyholder" includes a certificate holder.

13. "Preferred claim" means any claim with respect to which the terms of this chapter accord priority of payment from the general assets of the insurer.

14. "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

15. "Reciprocal state" means any state other than this state in which in substance and effect subsection 1 of section 26.1-06.1-17 and sections 26.1-06.1-51, 26.1-06.1-52, 26.1-06.1-54, 26.1-06.1-55, and 26.1-06.1-56 are in force, and in which provisions are in force

requiring that the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

16. "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

17. "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

18. "State" means any state, district, or territory of the United States and the Panama Canal Zone.

19. "Transfer" includes the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

26.1-06.1-04. Jurisdiction and venue.

1. No delinquency proceeding may be commenced under this chapter by anyone other than the commissioner and no court has jurisdiction to entertain, hear, or determine any proceeding commenced by any other person.

2. No court of this state has jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this chapter.

3. In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the North Dakota Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

   a. If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

   b. If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a

delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract;

c. If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

d. If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

e. If the person served is obligated to the insurer in any way whatsoever, in any action on, or incident to the obligation.

4. If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

5. All action herein authorized must be brought in the district court in Burleigh County, North Dakota.

26.1-06.1-05. Injunctions and orders.

1. Any receiver appointed in a proceeding under this chapter may at any time apply for, and any district court may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

a. The transaction of further business;

b. The transfer of property;

c. Interference with the receiver or with a proceeding under this chapter;

d. Waste of the insurer's assets;

e. Dissipation and transfer of bank accounts;

f. The institution or further prosecution of any actions or proceedings;

g. The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its policyholders;

h. The levying of execution against the insurer, its assets, or its policyholders;

i. The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

j. The withholding from the receiver of books, accounts, documents, or other records including all written, printed, computer stored, visual, and audiovisual materials relating to the business of the insurer; or

k. Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this chapter.

2. The receiver may apply to any court outside of the state for the relief described in subsection 1.

26.1-06.1-06. Cooperation of officers, owners, and employees.

1. Any officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner in any proceeding under this chapter, or any investigation preliminary to the proceeding. The term "person" as used in this section includes any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" includes the following:

   a. To reply promptly in writing to any inquiry from the commissioner requesting a reply;

   b. To make available to the commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in possession, custody, or control of that person; and

   c. To be available for oral statements and interviews by the commissioner if so requested.

2. No person may obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

3. Any person included within subsection 1 who fails to cooperate with the commissioner, or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any valid order issued by the commissioner under this chapter is guilty of a class A misdemeanor and, after a hearing, may be subject to the imposition by the commissioner of a civil penalty not to exceed ten thousand dollars and may be subject further to the revocation or suspension of any insurance licenses issued by the commissioner.

26.1-06.1-07. Continuation of delinquency proceedings. Every proceeding heretofore commenced under the laws in effect before the enactment

of this chapter shall be deemed to have commenced under this chapter for the purpose of conducting the proceeding henceforth, except that in the discretion of the commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this chapter not been enacted.

26.1-06.1-08. Condition on release from delinquency proceedings. No insurer subject to any delinquency proceedings, whether administrative or judicial, may, until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, have been repaid to the guaranty associations, or until a plan of repayment by the insurer has been approved by the guaranty associations:

1. Be released from the proceeding, unless the proceeding is converted into a judicial rehabilitation or liquidation proceeding;

2. Be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

3. Be returned to the control of its shareholders or private management; or

4. Have any of its assets returned to the control of its shareholders or private management.

26.1-06.1-09. Court's seizure order.

1. The commissioner may file in the district court of this state a petition alleging, with respect to a domestic insurer:

   a. That grounds exist which justify a court order for a formal delinquency proceeding against an insurer under this chapter;

   b. That the interests of policyholders, creditors, or the public will be endangered by delay; and

   c. The contents of an order deemed necessary by the commissioner.

2. Upon a filing under subsection 1, the court may issue forthwith, ex parte, and without a hearing the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business; and, until further order of the court, enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

3. The court shall specify in the order the duration of the order which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems necessary after such notice as it deems appropriate, and may modify the terms or duration of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this

chapter after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this chapter shall ipso facto vacate the seizure order.

4. Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

5. An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of the order for a hearing and review of the order. The court shall hold a hearing and review not more than fifteen days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

6. If, at any time after the issuance of a seizure order under this section, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

26.1-06.1-10. Confidentiality of hearings. In all proceedings and judicial reviews thereof under section 26.1-06.1-09, all records of the insurer, other documents, and all insurance department files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the district court, after hearing arguments from the parties in chambers, orders otherwise; or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the district court shall be held by the clerk in a confidential file.

26.1-06.1-11. Grounds for rehabilitation. The commissioner may apply by petition to the district court for an order authorizing the rehabilitation of a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

1. The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public.

2. There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration, or diversion of the insurer's assets, forgery, or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

3. The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

4. Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

5. Any person, whether an officer, manager, general agent, director, trustee, employee, or other person, who in fact has executive authority in the insurer, has refused to be examined under oath by the commissioner concerning its affairs, whether in this state or elsewhere.

6. After demand by the commissioner pursuant to the provisions of sections 26.1-03-19 through 26.1-03-21, or pursuant to the provisions of this chapter, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

7. Without first obtaining the written consent of the commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to chapter 26.1-10 or 26.1-07, substantially its entire property or business, or has entered into any other transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

8. The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and the appointment has been made or is imminent, and the appointment might remove the insurer or its property from the jurisdiction of this state, or might prejudice orderly delinquency proceedings under this chapter.

9. Within the previous four years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the commissioner.

10. The insurer has failed to pay within sixty days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which the judgment was entered had jurisdiction over the subject matter except that the nonpayment shall not be a ground until sixty days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

11. The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to immediately respond with an adequate explanation.

12. The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities, request or consent to rehabilitation under this chapter.

13. Has been found after examination that, in the case of a stock insurance company, its minimum basic paid-in capital required by section 26.1-05-04 is impaired, or that, in the case of a domestic mutual insurance company, its surplus required by sections 26.1-12-08 and 26.1-12-10 is impaired.

26.1-06.1-12. Rehabilitation orders.

1. An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the commissioner and successor commissioners in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the district court or register of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

2. Any order issued under this section shall require accounting to the court by the rehabilitator. Accounting shall be at such intervals as the court specifies in its order, but no less frequently than semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under subsection 4 of section 26.1-06.1-13 will be prepared by the rehabilitator and the timetable for doing so.

3. Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer, unless such revocation or cancellation is done by the rehabilitator pursuant to section 26.1-06.1-13.

26.1-06.1-13. Powers and duties of the rehabilitator.

1. The commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ such counsel, clerks, and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, with the approval of the court and shall be paid out of the funds or assets of the insurer. The commissioner, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants, or other creditors, including guaranty associations, should such a committee be deemed necessary. The committee shall serve at the pleasure of the commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or the court in rehabilitation proceedings conducted under this chapter.

2. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance department out of the first available money of the insurer.

3. The rehabilitator may take such action deemed necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire, and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

4. If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

5. If it is determined that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period, and to such an extent as may be necessary.

6. The rehabilitator shall have the power under sections 26.1-06.1-25 and 26.1-06.1-26 to avoid fraudulent transfers.

26.1-06.1-14. Actions by and against rehabilitator.

1. Whenever any action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending at the time a rehabilitation order against the insurer is entered, the court before which the action or proceeding is pending shall stay the action or proceeding for ninety days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as deemed necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall

petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

2. No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered.

3. Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

26.1-06.1-15. Termination of rehabilitation.

1. Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the commissioner may petition the district court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under section 26.1-06.1-16. The district court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

2. The protection of the interests of insureds, claimants, and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of six months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under subsection 4 of section 26.1-06.1-13, the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

3. The rehabilitator may at any time petition the district court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the district court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 26.1-06.1-11 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The district court may also make that finding and issue that order at any time upon its own motion.

26.1-06.1-16. Grounds for liquidation. The commissioner may petition the district court for an order directing the liquidation of a domestic insurer or an alien insurer domiciled in this state on the basis:

1. Of any ground for an order of rehabilitation as specified in section 26.1-06.1-11, whether or not there has been a prior order directing the rehabilitation of the insurer;

2. That the insurer is insolvent; or

3. That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

26.1-06.1-17. Liquidation orders.

1. An order to liquidate the business of a domestic insurer shall appoint the commissioner and successor commissioners in office as liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the district court and the register of deeds of the county in which its principal office or place of business is located or, in the case of real estate, with the register of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds.

2. Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in sections 26.1-06.1-18 and 26.1-06.1-36.

3. An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

4. At the time of petitioning for an order of liquidation, or at any time thereafter, the commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper, the court may make the declaration.

5. Any order issued under this section shall require financial reports to the court by the liquidator. Financial reports must include the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports must be filed within one year of the liquidation order and at least annually thereafter.

6. a. Within five days of the effective date of this section, or, if later, within five days after the initiation of an appeal of an order of liquidation, which order has not been stayed, the commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. Such plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. In the event the defendant company's financial condition will not, in the judgment of the commissioner, support the full performance of all policy claims obligations during the appeal pendency period, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties as well as other policyholders and claimants, as the commissioner finds to be fair and equitable considering the relative circumstances of such policyholders and claimants. The court shall examine the plan submitted by the commissioner and if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the commissioner, or any deputies, agents, clerks, assistants, or attorneys employed or appointed by the commissioner by any party based on preference in an appeal pendency plan approved by the court.

b. The appeal pendency plan shall not supersede or affect the obligations of any insurance guaranty association.

c. Any such plans shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, in the event that the liquidator pays claims from assets of the estate, which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, such that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. Further, in the event an order of liquidation is set aside upon any appeal, the company shall not be released from delinquency proceedings unless and until all funds advanced by any guaranty association, including reasonable administrative expenses in connection therewith relating to obligations of the company, shall be repaid in full, together with interest at the judgment rate of interest or unless an arrangement for repayment thereof has been made with the consent of all applicable guaranty association.

26.1-06.1-18. Continuance of coverage.

1. All policies, including bonds and other noncancelable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only until the earlier of:

a. Thirty days from the date of entry of the liquidation orders;

b. The expiration of the policy coverage;

c. The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

d. The liquidator has effected a transfer of the policy obligation pursuant to subdivision i of subsection 1 of section 26.1-06.1-20; or

e. The date proposed by the liquidator and approved by the court to cancel coverage.

2. An order of liquidation under section 26.1-06.1-17 shall terminate coverages at the time specified in subsection 1 for purposes of any other statute.

3. Policies of life or health insurance or annuities shall continue in force for such period and under such terms as provided for by any applicable guaranty association or foreign guaranty association.

4. Policies of life or health insurance or annuities, or any period or coverage of such policies, not covered by a guaranty association or foreign guaranty association shall terminate under subsections 1 and 2.

26.1-06.1-19. Dissolution of insurer. The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time of application for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

26.1-06.1-20. Powers of liquidator.

1. The liquidator shall have the power:

a. To appoint a special deputy or deputies and to determine their reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section.

b. To employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and such other personnel as the liquidator may deem necessary to assist in the liquidation.

c. To appoint, with the approval of the court, an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. The committee shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or the court in liquidation proceedings conducted under this chapter.

d. To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers, and consultants with the approval of the court.

e. To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance department out of the first available moneys of the insurer.

f. To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to their testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records, or other documents the liquidator deems relevant to the inquiry.

g. To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer.

h. To collect all debts and moneys due and claims belonging to the insurer, wherever located, and for the following purposes:

(1) To institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts;

(2) To do such other acts as are necessary or expedient to collect, conserve, or protect its assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon such terms and conditions as deemed best; and

(3) To pursue any creditor's remedies available to enforce his claims.

i. To conduct public and private sales of the property of the insurer.

j. To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 26.1-06.1-41.

k. To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. The liquidator

shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

l. To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in class one under the priority of distribution.

m. To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

n. To continue to prosecute and to institute in the name of the insurer or in the name of the liquidator, any and all suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims the liquidator deems unprofitable to pursue further. If the insurer is dissolved under section 26.1-06.1-19, the liquidator shall have the power to apply to any court in this state or elsewhere for leave to substitute the liquidator for the insurer as plaintiff.

o. To prosecute any action which may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer, or any other person.

p. To remove any or all records and property of the insurer to the offices of the commissioner or to another place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations.

q. To deposit in one or more banks in this state any amounts of money required for meeting current administration expenses and dividend distributions.

r. To invest all moneys not currently needed, unless the court orders otherwise.

s. To file any necessary documents for record in the office of any register of deeds or record office in this state or elsewhere where property of the insurer is located.

t. To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of fraud, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation

and may defend only in the absence of a defense by such guaranty associations.

u. To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included in section 26.1-06.1-25, 26.1-06.1-26, or 26.1-06.1-27.

v. To intervene in any proceeding, wherever instituted, that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered.

w. To enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states.

x. To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this chapter.

2. a. If a company placed in liquidation issued liability policies on a claims-made basis, which provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of such policies, for a charge, an extended period to report claims as stated herein. The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or eighteen months from the order of liquidation.

b. The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such extended period within sixty days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. The offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within ninety days after the order of liquidation. No commissions, premium taxes, assessments, or other fees shall be due on the charge pertaining to the extended period to report claims.

3. The enumeration of the powers and authority of the liquidator in this section shall not be construed as a limitation upon the liquidator, nor shall it exclude in any manner the liquidator's right to do such other acts not herein specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

4. Notwithstanding the powers of the liquidator as stated in subsections 1 and 2, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

26.1-06.1-21. Notice to creditors and others.

1. Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

   a. By first-class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is doing business;

   b. By first-class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

   c. By first-class mail to all insurance agents of the insurer;

   d. By first-class mail to all persons known or reasonably expected to have claims against the insurer including all policyholders, at their last known address as indicated by the records of the insurer; and

   e. By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

2. Except as otherwise established by the liquidator with approval of the court, notice to potential claimants under subsection 1 shall require claimants to file with the liquidator their claims together with proper proofs thereof under section 26.1-06.1-35, on or before a date the liquidator shall specify in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

3. a. Notice under subsection 1 to agents of the insurer and to potential claimants who are policyholders must include, where applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

   b. The liquidator shall promptly provide to the guaranty associations any information concerning the identities and addresses of the policyholders and their policy coverages in the liquidator's possession or control, and otherwise cooperate with guaranty associations to assist them in providing to the policyholders timely notice of the guaranty associations' coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

4. If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

26.1-06.1-22. Duties of agents.

1. Every agent who receives notice in the form prescribed in section 26.1-06.1-21 that an insurer represented by that agent is the subject of a liquidation order, shall within thirty days of such notice provide to the liquidator, in addition to the information the agent may be required to provide pursuant to section 26.1-06.1-06, the information in the agent's records related to any policy issued by the insurer through the agent, and, if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through a subagent under contract with the agent, including the name and address of the subagent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had possession of a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

2. Any agent failing to provide information to the liquidator as required in subsection 1 may, following a hearing held by the commissioner, be subject to license suspension and payment of a penalty of not more than one thousand dollars.

26.1-06.1-23. Actions by and against liquidator.

1. Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any existing actions be maintained or further presented after issuance of the order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when the injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, the liquidator may intervene in the action. In any action in which the liquidator intervenes under this section, the liquidator may defend the action at the expense of the estate of the insurer.

2. The liquidator may, upon or after an order for liquidation, within two years or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any action or do any act, required of

or permitted to the insurer, within a period of one hundred eighty days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

3. No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the petition is denied.

4. Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if the association is or may become liable to act as a result of the liquidation.

26.1-06.1-24. Collection and list of assets.

1. As soon as practicable after the liquidation order, but not later than one hundred twenty days thereafter, unless extended by order of the court, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the clerk of the district court and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

2. The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

3. A submission to the court for disbursement of assets in accordance with section 26.1-06.1-33 fulfills the requirements of subsection 1 of this section.

26.1-06.1-25. Fraudulent transfers prior to petition.

1. Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

2. a. A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under subsection 3 of section 26.1-06.1-27.

   b. A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

   c. A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

   d. Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

   e. The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

3. Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection 1 if:

   a. The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

   b. Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

4. Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection 1 shall be personally liable therefore and shall be bound to account to the liquidator.

26.1-06.1-26. Fraudulent transfer after petition.

1. After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value. If the transfer is not made for a present fair equivalent value, then the transfer is valid to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the register of deeds in the county where any real property in question is located. The exercise by a court of

the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

2. After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

   a. A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value. If the transfer is not made for a present fair equivalent value, then the transfer is valid to the extent of the present consideration actually paid therefore, for which amount the transferee shall have a lien on the property so transferred.

   b. A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

   c. A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

   d. A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

3. Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection 1 shall be personally liable therefore and shall be bound to account to the liquidator.

4. Nothing in this chapter shall impair the negotiability of currency or negotiable instruments.

26.1-06.1-27. Voidable preferences and liens.

1. a. A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this chapter, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or

within two years before the filing of the successful petition for liquidation, whichever time is shorter.

b. Any preference may be avoided by the liquidator if:

(1) The insurer was insolvent at the time of the transfer;

(2) The transfer was made within four months before the filing of the petition;

(3) The creditor receiving it or to be benefited thereby or the creditor's agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(4) The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer, whether or not that person held such position, or any shareholder holding directly or indirectly more than five percent of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

c. Where the preference is voidable, the liquidator may recover the property or, if it has been converted, the liquidator may recover its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

2. a. A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

b. A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

c. A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

d. A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

e. The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

3. a. A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

b. A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection 2, if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection 2 through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

4. A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection 2 to be made or suffered after the transfer because of delay in perfecting it, does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

5. If any lien deemed voidable under subdivision b of subsection 1 has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this chapter which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

6. The property affected by any lien deemed voidable under subsections 1 and 5 shall be discharged from the lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

7. The district court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or less than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment to the liquidator of its value, as ascertained by the court, within such reasonable times as the court shall fix.

8. The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or, where the property is retained under subsection 7, to the extent of the amount paid to the liquidator.

9. If a creditor has been preferred, and afterward in good faith gives the insurer further credit, without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from the creditor.

10. If an insurer, directly or indirectly, within four months before the filing of a successful petition for liquidation under this chapter, or at any time in contemplation of a proceeding to liquidate it, pays money or transfers property to an attorney at law for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of the reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefits of the estate provided that where the attorney is in a position of influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney at law for services rendered or to be rendered shall be governed by the provision of subparagraph 4 of subdivision b of subsection 1.

11. a. Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when that person has reasonable cause to believe the insurer is insolvent or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to believe the insurer is insolvent or is about to become insolvent if the transfer was made within four months prior to the date of filing of the successful petition for liquidation.

b. Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection 1 shall be personally liable therefor and shall be bound to account to the liquidator.

c. Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

26.1-06.1-28. Claims of holders of void or voidable rights.

1. No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this chapter shall be allowed unless the creditor surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

2. A claim allowable under subsection 1 by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused last filing under section 26.1-06.1-34 if filed within thirty days from the date of the avoidance, or within the further time allowed by the court under subsection 1.

26.1-06.1-29. Setoffs.

1. Mutual debts or mutual credits, whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under this chapter, shall be set off and the balance only shall be allowed or paid, except as provided in subsections 2, 3, and 4 and section 26.1-06.1-32.

2. No setoff shall be allowed in favor of any person where:

a. The obligation of the insurer to the person would not at the date of filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

b. The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

c. The obligation of the insurer is owed to an affiliate of the person, or any other entity or association other than the person;

d. The obligation of the person is owed to an affiliate of the insurer, or any other entity or association other than the insurer;

e. The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay

a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

f. The obligations between the person and the insurer arise from business which is both ceded to and assumed from the insurer except that the rehabilitator may, with regard to such business, allow certain setoffs in rehabilitation if the liquidator finds the allowance of the setoffs appropriate.

3. The liquidator shall provide persons that assumed business from the insurer with accounting statements identifying debts which are currently due and payable. Such persons may set off against such debts only mutual credits which are currently due and payable by the insurer to such persons for the period covered by the accounting statement.

4. A person that ceded business to the insurer may set off debts due the insurer against only those mutual credits which the person has paid or which have been allowed in the insurer's delinquency proceeding.

5. Notwithstanding the foregoing, a setoff of sums due on obligations in the nature of those set forth in subdivision f of subsection 2 shall be allowed for those sums accruing from business written where the contracts were entered into, renewed, or extended with the express written approval of the commissioner of insurance of the state of domicile of the now insolvent insurer, when in the judgment of such commissioner it was necessary to provide reinsurance in order to prevent or mitigate a threatened impairment or insolvency of a domiciliary insurer in connection with the exercise of the commissioner's regulatory responsibilities.

6. These amendments shall become effective six months from the date of enactment and shall apply to all contracts entered into, renewed, extended, or amended on or after that date, and to debts or credits arising from any business written or transactions occurring after the effective date pursuant to any contract including those in existence prior to the effective date, and shall supersede any agreements or contractual provisions which might be construed to enlarge the setoff rights of any person under any contract with the insurer. For purposes of this section, any change in the terms of, or consideration for, any such contract shall be deemed an amendment.

26.1-06.1-30. Assessments.

1. As soon as practicable but not more than two years from the date of an order of liquidation under section 26.1-06.1-17 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

a. The reasonable value of the assets of the insurer;

b. The insurer's probable total liabilities;

c. The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

d. A recommendation as to whether or not an assessment should be made and in what amount.

2. a. Upon the basis of the report provided in subsection 1, including any supplements and amendments thereto, the district court may levy one or more assessments against all members of the insurer who are subject to assessment.

b. Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

3. After levy of assessment under subsection 2, the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order, to show cause why the liquidator should not pursue a judgment therefor.

4. The liquidator shall give notice of the order to show cause by publication and by first-class mail to each member liable thereunder mailed to the member's last known address as it appears on the insurer's records, at least twenty days before the return day of the order to show cause.

5. a. If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection 3, the court shall make an order adjudging the member liable for the amount of the assessment against the member pursuant to subsection 3, together with costs, and the liquidator shall have a judgment against the member therefor.

b. If, on or before the return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

6. The liquidator may enforce any order or collect any judgment under subsection 5 by any lawful means.

26.1-06.1-31. Reinsurer's liability. The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

1. a. An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits or setoffs, or both, shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

   b. An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

2. Upon satisfactory evidence of a violation of this section, the commissioner may pursue either one or both of the following courses of action:

   a. Suspend or revoke or refuse to renew the licenses of such offending party or parties.

   b. Impose a penalty of not more than one thousand dollars for each and every act in violation of this section by said party or parties.

3. Before taking any action as set forth in subsection 2, the commissioner shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation and fixing a time and place, at least ten days thereafter, when a hearing on the matter shall be held. After the hearing, or upon failure of the accused to appear at the hearing, if a violation is found to have been made, the commissioner shall impose any of the penalties under subsection 2 as deemed advisable.

4. When the commissioner takes action in any or all of the ways set out in subsection 2, the party aggrieved may appeal from said action to the district court.

26.1-06.1-33. Domiciliary liquidator's proposal to distribute assets.

1. Within one hundred twenty days of a final determination of insolvency of an insurer by the district court, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshaled assets, from time to time as the assets become available, to a guaranty association or foreign guaranty association having obligations because of the insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

2. The proposal to disburse assets referred to in subsection 1 shall at least include provisions for:

   a. Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and the payment of claims falling within the priorities established in section 26.1-06.1-41, classes one and two;

   b. Disbursement of the assets marshaled to date and subsequent disbursement of assets as they become available;

   c. Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

   d. The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section 26.1-06.1-41 in accordance with such priorities. No bond shall be required of any such association; and

   e. A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

3. The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association, then disbursements shall be in the amount of available assets.

4. The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating such associations.

5. Notice of such application shall be given to the association in and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mail, first-class postage prepaid, at least thirty days prior to submission of the application to the court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the liquidator's proposal complies with subdivisions a and b of subsection 2.

26.1-06.1-34. Filing of claims.

1. Proof of all claims shall be filed with the liquidator in the form required by section 26.1-06.1-35 on or before the last day for filing specified in the notice required under section 26.1-06.1-21, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

2. The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if the claimant did not file late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under any of the following circumstances:

   a. The existence of the claim was not known to the claimant and the claim was filed promptly once the claim became known to the claimant.

   b. A transfer to a creditor was avoided under sections 26.1-06.1-25, 26.1-06.1-26, and 26.1-06.1-27, or was voluntarily surrendered under section 26.1-06.1-28, and the filing satisfies the conditions of section 26.1-06.1-28.

   c. The valuation under section 26.1-06.1-40, of security held by a secured creditor shows a deficiency, which is filed within thirty days after the valuation.

3. The liquidator shall permit late filing claims to share in distribution, whether past or future, as if the claims were not filed late, if the claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

4. The liquidator may consider any claim filed late which is not covered by subsection 2, and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late filing claimant shall receive, at each distribution, the same percentage of the amount allowed on the late filed claim as is then being paid to claimants of any lower priority. This shall continue until the late filed claim has been paid in full.

26.1-06.1-35. Proof of claim.

1. Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

   a. The particulars of the claim including the consideration given for it;

   b. The identity and amount of the security on the claim;

   c. The payments made on the debt, if any;

d. That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;

e. Any right of priority of payment or other specific right asserted by the claimants;

f. A copy of the written instrument which is the foundation of the claim; and

g. The name and address of the claimant and the attorney who represents the claimant, if any.

2. No claim need be considered or allowed if it does not contain all the information in subsection 1 which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

3. At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection 1 and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

4. No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion need be considered as evidence of liability or of the amount of damages. No judgment or order against an insured or the insurer entered within four months before the filing of the petition need be considered as evidence of liability or of the amount of damages.

5. All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

26.1-06.1-36. Special claims.

1. The claim of a third party which is contingent only on first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

2. A claim may be allowed even if contingent, if it is filed in accordance with section 26.1-06.1-34. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

3. Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

4. Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under section 26.1-06.1-12 or 26.1-06.1-17.

26.1-06.1-37. Special provisions for third party claims.

1. Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

2. Whether or not the third party files a claim, the insured may file a claim in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty days after mailing of the notice required by section 26.1-06.1-21, whichever is later, the insured is an unexcused late filer.

3. The liquidator shall make recommendations to the court under section 26.1-06.1-41, for the allowance of an insured's claim under subsection 2 after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, the liquidator shall reconsider the claim on the basis of additional information and amend recommendations made to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it deems appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of:

   a. The amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expenses of defense; or

   b. The amount allowed on the claims by the court.

   After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

4. If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection 3. If any insured's claim is subsequently reduced under subsection 3, the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

5. No claim may be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

26.1-06.1-38. Disputed claims.

1. When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or the claimant's attorney by first-class mail at the address shown in the proof of claim. Within sixty days from the mailing of the notice, the claimant may file objections to the determination with the liquidator. If no such filing is made, the claimant may not further object to the determination.

2. Whenever objections are filed with the liquidator and the liquidator does not alter the denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first-class mail to the claimant or the claimant's attorney and to any other persons directly affected, not less than ten nor more than thirty days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with a recommendation.

26.1-06.1-39. Claims of surety. Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that the other person discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution; however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person" as used in this section is not intended to apply to a guaranty association or foreign guaranty association.

26.1-06.1-40. Secured creditor's claims.

1. The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

   a. By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

   b. By agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

2. The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant surrenders the security to the liquidator, the entire claim shall be allowed as if unsecured.

26.1-06.1-41. Priority of distribution. The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class

shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

1. Class 1. The costs and expenses of administration during rehabilitation and liquidation, including the following:

   a. The actual and necessary costs of preserving or recovering the assets of the insurer;

   b. Compensation for all authorized services rendered in the rehabilitation and liquidation;

   c. Any necessary filing fees;

   d. The fees and mileage payable to witnesses;

   e. Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation; and

   f. The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

2. Class 2. Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for service performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

3. Class 3. All claims under policies including such claims of the federal or any state or local government for losses incurred, ("loss claims") including third party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits, or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to employees shall be treated as a gratuity.

4. Class 4. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors including claims of ceding and assuming companies in their capacity as such.

5. Class 5. Claims of the federal or any state or local government except those under class 3 above. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or

forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection 8.

6. Class 6. Claims filed late or any other claims other than claims under subsections 7 and 8.

7. Class 7. Surplus or contribution notes, or similar obligations, and premium funds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

8. Class 8. The claims of shareholders or other owners in their capacity as shareholders.

26.1-06.1-42. Liquidator's recommendations to the court.

1. The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as deemed necessary. The liquidator may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under section 26.1-06.1-38. As soon as practicable, the liquidator shall present to the court a report of the claims against the insurer along with the recommendations of the liquidator. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

2. The court may approve, disapprove, or modify the report on claims by the liquidator. The reports which are not modified by the court within a period of sixty days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to section 26.1-06.1-38. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

26.1-06.1-43. Distribution of assets. Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

26.1-06.1-44. Unclaimed and withheld funds.

1. All unclaimed funds subject to distribution remaining under the liquidator's control when the liquidator is ready to apply to the court for discharge, including the amount distributable to any

creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the state treasurer, and shall be paid without interest except in accordance with section 26.1-06.1-41 to the person entitled thereto or the person's legal representative upon proof satisfactory to the state treasurer of the person's right thereto. Any amount on deposit not claimed within six years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the general fund.

2. All funds withheld under section 26.1-06.1-36 and not distributed shall upon discharge of the liquidator be deposited with the state treasurer and paid out in accordance with section 26.1-06.1-41. Any sums remaining which under section 26.1-06.1-41 would revert to the undistributed assets of the insurer shall be transferred to the state treasurer and become the property of the state under subsection 1, unless the commissioner petitions the court to reopen the liquidation under section 26.1-06.1-46.

26.1-06.1-45. Termination of proceedings.

1. When all assets justifying the expense of collection and distribution have been collected and distributed under this chapter, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be deemed appropriate.

2. Any other person may apply to the court at any time for an order under subsection 1. If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

26.1-06.1-46. Reopening liquidation. After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the district court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

26.1-06.1-47. Disposition of records during and after termination of liquidation. Whenever it appears to the commissioner that the records of any liquidated insurer or any insurer in the process of liquidation are no longer useful, the commissioner may recommend to the court and the court direct which records should be retained for future reference and which records should be destroyed.

26.1-06.1-48. External audit of the receiver's books. The district court may, as it deems necessary, cause audits to be made of the books of the commissioner relating to any receivership established under this chapter, and a report of each audit shall be filed with the commissioner and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

26.1-06.1-49. Conservation of property of foreign or alien insurers found in this state.

1. If a domiciliary liquidator has not been appointed, the commissioner may apply to the district court by verified petition for an order directing the commissioner to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

   a. Any of the grounds in section 26.1-06.1-11;

   b. That any of its property has been sequestered by official action in its domiciliary state, or in any other state;

   c. That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent; and

   d. (1) That its certificate of authority to do business in this state has been revoked or that none was ever issued; and

   (2) That there are residents of this state with outstanding claims or outstanding policies.

2. When an order is sought under subsection 1, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

3. The court may issue the order in whatever terms it deems appropriate. The filing or recording of the order with the clerk of the district court or the register of deeds of the county in which the principal business of the company is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds.

4. The conservator may at any time petition for and the court may grant an order under section 26.1-06.1-50 to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, an order to be appointed ancillary receiver under section 26.1-06.1-52.

5. The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if the motion is denied, all costs shall be assessed against the moving party.

26.1-06.1-50. Liquidation of property of foreign or alien insurers found in this state.

1. If no domiciliary receiver has been appointed, the commissioner may apply to the district court by verified petition for an order directing the commissioner to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

a. Any of the grounds in section 26.1-06.1-11 or 26.1-06.1-16; or

b. Any of the grounds specified in subdivisions b, c, and d of subsection 1 of section 26.1-06.1-49.

2. When an order is sought under subsection 1, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

3. If it shall appear to the court that the best interests of creditors, policyholders, and the public require, the court may issue an order to liquidate in whatever terms it deems appropriate. The filing or recording of the order with the clerk of the district court or the register of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds.

4. If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 26.1-06.1-52. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under section 26.1-06.1-52.

5. On the same grounds as are specified in subsection 1, the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and creditors in this state.

6. Once the assets of a foreign or alien insurer have been liquidated by the commissioner under this section, the court may order the commissioner to pay claims or residents of this state against the insurer under such rules as to the liquidation of insurers under this chapter as are otherwise compatible with the provisions of this section.

26.1-06.1-51. Domiciliary liquidators in other states.

1. The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under subsection 3 of section 26.1-06.1-52, be vested by operation of law with the title to all of the assets, property, contracts and rights of action, agents' balances, and all of the books, accounts, and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting or property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain

possession of the books, accounts, and other records of the insurer located in this state. The domiciliary liquidator shall also have the right to recover all other assets of the insurer located in this state, subject to section 26.1-06.1-52.

2. If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state shall be vested by operation of law with the title to all of the property, contracts and right of action, and all of the books, accounts, and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under section 26.1-06.1-49 or 26.1-06.1-50, or for an ancillary receivership under section 26.1-06.1-52, or after approval by the district court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

3. Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

26.1-06.1-52. Ancillary formal proceedings.

1. If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the commissioner may file a petition with the district court requesting appointment as ancillary receiver in this state:

   a. If the commissioner finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver; or

   b. If the protection of creditors or policyholders in this state so requires.

2. The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the register of deeds in this state imparts that same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds.

3. When a domiciliary liquidator has been appointed in a reciprocal state, the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. The ancillary receiver shall promptly transfer all remaining assets, books, accounts, and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and deputies of the ancillary receiver shall have the same powers and

be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

4. When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties, and powers to those provided in subsection 3 for ancillary receivers appointed in this state.

26.1-06.1-53. Ancillary summary proceedings. The commissioner has sole discretion to institute proceedings under sections 26.1-06.1-09 and 26.1-06.1-10 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

26.1-06.1-54. Claims of nonresidents against insurers domiciled in this state.

1. In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

2. Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this chapter, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in subsection 2 of section 26.1-06.1-55 with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under section 26.1-06.1-41.

26.1-06.1-55. Claims of residents against insurers domiciled in reciprocal states.

1. In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

2. Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove a claim in this state, the claimant shall file the claim with the liquidator in the manner provided in sections 26.1-06.1-34 and 26.1-06.1-35. The ancillary receiver shall make a

recommendation to the court as under section 26.1-06.1-42. The ancillary receiver shall also arrange a date for hearing if necessary under section 26.1-06.1-38 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of intention to contest the claim, the domiciliary liquidator shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

3. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

26.1-06.1-56. Attachment, garnishment, and levy of execution. During the pendency of a liquidation proceeding in this or any other state, whether the liquidation proceeding is identified as such or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

26.1-06.1-57. Interstate priorities.

1. In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

2. The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

3. The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender the security and file a claim as a general creditor, or the claim may be discharged by resort to the security in accordance with section 26.1-06.1-40, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

26.1-06.1-58. Subordination of claims for noncooperation. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within the control of the ancillary receiver, other than

special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under subsection 7 of section 26.1-06.1-41.

26.1-06.1-59. Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

* SECTION 2. AMENDMENT. Subsections 2 and 4 of section 26.1-10-02 of the North Dakota Century Code are amended and reenacted as follows:

2. In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under all other sections, a domestic insurance company may also:

   a. Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of five percent of the insurance company's admitted assets or fifty percent of the company's surplus as regards policyholders; provided, that after the investments the company's surplus as regards policyholders will be reasonable in relation to the company's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, there must be included:

      (1) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by the purchase of capital stock or issuance of other securities.

      (2) All amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation.

   b. ~~If the insurance company's total liabilities, as calculated for national association of insurance commissioners annual statement purposes, are less than ten percent of assets, invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries; provided, that after the investment the company's surplus as regards policyholders, considering the investment as if it were a disallowed asset, will be reasonable in relation to the company's outstanding liabilities and adequate to its financial needs.~~

   ~~c.~~ Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries; provided, that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurance company to exceed any of the investment limitations specified in subsection 1 and

* NOTE: Section 26.1-10-02 was also amended by section 8 of Senate Bill No. 2266, chapter 301.

subdivision a of subsection 2. "The total investment of the insurance company" includes:

(1) Any direct investment by the company in an asset.

(2) The company's proportionate share of any investment in an asset by any subsidiary of the company, which must be calculated by multiplying the amount of the subsidiary's investment by the percentage of the company's ownership of such subsidiary.

~~d.~~ c. With the approval of the commissioner, invest any amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided, that after such investment the insurance company's surplus as regards policyholders will be reasonable in relation to the company's outstanding liabilities and adequate to its financial needs.

~~e. Invest any amount in the common stock, preferred stock, debt obligations, or other securities of any subsidiary exclusively engaged in holding title to and managing or developing real or personal property, if after considering as a disallowed asset so much of the investment as is represented by subsidiary assets which if held directly by the insurance company would be considered as a disallowed asset, the company's surplus as regards policyholders will be reasonable in relation to the company's outstanding liabilities and adequate to its financial needs, and if following the investment all voting securities of the subsidiary would be owned by the company.~~

4. Whether any investment pursuant to subsection 2 meets the applicable requirements thereof is to be determined immediately after such investment is made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the date they were made net of any return of capital invested, not including dividends.

SECTION 3. AMENDMENT. Subsections 4 and 5 of section 26.1-10-03 of the North Dakota Century Code are amended and reenacted as follows:

4. The commissioner shall approve any merger or other acquisition of control referred to in subsection 1 unless, after a public hearing, the commissioner finds that:

a. After the change of control, the domestic insurance company referred to in subsection 1 would not be able to satisfy the requirements for the issuance of a certificate of authority to write the lines of insurance for which it is presently licensed.

b. The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein.

c. The financial condition of any acquiring party might jeopardize the financial stability of the insurance company, or prejudice

the interest of its policyholders ~~or the interests of any remaining securityholders who are unaffiliated with the acquiring party~~.

d. ~~The terms of the offer, request, invitation, agreement, or acquisition referred to in subsection 1 are unfair and unreasonable to the securityholders of the insurance company.~~

~~c.~~ The plans or proposals which the acquiring party has to liquidate the insurance company, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the company and not in the public interest.

~~f.~~ e. The competence, experience, and integrity of those persons who would control the operation of the insurance company are such that it would not be in the interest of policyholders of the company and of the public to permit the merger or other acquisition of control.

f. The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

The commissioner shall hold the public hearing referred to in this subsection within thirty days after the statement required by subsection 1 is filed, and shall give at least twenty days' notice to the person filing the statement. Not less than seven days' notice of the hearing must be given by the person filing the statement to the insurance company and to other persons designated by the commissioner. ~~The insurance company shall give notice to its securityholders.~~ The commissioner shall make a determination within thirty days after the conclusion of the hearing. At the hearing, the person filing the statement, the insurance company, any person to whom notice of hearing was sent, and any other person whose interests may be affected have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith are entitled to conduct discovery proceedings in the same manner allowed in district court of this state. All discovery proceedings must be concluded not later than three days prior to the hearing. The commissioner may retain at the acquiring person's expense any 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 proposed acquisition of control.

~~5. The insurance company shall mail all statements, amendments, or other material filed pursuant to subsection 1 or 2, and all notices of public hearings held pursuant to subsection 4, to its shareholders within five business days after receipt by the company. The person making the filing shall bear the expenses of mailing. As security for the payment of the expenses, the person shall file with the commissioner an acceptable bond or other deposit in an amount determined by the commissioner.~~

SECTION 4. Section 26.1-10-03.1 of the North Dakota Century Code is created and enacted as follows:

26.1-10-03.1. Acquisitions involving insurance companies not otherwise covered.

1. For the purpose of this section:

   a. "Acquisition" means any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes the acquisition of voting securities, the acquisition of assets, bulk reinsurance, and mergers.

   b. An "involved insurance company" includes an insurance company which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

2. a. Except as exempted in subdivision b of this subsection, this section applies to any acquisition in which there is a change in control of an insurance company authorized to do business in this state.

   b. This section does not apply to the following:

      (1) An acquisition subject to approval or disapproval by the commissioner pursuant to section 26.1-10-03;

      (2) A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under subsection 2 of section 26.1-10-01, it is not solely for investment purposes unless the commissioner of the insurance company's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;

      (3) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the commissioner in accordance with subdivision 1 of subsection 3 thirty days prior to the proposed effective date of the acquisition. However, the preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other paragraph of this subdivision;

      (4) The acquisition of already affiliated persons;

      (5) An acquisition if, as an immediate result of the acquisition:

         (a) In no market would the combined market share of the involved insurance companies exceed five percent of the total market;

(b) There would be no increase in any market share; or

(c) In no market would the combined market share of the involved insurance companies exceed twelve percent of the total market, and in no market would the market share increase by more than two percent of the total market.

For the purpose of paragraph 5 of subdivision b, a "market" means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurance companies licensed to do business in this state;

(6) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

(7) An acquisition of an insurance company whose domiciliary commissioner affirmatively finds that the insurance company is in failing condition; there is a lack of feasible alternative to improving the insurance company's condition; the public benefits of improving the insurance company's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary commissioner to the commissioner of this state.

3. An acquisition covered by subsection 2 may be subject to an order pursuant to subsection 5 unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in section 26.1-10-07.

a. The preacquisition notification must be in the form and contain the information prescribed by the national association of insurance commissioners relating to those markets which, under paragraph 5 of subdivision b of subsection 2, cause the acquisition not to be exempted from the provisions of this section. The commissioner may require additional material and information as he deems necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection 4. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating that person's ability to render an informed opinion.

b. The waiting period required begins on the date of receipt of the commissioner of a preacquisition notification and ends on the earlier of the thirtieth day after the date of its receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a

one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period ends on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

4. a. The commissioner may enter an order under subdivision a of subsection 5 with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein or if the insurance company fails to file adequate information in compliance with subsection 3.

b. In determining whether a proposed acquisition would violate the competitive standard of subdivision a of this subsection, the commissioner shall consider the following:

(1) Any acquisition covered under subsection 2 involving two or more insurance companies competing in the same market is prima facie evidence of violation of the competitive standards:

(a) If the market is highly concentrated and the involved insurance companies possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

(b) Or, if the market is not highly concentrated and the involved insurance companies possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the four largest insurance companies is seventy-five percent or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurance companies are involved, exceeding the total of the two columns in the table is prima facie evidence of violation of the competitive standard in subdivision a of this subsection. For the purpose of this paragraph, the insurance company with the largest share of the market shall be deemed to be insurer A.

(2) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurance companies in the market,

from the two largest to the eight largest, has increased by seven percent or more of the market over a period of time extending from any base year five to ten years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection 2 involving two or more insurance companies competing in the same market is prima facie evidence of violation of the competitive standard in subdivision a of this subsection if:

(a) There is a significant trend toward increased concentration in the market;

(b) One of the insurance companies involved is one of the insurance companies in a grouping of large insurance companies showing the requisite increase in the market share; and

(c) Another involved insurance company's market is two percent or more.

(3) For the purposes of subdivision b of subsection 4:

(a) The term "insurance company" includes any company or group of companies under common management, ownership, or control;

(b) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the national association of insurance commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurance companies doing business in this state, and the relevant geographical market is assumed to be this state.

(c) The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(4) Even though an acquisition is not prima facie violative of the competitive standard under paragraphs 1 and 2 of this subdivision, the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under paragraphs 1 and 2 of this subdivision, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not

limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry into and exit from the market.

c. An order may not be entered under subdivision a of subsection 5 if:

(1) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(2) The acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

5. a. If an acquisition violates the standards of this section, the commissioner may enter an order:

(1) Requiring an involved insurance company to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation, or

(2) Denying the application of an acquired or acquiring insurance company for a license to do business in this state.

b. The order may not be entered unless there is a hearing, notice of such hearing is issued prior to the end of the waiting period and not less than fifteen days prior to the hearing, and the hearing is concluded and the order is issued no later than sixty days after the end of the waiting period. Every order must be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

c. An order entered under this subsection may not become final sooner than thirty days after it is issued, during which time the involved insurance company may submit a plan to remedy the anticompetitive impact of the acquisition within a reasonable time. Based upon the plan or other information, the commissioner shall specify the conditions, if any, under the time period during which the aspects of the acquisition causing a violation of the standards of this section would be remedied and the order vacated or modified.

d. An order pursuant to this subsection does not apply if the acquisition is not consummated.

e. Any person who violates a cease and desist order of the commissioner under this subsection and while the order is in effect, may after notice and hearing and upon order of the

commissioner, be subject at the discretion of the commissioner to any one or both of the following:

(1) A monetary penalty of not more than ten thousand dollars for every day of violation.

(2) Suspension or revocation of such person's license.

f. Any insurance company or other person who fails to make any filing required by this section and who also fails to demonstrate a good faith effort to comply with any such filing requirement, shall be subject to a fine of not more than fifty thousand dollars.

g. Subsections 2 and 3 of section 26.1-10-08 and section 26.1-10-10 do not apply to acquisitions covered under subsection 2.

SECTION 5. AMENDMENT. Section 26.1-10-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-10-04. Registration - Amendments - Termination - Alternative registration - Exceptions - Disclaimer - Violation.

1. Every insurance company which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurance company subject to disclosure requirements and standards adopted by statute or rule in the jurisdiction of its domicile which are substantially similar to those contained in this section and section 26.1-10-05. Any insurance company subject to registration under this section shall register before August 31, 1981, or fifteen days after it becomes subject to registration, whichever is later, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any authorized insurance company which is a member of a holding company system not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority of the domiciliary jurisdiction.

2. Every insurance company subject to registration shall file a registration statement on a form approved by the commissioner, which must contain current information about:

   a. The capital structure, general financial condition, ownership, and management of the insurance company and any person in control of the insurance company.

   b. The identity of every member of the insurance holding company system.

   c. The following agreements in force, relationships subsisting, and transactions currently outstanding between the insurance company and its affiliates:

(1) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurance company or of the insurance company by its affiliates.

(2) Purchases, sales, or exchange of assets.

(3) Transactions not in the ordinary course of business.

(4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurance company's assets to liability, other than insurance contracts entered into in the ordinary course of the insurance company's business.

(5) All management and service contracts and all cost-sharing arrangements~~, other than cost allocation arrangements based upon generally accepted accounting principles~~.

(6) Reinsurance agreements ~~covering all or substantially all of one or more lines of insurance of the ceding company~~.

(7) Dividends and other distributions to shareholders.

(8) Consolidated tax allocation agreements.

d. Any pledge of the insurance company's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

e. Other matters concerning transactions between registered insurance companies and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner.

3. No information need be disclosed on the registration statement filed pursuant to subsection 2 if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, involving one-half of one percent or less of an insurance company's admitted assets as of December thirty-first next preceding are not material for purposes of this section.

4. Each registered insurance company shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms approved by the commissioner within fifteen days after the end of the month in which it learns of each change or addition; provided, however, that subject to subsection 3 of section 26.1-10-05, each registered insurance company shall report all dividends and other distributions to shareholders within ~~two~~ ten business days following the declaration thereof.

5. The commissioner shall terminate the registration of any insurance company which demonstrates that it no longer is a member of an insurance holding company system.

6. The commissioner may require or allow two or more affiliated insurance companies subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

7. The commissioner may allow an insurance company which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurance company which is required to register under subsection 1 to file all information and material required to be filed under this section.

8. This section does not apply to any insurance company, information, or transaction if and to the extent excepted by the commissioner by rule or order.

9. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurance company or a disclaimer may be filed by the insurance company or any member of an insurance holding company system. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurance company as well as the basis for disclaiming the affiliation. After a disclaimer has been filed, the insurance company is relieved of any duty to register or report under this section which arises out of the insurance company's relationship with the person unless and until the commissioner disallows the disclaimer. The commissioner shall disallow the disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance.

10. All registration statements must contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

11. Any person within an insurance holding company system subject to registration must provide complete and accurate information to an insurance company, where the information is reasonably necessary to enable the insurance company to comply with the provisions of this chapter.

12. The failure to file a registration statement or any ~~amendment~~ summary of the registration statement thereto required by this section within the time specified for the filing is a violation of this section.

SECTION 6. AMENDMENT. Section 26.1-10-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-10-05. Standards - Transactions with affiliates - Adequacy of surplus - Dividends and other distributions.

1. ~~Material transactions by registered insurance companies with their affiliates are~~ Transactions within a holding company system to which an insurance company subject to registration is a party shall be subject to the following standards:

a. The terms must be fair and reasonable.

b. The books, accounts, and records of each party must clearly and accurately disclose the precise nature and details of the transactions.

c. The insurance company's surplus as regards to policyholders following any dividends or distributions to shareholder affiliates must be reasonable in relation to the insurance company's outstanding liabilities and adequate to its financial needs.

d. Charges or fees for services performed must be reasonable.

e. Expenses incurred and payment received must be allocated to the insurance company in conformity with customary insurance accounting practices consistently applied.

2. The following transactions involving a domestic insurance company and any person in its holding company system may not be entered into unless the insurance company has notified the commissioner in writing of its intention to enter into the transaction at least thirty days prior thereto, or a shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period.

a. Sales, purchases, exchanges, loans, or extensions of credit, guarantees, or investments provided the transactions are equal to or exceed:

(1) With respect to nonlife insurance companies, the lesser of three percent of the insurance company's admitted assets or twenty-five percent of surplus as regards policyholders as of December thirty-first next preceding.

(2) With respect to life insurance companies, three percent of the insurance company's admitted assets as of December thirty-first next preceding.

b. Loans or extensions of credit to any person who is not an affiliate, where the insurance company makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in any affiliate of the insurance company making the loans or extensions of credit provided the transactions are equal to or exceed:

(1) With respect to nonlife insurance companies, the lesser of three percent of the insurance company's admitted assets or twenty-five percent of surplus as regards policyholders as of December thirty-first next preceding.

(2) With respect to life insurance companies, three percent of the insurance company's admitted assets as of December thirty-first next preceding.

c. Reinsurance agreements or modifications thereto in which the reinsurance premium or a change in the insurance company's liabilities equals or exceeds five percent of the insurance company's surplus as regards policyholders, as of December thirty-first next preceding, including those agreements which may require as consideration the transfer of assets from an insurance company to a nonaffiliate, if an agreement or understanding exists between the insurance company and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurance company.

d. All management agreements, service contracts, and all cost-sharing arrangements.

e. Any material transactions, specified by rule, which the commissioner determines may adversely affect the interests of the insurance company's policyholders.

Nothing herein contained shall be deemed to authorize or permit any transactions which, in the case of an insurance company which is not a member of the same holding company system, would be otherwise contrary to law.

3. A domestic insurance company may not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the commissioner determines that the separate transactions were entered into over any twelve-month period for that purpose, he may exercise his authority under the penalty sections of this chapter.

4. The commissioner, in reviewing transactions pursuant to subsection 2 shall consider whether the transactions comply with the standards set forth in subsection 1 and whether they may adversely affect the interests of the policyholders.

5. The commissioner must be notified within thirty days of any investment of the domestic insurance company in any one corporation if the total investment in that corporation by the insurance holding company system exceeds ten percent of the corporation's voting securities.

~~2.~~ 6. For purposes of this chapter, in determining whether an insurance company's surplus as regards policyholders is reasonable in relation to the insurance company's outstanding liabilities and adequate to its financial needs, the following factors, among others, must be considered:

a. The size of the insurance company as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

b. The extent to which the insurance company's business is diversified among the several lines of insurance.

c. The number and size of risks insured in each line of business.

d. The extent of the geographical dispersion of the insurance company's insured risks.

e. The nature and extent of the insurance company's reinsurance program.

f. The quality, diversification, and liquidity of the insurance company's investment portfolio.

g. The recent past and projected future trend in the size of the insurance company's ~~surplus as regards policyholders~~ investment portfolio.

h. The surplus as regards policyholders maintained by other comparable insurance companies.

i. The adequacy of the insurance company's reserves.

j. The quality and liquidity of investments in subsidiaries made pursuant to section 26.1-10-02. The commissioner may treat the investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the commissioner's judgment the investment so warrants.

~~3.~~ 7. An insurance company subject to registration under section 26.1-10-04 may not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

a. Thirty days after the commissioner has received notice of the declaration thereof and has not within such period disapproved the payment; or

b. The commissioner has approved the payment within the thirty-day period.

~~4.~~ 8. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, where the fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds the greater of:

a. Ten percent of the insurance company's surplus as regards policyholders as of December thirty-first next preceding; or

b. The net gain from operations of the insurance company, if the company is a life insurance company, or the net investment income, if the company is not a life insurance company, for the twelve-month period ending December thirty-first next preceding, but may not include pro rata distributions of any class of the insurance company's own securities.

In determining whether a dividend or distribution is extraordinary, an insurance company other than a life insurance company may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carryforward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains,

less dividends paid in the second and immediate preceding calendar years.

~~5.~~ 9. Notwithstanding any other provision of law, an insurance company may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and the declaration confers no rights upon shareholders until:

a. The commissioner has approved the payment of the dividend or distribution; or

b. The commissioner has not disapproved the payment within the thirty-day period referred to in subsection 3.

SECTION 7. AMENDMENT. Section 26.1-10-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-10-10. Receivership. Whenever it appears to the commissioner that any person has committed a violation of this chapter which so impairs the financial condition of a domestic insurance company as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, then the commissioner may proceed as provided in chapter ~~26.1-07~~ 26.1-06.1 to take possession of the property of the insurance company and to carry on its business.

SECTION 8. Section 26.1-10-10.1 of the North Dakota Century Code is created and enacted as follows:

26.1-10-10.1. Recovery.

1. Subject to other limitations of this section, if an order for liquidation, conservation, or rehabilitation of a domestic insurance company has been entered, and if distribution of payment identified in subdivisions a or b are made at any time during the one year preceding the petition for liquidation, conservation, or rehabilitation, the receiver appointed under the order may recover on behalf of the insurance company:

   a. From any parent corporation or holding company or person or affiliate who otherwise controlled the insurance company, the amount of distributions other than distributions of shares of the same class of stock, paid by the insurance company on its capital stock; or

   b. Any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurance company or its subsidiaries to a director, officer, or employee.

2. A distribution may not be recovered if the parent or affiliate shows that, when paid, the distribution was lawful and reasonable, and that the insurance company did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurance company to fulfill its contractual obligations.

3. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurance company or affiliate at the time the distributions were paid is liable up to the amount of distributions or payments under subsection 1 the person received. Any person who otherwise controlled the insurance company at the time the distributions were declared is liable up to the amount of distributions the person would have received if the person had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

4. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the impaired or insolvent insurance company to pay the contractual obligations of the impaired or insolvent insurance company and to reimburse any guaranty funds.

5. To the extent that any person liable under subsection 3 is insolvent or otherwise fails to pay claims due from it pursuant to subsection 3, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

SECTION 9. AMENDMENT. Section 26.1-10-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-10-11. Criminal proceedings - Penalty.

1. Any insurance company failing, without just cause, to file any registration statement as required in this chapter shall be required, after notice and hearing, to pay a penalty of one hundred dollars for each day's delay. The commissioner may reduce the penalty if the insurance company demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurance company.

2. Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly permits any of the officers or agents of the insurance company to engage in transactions or make investments which have not been properly reported or submitted pursuant to sections 26.1-10-04 and 26.1-10-05, or which violate this chapter, shall pay, in their individual capacity, a civil penalty of not more than one thousand dollars per violation, after notice and hearing before the commissioner. In determining the amount of the civil penalty, the commissioner shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

3. Whenever it appears to the commissioner that any insurance company subject to this chapter or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which is subject to section 26.1-10-05 and which would not have been approved had such approval been requested, the

commissioner may order the insurance company to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the commissioner may also order the insurance company to void the contracts and restore the status quo it if is in the best interest of the policyholders, creditors, or the public.

4. Whenever it appears to the commissioner that any insurance company or any director, officer, employee, or agent thereof has committed a willful violation of this chapter, the commissioner may institute criminal proceedings in the district court of the county in which the principal office of the insurance company is located or if the insurance company has no principal office in the state, then in the district court of Burleigh County against the insurance company or the responsible director, officer, employee, or agent of the company. Any insurance company ~~which~~ that willfully violates this chapter is guilty of a class B misdemeanor. Any individual who willfully violates this chapter is guilty of a class A misdemeanor.

5. Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his duties under this chapter, may have criminal proceedings instituted against them. Any individual who violates this chapter is guilty of a class A misdemeanor. Any fines imposed shall be paid by the officer, director, or employee in their individual capacity.

SECTION 10. Chapter 26.1-26.2 of the North Dakota Century Code is created and enacted as follows:

26.1-26.2-01. Definitions. As used in this chapter, unless the context requires otherwise:

1. "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is under the control of, or is under common control with, the person specified.

2. "Control" or "controlled" 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 contract for goods or nonmanagement services, or otherwise. No person may be deemed to control another person solely by reason of being an officer or director of that person.

   a. 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 upon filing with the commissioner by any person a disclaimer of control of any authorized insurance company. The disclaimer must fully disclose all material relationships and basis for affiliation between the person and the insurance company as well as the basis for disclaiming control. After a disclaimer has been filed, the person is relieved of any duty

to register or report under this chapter which arises out of the person's relationship with the insurance company unless and until the commissioner disallows the disclaimer. The commissioner shall disallow the disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance.

b. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect. The commissioner may prospectively revoke or modify the determination after notice and opportunity to be heard, whenever in the commissioner's judgment, revocation or modification is consistent with this chapter.

3. "Independent casualty actuary" means a casualty actuary who is a member of the American academy of actuaries and who is not affiliated with, nor an employee, principal, nor the direct or indirect owner of, or in any way controlled by the insurer or insurance broker.

4. "Licensed property/casualty insurer" or "insurer" means any person, firm, association, or corporation duly licensed to transact a property/casualty insurance business in this state and which issues policies covered by chapter 26.1-42. The following, inter alia, are not licensed property/casualty insurers for the purposes of this chapter:

a. All nonadmitted insurers;

b. All risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986 [Pub. L. No. 99-499, 100 Stat. 1613 (1986)], the Risk Retention Act [15 U.S.C. section 3901 et seq. (1982 & Supp. 1986)], and chapter 26.1-46;

c. All residual market pools and joint underwriting authorities or associations; and

d. All captive insurers including insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks of member organizations or group members and their affiliates.

5. "Reinsurance intermediary" means any person, firm, association, or corporation who acts as an insurance broker in soliciting, negotiating, or procuring the making of any reinsurance contract or binder on behalf of a ceding insurer or acts as an insurance broker in accepting any reinsurance contract or binder on behalf of an assuming insurer.

6. "Violation" means a finding by the commissioner that:

a. The controlling insurance broker did not materially comply with section 26.1-26.2-02;

b. The controlled insurer, with respect to business placed by the controlling insurance broker, engaged in a pattern of charging premiums that were lower than those being charged by the insurer or other insurers for similar risks written during the same period and placed by noncontrolling insurance brokers. When determining whether premiums were lower than those prevailing in the market, the commissioner shall take into consideration applicable industry or actuarial standards at the time the business was written;

c. The controlling insurance broker failed to maintain records, sufficient:

(1) To demonstrate that the insurance broker's dealings with its controlled insurer were fair and equitable and in compliance with chapter 26.1-10; and

(2) To accurately disclose the nature and details of its transactions with the controlled insurer, including information as is necessary to support the charges or fees to the respective parties;

d. The controlled insurer, with respect to business placed by the controlling insurance broker, either failed to establish or deviated from its underwriting procedures;

e. The controlled insurer's capitalization, at the time the business was placed by the controlling insurance broker, was not in compliance with the requirements of this title; or

f. The controlling insurance broker or the controlled insurer failed to substantially comply with chapter 26.1-10 and any rules relative thereto.

26.1-26.2-02. Limitation on business placed with controlled insurer.

1. No insurance broker which has control of a licensed property/casualty insurer may directly or indirectly place business with that insurer in any transaction in which the insurance broker, at the time the business is placed, is acting as such on behalf of the insured for any compensation, commission, or other thing of value, unless:

a. There is a written contract between the controlling insurance broker and the insurer, which contract has been approved by the board of directors of the insurer;

b. The insurance broker, prior to the effective date of the policy, delivers written notice to the prospective insured disclosing the relationship between the insurance broker and the controlling insurer and obtains the prospective insured's signature on the disclosure. The signed disclosure must be retained in the underwriting file until the filing of the report on examination covering the period in which the coverage

is in effect. Except that, if the business is placed through a subinsurance broker who is not a controlling insurance broker, the controlling insurance broker shall retain a signed commitment from the subinsurance broker that the subinsurance broker is aware of the relationship between the insurer and the insurance broker and that the subinsurance broker has or will notify the insured;

c. All funds collected for the account of the insurer by the controlling insurance broker must be paid, net of commissions, cancellations, and other adjustments, to the insurer no less often than quarterly;

d. In addition to any other required loss reserve certification, the controlled insurer shall annually, on March first of each year, file with the commissioner an opinion of an independent casualty actuary, or other independent loss reserve specialist acceptable to the commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year end on business placed by the insurance broker;

e. The controlled insurer shall annually report to the commissioner the amount of commissions paid to the insurance broker, the percentage that amount represents of the net premiums written, and comparable amounts and percentage paid to noncontrolling insurance brokers for placements of the same kinds of insurance; and

f. Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. Prior to approval of the annual financial statement, the audit committee shall meet with management, the insurer's independent certified public accountants, and an independent casualty actuary, or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

2. No reinsurance intermediary which has control of an assuming insurer may directly or indirectly place business with the insurer in any transaction in which the reinsurance intermediary is acting as a broker on behalf of the ceding insurer. No reinsurance intermediary which has control of a ceding insurer may directly or indirectly accept business from that insurer in any transaction in which the reinsurance intermediary is acting as an insurance broker on behalf of the assuming insurer. The prohibitions in this subsection do not apply to a reinsurance intermediary which makes a full and complete written disclosure to the parties of its relationship with the assuming or ceding insurer prior to completion of the transaction.

26.1-26.2-03. Liability of controlling insurance broker in the event of insolvency of controlled insurer.

If the commissioner has reason to believe that a controlling insurance broker has committed or is committing an act which could be determined to be a violation, and that the violation

substantially contributed to the insolvency of a controlled insurer, the commissioner or receiver may maintain a civil action against the controlling insurance broker for all damages caused by the insurance broker's acts.

26.1-26.2-04. Administrative penalties. In addition to any other remedies provided herein, whenever it appears to the commissioner that a person has committed or is committing an act that could be determined to be a violation, the commissioner may institute a proceeding under chapter 28-32. After the hearing, the commissioner may order one or both of the following:

1. That the person permanently cease and desist from committing the acts found to be in violation of this chapter.

2. Payment of a penalty of not more than ten thousand dollars for each and every act or violation.

This Section does not affect the right of the commissioner to impose any other penalties provided for in title 26.1.

26.1-26.2-05. Third party remedies unaffected.

1. This chapter is not intended to and does not in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

2. This chapter is not intended to and does not in any manner create a defense to any claim of, or alter or affect the rights of, a receiver, existing in law or otherwise, to maintain a civil action against any person for all damages caused by that person's acts.

SECTION 11. Chapter 26.1-26.3 of the North Dakota Century Code is created and enacted as follows:

26.1-26.3-01. Definitions. As used in this chapter:

1. "Actuary" means a person who is a member in good standing of the American academy of actuaries.

2. "Insurer" means any person, firm, association, or corporation duly licensed in this state as an insurance company pursuant to this title.

3. "Managing general agent" means any individual, partnership, or corporation which:

   a. Negotiates and binds ceding reinsurance contracts on behald of an insurer or manages all or part of the insurance business of an insurer including the management of a separate division, department, or underwriting office, and acts as an agent for the insurer whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual

statement of the insurer in any one quarter or year, and who either:

(1) Adjusts or pays claims in excess of an amount determined by the commissioner; or

(2) Negotiates reinsurance on behalf of the insurer.

b. Notwithstanding the above, the following persons will not be considered as managing general agents for the purposes of this chapter:

(1) An employee of the insurer.

(2) A United States manager of the United States branch of an alien insurer.

(3) An underwriting manager which, pursuant to contract, manages all the insurance operations of the insurer, is under common control with the insurer, subject to chapter 26.1-10, and whose compensation is not based on the volume of premiums written.

(4) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

4. "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

26.1-26.3-02. Licensure.

1. No individual, partnership, or corporation may act in the capacity of a managing general agent with respect to risks located in this state for an insurer licensed in this state unless the individual, partnership, or corporation is licensed as an insurance agent in this state.

2. An individual, partnership, or corporation may not act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless the individual, partnership, or corporation is licensed as either a resident or nonresident insurance agent in this state pursuant to the provisions of this title.

3. The commissioner may require a bond in an amount acceptable to him for the protection of the insurer.

4. The commissioner may require the managing general agent to maintain an adequate errors and omissions policy.

26.1-26.3-03. Required contract provisions. No individual, partnership, or corporation acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function,

specifies the division of the responsibilities, and which contains the following minimum provisions:

1. The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.

2. The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

3. All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a bank which is a member of the federal reserve system. This account must be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months estimated claims payments and allocated loss adjustment expenses.

4. Separate records of business written by the managing general agent will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer and the commissioner shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the commissioner.

5. The contract may not be assigned in whole or in part by the managing general agent.

6. Appropriate underwriting guidelines including:

   a. The maximum annual premium volume;

   b. The basis of the rates to be charges;

   c. The types of risks which may be written;

   d. Maximum limits of liability;

   e. Applicable exclusions;

   f. Territorial limitations;

   g. Policy cancellation provisions; and

   h. The maximum policy period.

7. If the contract permits the managing general agent to settle claims on behalf of the insurer:

   a. All claims must be reported to the company in a timely manner.

   b. A copy of the claim file must be sent to the insurer at its request or as soon as it becomes known that the claim:

(1) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less;

(2) Involves a coverage dispute;

(3) May exceed the managing general agent's claims settlement authority;

(4) Is open for more than six months; or

(5) Is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less.

c. All claims files will be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, the files shall become the sole property of the insurer or its estate; the managing general agent shall have reasonable access to and the right to copy the files on a timely basis.

d. Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

8. Where electronic claims files are in existence, the contract must address the timely transmission of the data.

9. If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to section 26.1-26.3-04.

10. The managing general agent may not:

a. Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages, and amounts or percentages that may be reinsured and commission schedules.

b. Commit the insurer to participate in insurance or reinsurance syndicates.

c. Appoint any agent without assuring that the agent is licensed in the appropriate lines of insurance.

d. Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which may not exceed one percent of the insurer's policyholder's surplus as of December thirty-first of the last completed calendar year.

e. Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer.

f. Permit its subagent to serve on the insurer's board of directors.

g. Jointly employ an individual who is employed with the insurer.

h. Appoint a submanaging general agent.

26.1-26.3-04. Duties of insurers.

1. The insurer must have on file, in a form acceptable to the commissioner, an independent financial examination of each managing general agent with which it has done business.

2. If a managing general agent establishes loss reserves, the insurer must annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

3. The insurer must periodically and at least semiannually conduct an onsite review of the underwriting and claims processing operations of the managing general agent.

4. Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the managing general agent.

5. Within thirty days of entering into or termination of a contract with a managing general agent, the insurer must provide written notification of the appointment or termination to the commissioner. Notices of appointment of a managing general agent must include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

6. An insurer shall review its books and records each quarter to determine if any of its agents have become, by operation of subsection 3 of section 26.1-26.3-01, a managing general agent as defined in that section. If the insurer determines that an agent has become a managing general agent pursuant to the above, the

insurer shall promptly notify the agent and the commissioner of the determination and the insurer and agent must fully comply with the provisions of this Act within thirty days.

7. An insurer may not appoint to its board of directors an officer, director, employee, subagent, or controlling shareholder of its managing general agents. This subsection does not apply to relationships governed by chapter 26.1-10.

26.1-26.3-05. Examination authority. The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

26.1-26.3-06. Penalties and liabilities.

1. If the commissioner finds after a hearing conducted in accordance with chapter 28-32 that any person has violated any provision of this chapter, the commissioner may order:

   a. For each separate violation, a penalty in an amount of one thousand dollars;

   b. Revocation or suspension of the agent's license; and

   c. The managing general agent to reimburse the insurer, the rehabilitator, or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this chapter committed by the managing general agent.

2. Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance law.

3. Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

26.1-26.3-07. Rulemaking authority. The commissioner of insurance may adopt reasonable rules for the implementation and administration of the provisions of this chapter.

SECTION 12. Chapter 26.1-31.1 of the North Dakota Century Code is created and enacted as follows:

26.1-31.1-01. Definitions. As used in this chapter:

1. "Actuary" means a person who is a member in good standing of the American academy of actuaries.

2. "Controlling person" means any person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of the reinsurance intermediary.

3. "Insurer" means any person, firm, association, or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer.

4. "Licensed producer" means an agent, broker, or reinsurance intermediary licensed pursuant to the applicable provision of this title.

5. "Qualified United States financial institution" means an institution that:

   a. Is organized or in the case of a United States office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof;

   b. Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

   c. Has been determined by either the commissioner, or the securities valuation office of the national association of insurance commissioners, to meet standards of financial condition and standing considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

6. "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in subsections 7 and 8 of this section.

7. "Reinsurance intermediary-broker" means any person, other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

8. "Reinsurance intermediary-manager" means any person, firm, association, or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer including the management of a separate division, department, or underwriting office, and acts as an agent for the reinsurer whether known as a reinsurance intermediary-manager, manager, or other similar term. Notwithstanding this definition, the following persons shall not be considered a reinsurance itermediary-manager, with respect to such reinsurer, for the purposes of this chapter:

   a. An employee of the reinsurer.

   b. A United States manager of the United States branch of an alien reinsurer.

   c. An underwriting manager which, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer and be subject to chapter 26.1-10, and whose compensation is not based on the volume of premiums written.

   d. The manager of a group, association, pool, or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance

commissioner of the state in which the manager's principal business office is located.

9. "Reinsurer" means any person, firm, association, or corporation duly licensed in this state pursuant to the applicable provisions of this title as an insurer with the authority to assume reinsurance.

10. "To be in violation" means that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this chapter.

26.1-31.1-02. Licensure.

1. No person, firm, association, or corporation shall act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker maintains an office either directly or as a member or employee of a firm or association, or an officer, director, or employee of a corporation:

   a. In this state, unless the reinsurance intermediary-broker is a licensed producer in this state; or

   b. In another state, unless the reinsurance intermediary-broker is a licensed producer in this state or another state having a law substantially similar to this law or such reinsurance intermediary-broker is licensed in this state as a nonresident reinsurance intermediary.

2. No person, firm, association, or corporation shall act as a reinsurance intermediary-manager:

   a. For a reinsurer domiciled in this state, unless the reinsurance intermediary-manager is a licensed producer in this state.

   b. In this state, if the reinsurance intermediary-manager maintains an office either directly or as a member or employee of a firm or association, or as an officer, director or employee of a corporation in this state, unless the reinsurance intermediary-manager is a licensed producer in this state.

   c. In another state for a nondomestic insurer, unless the reinsurance intermediary-manager is a licensed producer in this state or another state having a law substantially similar to this law or the person is licensed in this state as a nonresident reinsurance intermediary.

3. The commissioner may require a reinsurance intermediary-manager subject to subsection 2 to:

   a. File a bond in an amount from an insurer acceptable to the commissioner for the protection of the reinsurer; and

   b. Maintain an errors and omissions policy in an amount acceptable to the commissioner.

4. a. The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation who has complied with the requirements of this chapter. Any such license issued to a firm or association will authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of the corporation, and all such persons shall be named in the application and any supplements thereto.

   b. If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this title for designation of service of process upon unauthorized insurers. The applicant shall also furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting the nonresident reinsurance intermediary may be served. The licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and the changes shall not become effective until acknowledged by the commissioner.

5. The commissioner may refuse to issue a reinsurance intermediary license if, in the commissioner's judgment, the applicant, any one named on the application, or any member, principal, officer or director of the applicant, is not trustworthy, or that any controlling person of the applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of the license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the commissioner will furnish a summary of the basis for refusal to issue a license.

26.1-31.1-03. Required contract provisions - Reinsurance intermediary-brokers. Transactions between a reinsurance intermediary-broker and the insurer it represents in such capacity shall only be entered into, pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, contain provisions that:

1. The insurer may terminate the reinsurance intermediary-broker's authority at any time.

2. The reinsurance intermediary-broker will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing, to the reinsurance intermediary-broker, and remit all funds due to the insurer within thirty days of receipt.

3. All funds collected for the insurer's account will be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank which is a qualified United States financial institution as defined by this chapter.

4. The reinsurance intermediary-broker will comply with section 26.1-31.1-04 of this chapter.

5. The reinsurance intermediary-broker will comply with the written standards established by the insurer for the cessions or retrocession of all risks.

6. The reinsurance intermediary-broker will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

26.1-31.1-04. Books and records - Reinsurance intermediary-brokers.

1. For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, the reinsurance intermediary-broker will keep a complete record for each transaction showing:

   a. The type of contract, limits, underwriting restrictions, classes or risks and territory;

   b. Period of coverage, including the effective date and the expiration date, cancellation provisions and notice required of cancellation;

   c. Reporting and settlement requirements of balances;

   d. Rate used to compute the reinsurance premium;

   e. Names and addresses of assuming reinsurers;

   f. Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker;

   g. Related correspondence and memoranda;

   h. Proof of placement;

   i. Details regarding retrocessions handled by the reinsurance intermediary-broker including the identity of retrocessionaires and percentage of each contract assumed or ceded;

   j. Financial records, including but not limited to, premium and loss accounts; and

   k. When the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:

      (1) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(2) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

2. The insurer will have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer.

26.1-31.1-05. Duties of insurers utilizing the services of reinsurance intermediary-broker.

1. An insurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-broker on its behalf unless the person, firm, association, or corporation is licensed as required by subsection 1 of section 26.1-31.1-02.

2. An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business, unless the reinsurance intermediary-broker is under common control with the insurer and subject to chapter 26.1-10.

3. The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

26.1-31.1-06. Required contract provisions - Reinsurance intermediary-managers. Transactions between a reinsurance intermediary-manager and the reinsurer it represents in that capacity shall only be entered into pursuant to a written contract, approved by the reinsurer's board of directors, which specifies the responsibilities of each party. At least thirty days before the reinsurer assumes or cedes business through the producer, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, contain provisions that:

1. The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

2. The reinsurance intermediary-manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to the reinsurance intermediary-manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

3. All funds collected for the reinsurer's account will be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank which is a qualified United States financial institution as defined by this chapter. The reinsurance intermediary-manager may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager

shall maintain a separate bank account for each reinsurer that it represents.

4. For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager will keep a complete record for each transaction showing:

   a. The type of contract, limits, underwriting restrictions, classes or risks, and territory;

   b. Period of coverage, including the effective date and the expiration date, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

   c. Reporting and settlement requirements of balances;

   d. Rate used to compute the reinsurance premium;

   e. Names and addresses of reinsurers;

   f. Rate of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;

   g. Related correspondence and memoranda;

   h. Proof of placement;

   i. Details regarding retrocessions handled by the reinsurance intermediary-manager, as permitted by subsection 4 of section 26.1-31.1-08, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

   j. Financial records, including but not limited to, premium and loss accounts; and

   k. When the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

      (1) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

      (2) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

5. The reinsurer will have access and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer.

6. The contract cannot be assigned in whole or in part by the reinsurance intermediary-manager.

7. The reinsurance intermediary-manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

8. Set forth the rates, terms, and purposes of commissions, charges, and other fees which the reinsurance intermediary-manager may levy against the reinsurer.

9. If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

   a. All claims will be reported to the reinsurer in a timely manner.

   b. A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

      (1) Has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

      (2) Involves a coverage dispute;

      (3) May exceed the reinsurance intermediary-manager's claims settlement authority;

      (4) Is open for more than six months; or

      (5) Is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer.

   c. All claim files will be the joint property of the reinsurer and reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer the files shall become the sole property of the reinsurer or its estate; the reinsurance intermediary-manager shall have reasonable access to and the right to copy the files on a timely basis.

   d. Any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

10. If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, the interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or a later period set by the commissioner for specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified pursuant to subsection 3 of section 26.1-31.1-08.

11. The reinsurance intermediary-manager will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified public accountant.

12. The reinsurer shall periodically and at least semiannually conduct an onsite review of the underwriting and claims processing operations of the reinsurance intermediary-manager.

13. The reinsurance intermediary-manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to this contract.

14. The acts of the reinsurance intermediary-manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

26.1-31.1-07. Prohibited acts. The reinsurance intermediary-manager shall not:

1. Bind retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. The guidelines shall include a list of reinsurers with which the automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

2. Commit the reinsurer to participate in reinsurance syndicates.

3. Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed.

4. Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder's surplus as of December thirty-first of the last complete calendar year.

5. Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

6. Jointly employ an individual who is employed by the reinsurer.

7. Appoint a subreinsurance intermediary-manager.

26.1-31.1-08. Duties of reinsurers utilizing the services of a reinsurance intermediary-manager.

1. A reinsurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-manager on its behalf unless such person, firm, association, or corporation is licensed as required by subsection 2 of section 26.1-31.1-02 of this chapter.

2. The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager which the reinsurer has engaged, prepared by an independent certified public accountant, in a form acceptable to the commissioner.

3. If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. This opinion shall be in addition to any other required loss reserve certification.

4. Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance intermediary-manager.

5. Within thirty days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of its termination to the commissioner.

6. A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder, or subproducer of its reinsurance intermediary-manager. This subsection shall not apply to relationships governed by chapter 26.1-10.

26.1-31.1-09. Examination authority.

1. A reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

2. A reinsurance intermediary-manager may be examined as if it were the reinsurer.

26.1-31.1-10. Penalties and liabilities.

1. A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing, to be in violation of any provision of this chapter, shall:

   a. For each separate violation, pay a penalty in an amount not exceeding five thousand dollars;

   b. Be subject to revocation or suspension of its license; and

   c. If a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

2. Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided in the insurance law.

3. Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights to such persons.

26.1-31.1-11. Rules. The commissioner may adopt reasonable rules for the implementation and administration of the provisions of this chapter.

26.1-31.1-12. Effective date. No insurer or reinsurer may continue to utilize the services of a reinsurance intermediary after the effective date of this chapter unless utilization is in compliance with this chapter.

SECTION 13. Chapter 26.1-31.2 of the North Dakota Century Code is created and enacted as follows:

26.1-31.2-01. Credit allowed a domestic ceding insurer. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of either subsection 1, 2, 3, 4, or 5. If meeting the requirements of subsection 3 or 4, the requirements of subsection 6 must also be met.

1. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state.

2. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state. An accredited reinsurer is one which:

   a. Files with the commissioner evidence of its submission to this state's jurisdiction;

   b. Submits to this state's authority to examine its books and records;

   c. Is licensed to transact insurance or reinsurance in at least one state, or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state; and

   d. Files each year by March first with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and either

      (1) Maintains a surplus as regards policyholders in an amount which is not less than twenty million dollars and whose accreditation has not been denied by the commissioner within ninety days of its submission; or

      (2) Maintains a surplus as regards policyholders in an amount less than twenty million dollars and whose accreditation has been approved by the commissioner.

   No credit shall be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing.

3. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer, is entered

through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:

a. Maintains a surplus as regards policyholders in an amount not less than twenty million dollars; and

b. Submits to the authority of this state to examine its books and records.

Provided, however, that the requirement of subdivision a of subsection 3 does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

4. a. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in subsection 2 of section 26.1-31.2-03, for the payment of a valid claims of its United States policyholders and ceding insurers, their assigns, and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars. In the case of a group of individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any member of the group; and the group shall make available to the commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent public accountants.

b. In the case of a group of incorporated insurers under common administration which complies with the filing requirements contained in subdivision a, and which is under the supervision of the department of trade and industry of the United Kingdom and submits to this state's authority to examine its books and records and bears the expense of the examination, and which has aggregate policyholders' surplus of ten million dollars; the trust shall be in an amount equal to the group's several liabilities attributable to business written in the United States plus the group shall maintain a joint trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any member of the group, and each member of the group shall make available to the commissioner an annual certification of the member's

solvency by the member's domiciliary regulator and its independent public accountant.

c. The trust must be established in a form approved by the commissioner of insurance. The trust instrument must provide that contested claims must be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner. The trust described herein must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

d. No later than March first of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the next following December thirty-first.

5. Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection 1, 2, 3, or 4 but only with respect to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

6. If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by subsections 3 and 4 of section 26.1-31.2-01 shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

a. In the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or of any appellate court in the event of an appeal; and

b. To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.

This provision is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

26.1-31.2-02. Reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer. A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 26.1-31.2-01 shall be allowed in an amount not

exceeding the liabilities carried by the ceding insurer and such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in subsection 2 of section 26.1-31.2-03. This security may be in the form of:

1. Cash.

2. Securities listed by the securities valuation office of the national association of insurance commissioners and qualifying as admitted assets under this state's investment statutes.

3. Clean, irrevocable, and unconditional letters of credit, as defined in subsection 1 of section 26.1-31.2-03, issued or confirmed by a qualified United States institution no later than December thirty-first in respect of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs.

4. Any other form of security acceptable to the commissioner.

26.1-31.2-03. Qualified United States financial institutions.

1. For purposes of subsection 3 of section 26.1-31.2-02, a "qualified United States financial institution" means an institution that:

   a. Is organized, or in case of a United States office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof;

   b. Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies;

   c. Has been determined by either the commissioner, or the securities valuation office of the national association of insurance commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

2. A "qualified United States financial institution" means, for purposes of those provisions of this chapter specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

a. Is organized, or in the case of a United States branch or agency office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

b. Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

26.1-31.2-04. Rulemaking authority. The commissioner may adopt reasonable rules for the implementation and administration of this chapter.

26.1-31.2-05. Reinsurance agreements affected. Sections 26.1-31.2-01, 26.1-31.2-02, 26.1-31.2-03, and 26.1-31.2-04 of this chapter apply to all cessions after the effective date of this chapter under reinsurance agreements which have had an inception, anniversary, or renewal date not less than six months after the effective date of this chapter.

SECTION 14. REPEAL. Sections 26.1-07-08, 26.1-07-09, 26.1-07-10, 26.1-07-11, 26.1-07-12, 26.1-07-13, 26.1-07-14, 26.1-07-15, 26.1-07-16, 26.1-07-17, 26.1-07-18, 26.1-07-19, and 26.1-07-20 of the North Dakota Century Code are repealed.

Approved April 8, 1991
Filed April 8, 1991

CHAPTER 306

HOUSE BILL NO. 1441
(Representatives Skjerven, R. Berg)
(Senator Thane)

COUNTY MUTUAL INSURANCE COMPANIES

AN ACT to amend and reenact sections 26.1-13-01, 26.1-13-02, and 26.1-13-15 of the North Dakota Century Code, relating to organization and territorial limits of a county mutual insurance company.

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 ~~fifteen~~ twenty counties in this state, who collectively own property of not less than one hundred thousand dollars in value which they desire to insure; or any number of persons, not less than twenty-five, residing in any one county in this state, who collectively own property of not less than twenty-five thousand dollars in value which they desire to insure.

SECTION 2. AMENDMENT. Section 26.1-13-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-13-02. Articles of incorporation - Territory of operation - Insurance applications required. Persons desiring to form a county mutual insurance company shall submit to the commissioner a description of the territory of operation and shall submit to the commissioner and to the attorney general the articles of incorporation of the proposed company. The territory of operation is subject to the review and approval of the commissioner. An existing county mutual insurance company that desires to expand its territory of operation shall submit a description of the current territory of operation and proposed territory of operation to the commissioner for review and approval. If merger of two or more county mutual insurance companies is proposed, the commissioner shall determine the territory of operation of the merged company. If the articles are found to comply with this chapter, the commissioner shall approve the articles and the articles must be filed in the office of the secretary of state and a certified copy must be filed with the commissioner. The articles must be signed by the number of persons required to incorporate the company and must be accompanied by sufficient evidence of the execution of bona fide applications for insurance to the number and in the amount stated in section 26.1-13-01. The articles of incorporation must set forth:

1. The name of the company.

2. The name of the city in or near which the business office of the company is to be located.

3. The intended duration of the company, which is perpetual.

SECTION 3. 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. A county mutual insurance company may not insure any property beyond ~~the limits of the~~ its authorized territory ~~comprised in the formation of the company~~ of operation except as provided in subsection 3 of section 26.1-13-12 and except that this territorial limitation does not apply to reinsurance contracts. A policy may not be issued to exceed five years. A policy may not be issued covering property located within the platted limits of any incorporated city in this state unless:

1. The policy issued provides coverage on the actual place of residence occupied by the policyholder and appurtenant structures and the contents thereof as specified in sections 26.1-13-14 and 26.1-13-16 to existing members within the platted limits of any incorporated city in this state; or

2. The policy issued provides coverage specified in sections 26.1-13-14 and 26.1-13-16 on property located within the platted limits of any incorporated city with a population of less than ~~two~~ ten thousand ~~five hundred~~ located within the territory comprised in the formation of the company.

The company may insure all property located outside of incorporated cities within the limits of the territory comprised in the formation of the company. Policies issued on property located within the platted limits of any incorporated city may only cover the actual place of residence occupied by the policyholder and appurtenant structures and the contents thereof and must conform to rules adopted by the commissioner establishing requirements for underwriting risks and safeguarding financial solvency.

A policy issued by the company, if it so provides, may cover loss or damage to livestock, personal property, vehicles, and farm machinery while temporarily removed from the premises of the insured to other locations.

Approved April 16, 1991
Filed April 18, 1991

CHAPTER 307

SENATE BILL NO. 2375
(Senators Wogsland, Schoenwald, Keller)
(Representatives Laughlin, Williams, Stofferahn)

NONPROFIT HEALTH SERVICE CORPORATION DIRECTORS

AN ACT to amend and reenact section 26.1-17-04 of the North Dakota Century Code, relating to the board of directors for nonprofit health service corporations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-17-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-17-04. Directors - Responsibilities. A board of directors shall manage the business and affairs of a health service corporation. The board is to consist of at least nine members. At least a majority of the directors of a health service corporation writing hospital or medical service contracts under this chapter must be at all times subscribers.

A subscriber director is a director who is a subscriber and who is not a provider of health care, a person who has a material financial or fiduciary interest in the delivery of health care services or a related industry, an employee of an institution that provides health care services, or a spouse or a member of the immediate family of such a person. Nominations for the replacement of subscriber directors must be made by the existing subscriber directors.

A director may serve on the board of only one corporation subject to this chapter at a time.

Population factors, representation of different geographic regions, and the demography of the service area of the corporation subject to this chapter must be considered when making nominations for the board of directors of a corporation subject to this chapter.

A health service corporation may not reimburse or compensate a director for more than necessary and actual expenses for service as a member of the board of directors.

Approved March 14, 1991
Filed March 15, 1991

CHAPTER 308

HOUSE BILL NO. 1424
(Larson)

HEALTH SERVICE CORPORATION PRACTITIONER CONTRACTS

AN ACT to amend and reenact section 26.1-17-12 of the North Dakota Century Code, relating to contract limitations of a health service corporation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-17-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-17-12. Contract limitations. ~~Every~~ Except as provided in this section, every physician, oral surgeon, dentist, or practitioner licensed and registered in the state of North Dakota has the right to contract with any health service corporation for furnishing general or special medical care, dental care, or optometric care, as the case may be, but the governing board of a corporation may refuse to contract or may terminate a contract if the board determines that a physician, oral surgeon, dentist, or practitioner is providing inappropriate or substandard care to the corporation's subscribers. A corporation may not impose any restriction as to the methods of diagnosis or treatment. The private relationship of physician and patient, dentist and patient, or practitioner and patient is to be maintained at all times and the subscriber has the right of free choice in selecting any physician, oral surgeon, dentist, or practitioner.

A health service corporation may, in its discretion, by its articles of incorporation, articles of association, or bylaws, and in its contract with its subscribers, limit the benefits that the corporation will furnish, and may provide for a division of benefits it agrees to furnish into classes or kinds. In the absence of any limitation or division of services, a corporation may provide both general and special medical and surgical, dental, or optometric care benefits, including such service as may necessarily be incident to such care. A corporation may, in its discretion, limit the issuance of contracts as specified in its bylaws.

A dental or optometric service contract by a health service corporation may not provide the payment of any cash indemnification by the corporation to the subscriber or the subscriber's estate on account of death, illness, or other injury.

Approved April 16, 1991
Filed April 18, 1991

CHAPTER 309

HOUSE BILL NO. 1425
(Wentz)

DENTAL AND OPTOMETRIC SERVICE CONTRACTS

AN ACT to amend and reenact section 26.1-17-21 of the North Dakota Century Code, relating to limitations on dental and optometric service contracts.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-17-21 of the North Dakota Century Code is amended and reenacted as follows:

26.1-17-21. Limitations on dental and optometric service contracts. Every subscriber under a dental or optometric service plan must receive a copy of the contract. The contract must clearly state the care, appliances, materials, and supplies to be provided under the contract and the rate charged the subscriber. Every subscriber must have, at all times, free choice of the dentist or practitioner who is to treat the subscriber, and this right must be prominently printed in the contract. Every optometric service contract must provide that a subscriber has the freedom of choice to have the materials and supplies furnished by any practitioner or optician, the cost for which is to be covered in accordance with the terms of the contract. ~~A health service corporation may not enter into any contract, agreement, or understanding, directly or indirectly, with any dentist or practitioner whereby the dentist or practitioner is to render any services to any subscriber, but all such services must be a matter of agreement directly between the patient and the dentist or practitioner selected by the patient to treat the patient.~~

Approved April 2, 1991
Filed April 4, 1991

CHAPTER 310

HOUSE BILL NO. 1220
(Committee on Human Services and Veterans Affairs)
(At the request of the State Department of Health and Consolidated Laboratories)

HEALTH MAINTENANCE ORGANIZATIONS

AN ACT to amend and reenact subsections 14 and 16 of section 26.1-18-03, sections 26.1-18-06, 26.1-18-17, 26.1-18-18, 26.1-18-27, 26.1-18-28, and 26.1-18-30 of the North Dakota Century Code, relating to the role of the department of health and consolidated laboratories in the review and issuance of certificates of authority for health maintenance organizations' complaint systems, annual reports, examinations, suspensions or revocations, and administrative procedures; and to repeal sections 26.1-18-05 and 26.1-18-33 of the North Dakota Century Code, relating to applications for certificate of authority for health maintenance organizations and the department of health and consolidated laboratories' authority to contract.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsections 14 and 16 of section 26.1-18-03 of the North Dakota Century Code are amended and reenacted as follows:

14. A description of the procedures and programs to be implemented to meet the quality of health care requirements in subsection 7 of section ~~26.1-18-05~~ 26.1-18-06.

16. Any other information the commissioner requires to make the determinations required under ~~sections 26.1-18-05 and~~ section 26.1-18-06.

SECTION 2. AMENDMENT. Section 26.1-18-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18-06. Review of application by commissioner - Issuance of certificate of authority. The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section 26.1-18-03 within ninety days following receipt of the ~~certification from the state department of health and consolidated laboratories given pursuant to section 26.1-18-05~~ application. The certificate of authority must be issued upon payment of the application fee prescribed if the commissioner is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are honest, competent, and trustworthy.

2. The ~~state department of health and consolidated laboratories certifies, in accordance with section 26.1-18-05, that the health maintenance organization's proposed plan of operation meets the~~

~~requirements of that section~~ health maintenance organization has demonstrated the willingness and potential ability to assure that the health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility, and continuity of service.

3. The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

4. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

   a. The financial soundness of the health care plan's arrangements for health care services.

   b. A schedule of premium rates with supporting actuarial and other data.

   c. The adequacy of working capital.

   d. Any agreement with an insurer, a health service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan.

   e. Any agreement with providers for the provision of health care services. This subsection does not apply to agreements between individual providers, groups of providers, individual providers and groups of providers, or between other persons who are not applicants.

   f. Any surety bond or deposit of cash or securities submitted in accordance with section 26.1-18-23 as a guarantee that the obligations will be duly performed.

5. The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section 26.1-18-08.

6. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 26.1-18-03 or by independent investigation, is contrary to the public interest.

7. ~~Any deficiencies certified by the state department of health and consolidated laboratories have been corrected.~~ The health maintenance organization has established arrangements, in accordance with rules adopted by the commissioner, for an ongoing quality of health care assurance program concerning health care processes and outcomes.

8. The health maintenance organization has established a procedure, in accordance with rules adopted by the commissioner, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and any other matters reasonably required by the commissioner.

Denial of a certificate of authority is effective only after compliance with the requirements of section 26.1-18-30.

SECTION 3. AMENDMENT. Section 26.1-18-17 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18-17. Complaint system - Approval of commissioner - Annual report - Contents - Examinations.

1. A health maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner~~, after consultation with the state department of health and consolidated laboratories,~~ to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

2. A health maintenance organization shall submit to the commissioner ~~and the state department of health and consolidated laboratories~~ an annual report in a form prescribed by the commissioner~~, after consultation with the state department of health and consolidated laboratories,~~ which must include:

   a. A description of the procedures of the complaint system.

   b. The total number of complaints handled through the complaint system and a compilation of causes underlying the complaints filed.

   c. The number, amount, and disposition of malpractice claims during the year filed by enrollees of the health maintenance organization against the health maintenance organization and any of the providers used by it.

3. A health maintenance organization shall maintain records of written complaints filed with it concerning other than health care services and shall submit to the commissioner a summary report at the times and in the format required by the commissioner. The complaints involving other persons must be referred to the persons with a copy to the commissioner.

4. The commissioner ~~or the state department of health and consolidated laboratories, or both,~~ may examine the complaint system.

SECTION 4. AMENDMENT. Section 26.1-18-18 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18-18. Annual report - Form prescribed by commissioner. Every health maintenance organization shall annually, on or before March first, file a report, verified by at least two principal officers, with the commissioner ~~with a copy to the state department of health and consolidated~~

~~laboratories~~ covering the preceding calendar year. The report must be on forms prescribed by the commissioner and must include:

1. A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant.

2. Any material changes in the information submitted pursuant to section 26.1-18-03.

3. The number of persons enrolled during the year, the number of enrollees terminated during the year, and the number of enrollees as of the end of the year.

4. A summary of information compiled pursuant to subsection 8 of section ~~26.1-18-05~~ 26.1-18-06 in the form required by the ~~state department of health and consolidated laboratories~~ commissioner.

5. Any other information relating to the performance of the health maintenance organization necessary to enable the commissioner to carry out the commissioner's duties under this chapter.

SECTION 5. AMENDMENT. Section 26.1-18-27 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18-27. Examinations by commissioner ~~and state department of health and consolidated laboratories~~ - Expenses - Acceptance of other examinations. The commissioner may examine the affairs of any health maintenance organization as often as necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

~~The state department of health and consolidated laboratories may make an examination concerning the quality of health care services of any health maintenance organization as often as necessary for the protection of the interests of the people of this state but not less frequently than once every three years.~~

For the purpose of examinations, the commissioner ~~and the state department of health and consolidated laboratories~~ may administer oaths to, and examine, the officers and agents of the health maintenance organization and the principals of providers with whom the organization has contracts, agreements, or other arrangements pursuant to its health care plan. To the extent that examinations may require the disclosure of personally identifying information relating to either financial transactions or medical information concerning a plan enrollee in the records of the health maintenance organization or the records of a provider with whom the organization has contracts, agreements, or other arrangements pursuant to its health care plan, the information ~~is to~~ must be used for the sole purpose of assessing the quality of care provided and the degree of compliance with provisions of this chapter. The information ~~is to~~ must be held in confidence and may not be disclosed except upon the express consent of the enrollee, or pursuant to a court order for the production or discovery of evidence, or in the event of a claim or litigation between the enrollee and the health maintenance organization when the information is pertinent.

The expenses of examinations under this section must be assessed against the organization being examined and remitted to the commissioner ~~or the state department of health and consolidated laboratories for whom the examination is being conducted~~.

The commissioner ~~or the state department of health and consolidated laboratories~~ may accept an examination or the report of an examination made by the commissioner or the state department of health of another state, the federal government, or an approved independent accrediting organization.

SECTION 6. AMENDMENT. Section 26.1-18-28 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18-28. Suspension or revocation of certificate of authority - Grounds - Procedure - Duty of organization. The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if the commissioner finds that any of the following exist:

1. The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under sections 26.1-18-02, 26.1-18-03, and 26.1-18-04, unless amendments to the submissions have been filed with and approved by the commissioner.

2. The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of sections 26.1-18-12 and 26.1-18-14.

3. The health care plan does not provide or arrange for basic health care services or the health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan.

4. The ~~state department of health and consolidated laboratories certifies to the commissioner that~~:

   ~~a.~~ ~~The~~ health maintenance organization does not meet the requirements of subsection 8 of section ~~26.1-18-05;~~ ~~or~~

   ~~b. The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan~~ 26.1-18-06.

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

6. The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 26.1-18-08.

7. The health maintenance organization has failed to implement the complaint system required by section 26.1-18-17 in a manner to reasonably resolve valid complaints.

8. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

9. The continued operation of the health maintenance organization would be hazardous to its enrollees.

10. The health maintenance organization has otherwise failed to substantially comply with this chapter.

A certificate of authority may be suspended or revoked only after compliance with the requirements of section 26.1-18-30.

When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and may not engage in any advertising or solicitation.

When the certificate of authority of a health maintenance organization is revoked, the organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and may conduct no further business except as may be essential to the orderly conclusion of the affairs of ~~such~~ the organization. It may not engage in any further advertising or solicitation ~~whatsoever~~. The commissioner may, by written order, permit any further operation of the organization as the commissioner finds to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

SECTION 7. AMENDMENT. Section 26.1-18-30 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18-30. Administrative procedures. When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the health maintenance organization ~~and the state department of health and consolidated laboratories~~ in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time for a hearing on the matter as provided in chapter 28-32.

~~The state department of health and consolidated laboratories, or its designated representative, must be in attendance at the hearing and shall participate in the proceedings. The recommendation and findings of the department with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority, are conclusive and binding upon the commissioner. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take action as is deemed advisable on written findings which must be mailed to the health maintenance organization with a copy to the state department of health and consolidated laboratories.~~

SECTION 8. REPEAL. Sections 26.1-18-05 and 26.1-18-33 of the North Dakota Century Code are repealed.

Approved March 8, 1991
Filed March 8, 1991

CHAPTER 311

HOUSE BILL NO. 1217
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

FIRE AND TORNADO AND BONDING FUND

AN ACT to amend and reenact sections 26.1-21-09.1, 26.1-22-06, 26.1-22-13, and 26.1-22-17 of the North Dakota Century Code, relating to the fire and tornado fund and the state bonding fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

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

* SECTION 2. AMENDMENT. Section 26.1-22-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-06. Commissioner to adopt guidelines on insurable values for property. The commissioner shall adopt guidelines to be used by state agencies, departments, offices, officers, boards, commissions, international peace gardens, and winter shows for the purpose of determining insurable values of state-owned property and property belonging to an international peace garden or a winter show for insurance coverage as authorized by law. Notwithstanding any other provision of this chapter, the expenses for necessary rating inspections for the purpose of determining the proper premium rate to be applied to the property insured by the fund must be paid out of the fund.

SECTION 3. AMENDMENT. Section 26.1-22-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-13. Reserve balance - Payment of loss. All assessments, interest, and profits on investments and all other income of the fund must be added to a reserve balance within the fund. All losses incurred including loss adjustment expenses and operating expenses appropriated by the

* NOTE: Section 26.1-22-06 was also amended by section 4 of House Bill No. 1029, chapter 313.

legislative assembly must be paid from the reserve balance in the manner provided by law.

* **SECTION 4. AMENDMENT.** Section 26.1-22-17 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-17. Loss - How paid. All losses occasioned by the hazards provided for by this chapter must be paid out of the fund in an amount not exceeding the amount of the insurance upon any particular risk. The loss upon any building or property insured in the fund, whether totally destroyed or partially damaged by reason of the hazards, must be adjusted by the commissioner or a duly authorized adjuster or adjusting company. All necessary loss adjustment expenses must be included as a component of the loss and be paid out of the fund. Immediately upon the happening or occasion of any such loss or damage, the officer, board, or agency having charge or control of the property destroyed or damaged shall notify the commissioner by telegram or in writing, giving the description of the property, the amount of insurance carried, the probable amount of loss or damage, and the probable cause of loss or damage. The officer, board, or agency having control of the damaged property may not disturb the property except as provided in the policy until the commissioner or the commissioner's agent has adjusted the loss or has given notice that the information on which the adjustment is to be made has been secured. Allowances for loss and damage to insured property must be paid out of the fund upon warrants drawn by the office of management and budget upon the state treasurer against the fund after the submission of a voucher prepared by the commissioner to the office of management and budget specifying the amount to be paid and the payee to whom the warrants must be drawn. However, if at any time due to a catastrophe or disaster, or a succession of catastrophes or disasters, the reserve balance has been depleted below two million dollars, the commissioner may, with the approval of the industrial commission, issue premium anticipation certificates in an amount sufficient to bring the reserve balance up to two million dollars. The premium anticipation certificates must be issued for a period of from ten to twenty years, as determined by the commissioner with the approval of the industrial commission, and the interest and principal must be paid and retired by assessments levied on all policies in force with the fund. To retire these premium anticipation certificates, the commissioner shall levy a special assessment against all property insured in the fund; however, the total of all assessments and premiums provided for in section 26.1-22-14 may not exceed the full ~~bureau~~ rate as developed by an advisory organization at the direction of the commissioner. Any state department may invest its funds in the purchase of the premium anticipation certificates.

Approved March 25, 1991
Filed March 26, 1991

* NOTE: Section 26.1-22-17 was also amended by section 7 of House Bill No. 1029, chapter 313.

CHAPTER 312

HOUSE BILL NO. 1028
(Legislative Council)
(Interim Budget Committee on Government Administration)

STATE BUILDING INSURANCE LEVELS

AN ACT to create and enact two new sections to chapter 26.1-22 of the North Dakota Century Code, relating to insuring state-owned property through the state fire and tornado fund; to amend and reenact section 26.1-22-01 of the North Dakota Century Code, relating to definitions; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

* SECTION 1. AMENDMENT. Section 26.1-22-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-01. Definitions. In this chapter, unless the context ~~or subject matter~~ otherwise requires:

1. "Fund" means the state fire and tornado fund.

2. "International peace garden" means an entity located upon the international boundary line between the United States of America and Canada used and maintained as a memorial to commemorate the long-existing relationship of peace and good will between the people and the governments of the United States of America and Canada and to further international peace among the nations of the world.

3. "Permanent contents" refers only to such public property, either owned or leased, usually kept or used in or about public buildings insured in the fund, and to all public personal property usually kept or used in or about all buildings used for public purposes, or within one hundred feet [30.48 meters] of all such buildings, or while on sidewalks, streets, alleys, yards, detached platforms, and in or on railway cars. ~~Permanent contents~~ The term includes similar property owned by an international peace garden or a winter show. ~~Permanent contents~~ The term does not include automobiles, trucks, tractors, road machinery, or similar property used principally outside ~~of~~ such buildings.

4. "Political subdivision" includes a county, city, township, school district, or park district of this state.

5. "Replacement cost" is the cost to replace a building or its permanent contents with a similar structure of like materials or a similar product at current prices.

* NOTE: Section 26.1-22-01 was also amended by section 1 of House Bill No. 1029, chapter 313.

6. "Winter show" means an agricultural exhibition sponsored each year in March by a nonprofit corporation.

SECTION 2. Two new sections to chapter 26.1-22 of the North Dakota Century Code are created and enacted as follows:

State-owned property - Insured at replacement cost. State-owned buildings constructed after 1939 and fixtures and permanent contents insured under this chapter must be insured at replacement cost or for another value in accordance with underwriting guidelines adopted by the commissioner.

Replacement cost appraisal required on state-owned property. Once every six years each state agency and institution shall obtain from the fund a replacement cost appraisal on all buildings and fixtures and permanent contents under its control. The fund shall determine the manner of conducting the appraisal. Annually, except for any year an appraisal is conducted, the agency or institution shall adjust the appraisal amount in the manner authorized by the fund.

SECTION 3. APPROPRIATION. There is hereby appropriated out of any moneys in the state fire and tornado fund in the state treasury, not otherwise appropriated, the sum of $99,688, or so much thereof as may be necessary, to the commissioner of insurance for the purpose of implementing this Act for the biennium beginning on July 1, 1991, and ending on June 30, 1993.

Approved April 10, 1991
Filed April 10, 1991

CHAPTER 313

HOUSE BILL NO. 1029
(Legislative Council)
(Interim Budget Committee on Government Administration)

FIRE AND TORNADO FUND COVERAGE

AN ACT to create and enact a new section to chapter 26.1-22 of the North Dakota Century Code, relating to indirect loss insurance by the state fire and tornado fund; and to amend and reenact sections 26.1-22-01, 26.1-22-02, 26.1-22-06, 26.1-22-14, 26.1-22-15, 26.1-22-17, and 26.1-22-18 of the North Dakota Century Code, relating to the state fire and tornado fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

* SECTION 1. AMENDMENT. Section 26.1-22-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Fund" means the state fire and tornado fund.

2. "Indirect loss" means a loss in income or the additional expenses incurred because of a property loss.

3. "International peace garden" means an entity located upon the international boundary line between the United States of America and Canada used and maintained as a memorial to commemorate the long-existing relationship of peace and good will between the people and the governments of the United States of America and Canada and to further international peace among the nations of the world.

~~3.~~ 4. "Permanent contents" refers only to such public property, either owned or leased, usually kept or used in or about public buildings insured in the fund, and to all public personal property usually kept or used in or about all buildings used for public purposes, or within one hundred feet [30.48 meters] of all such buildings, or while on sidewalks, streets, alleys, yards, detached platforms, and in or on railway cars. Permanent contents includes similar property owned by an international peace garden or a winter show. Permanent contents does not include automobiles, trucks, tractors, road machinery, or similar property used principally outside ~~of~~ such buildings.

~~4.~~ 5. "Political subdivision" includes a county, city, township, school district, or park district of this state.

* NOTE: Section 26.1-22-01 was also amended by section 1 of House Bill No. 1028, chapter 312.

~~5.~~ 6. "Winter show" means an agricultural exhibition sponsored each year in March by a nonprofit corporation.

SECTION 2. AMENDMENT. Section 26.1-22-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-02. State fire and tornado fund under management of commissioner - Purpose of fund. The commissioner shall manage the fund. The fund must be maintained as a fund to insure the various state industries, the various political subdivisions, any international peace garden, and any winter show against loss to the public buildings, or buildings owned by an international peace garden or a winter show, and fixtures and permanent contents therein, and against indirect loss, through fire, lightning, inherent explosion, windstorm, cyclone, tornado and hail, explosion, riot attending a strike, aircraft, smoke, and vehicles~~, and at~~. At the option of the insured, the fund ~~has the authority to~~ may insure against ~~any~~ other risks of direct physical loss and indirect loss from those risks. All moneys collected under this chapter must be paid into the fund for use only for the purposes provided for in this chapter.

SECTION 3. A new section to chapter 26.1-22 of the North Dakota Century Code is created and enacted as follows:

Insurance against indirect losses. The commissioner shall provide, upon request of an entity insured with the fund, coverage by the fund for an indirect loss incurred because of a loss arising out of a peril insured against by the fund.

* SECTION 4. AMENDMENT. Section 26.1-22-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-06. Commissioner to adopt guidelines on insurable values ~~for property~~. The commissioner shall adopt guidelines to be used by state agencies, departments, offices, officers, boards, commissions, international peace gardens, and winter shows for the purpose of determining insurable values of state-owned property and property belonging to an international peace garden or a winter show for insurance coverage as authorized by law. The commissioner shall adopt guidelines in determining insurable values to assist state agencies and institutions and political subdivisions in determining whether to select indirect loss coverage.

SECTION 5. AMENDMENT. Section 26.1-22-14 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-14. Assessments and reporting of premiums and losses. If the reserve balance is less than twelve million dollars, the commissioner shall determine the amount of money necessary to bring the reserve balance up to twelve million dollars ~~and the~~. The commissioner shall then levy an assessment against every policy in force with the fund ~~on all public property or property belonging to an international peace garden or a winter show~~. The assessment must be computed as follows:

The eighty percent or ninety percent coinsurance rate established by the insurance services office for each insured property ~~to~~ for which ~~the eighty percent or ninety percent coinsurance~~ that rate may be applicable, and the full rate established for policies providing coverage against indirect losses and for properties to which the eighty

* NOTE: Section 26.1-22-06 was also amended by section 2 of House Bill No. 1217, chapter 311.

percent or ninety percent coinsurance rate is not applicable under the rules of the insurance services office, must be applied to the amount of insurance provided in each policy and the result of the application of the rate to the amount of insurance ~~shall set~~ sets the tentative assessment to be made against the policy. The total of all tentative assessments must then be ascertained. The percentage of the assessment necessary to restore the reserve balance to the sum of twelve million dollars must then be computed and collected on each policy; provided, that until the reserve balance reaches twelve million dollars, the assessment must be in an amount determined by the commissioner but ~~in no event in excess of~~ may not exceed sixty percent of the rates set by the insurance services office for insured property unless the reserve balance is depleted below three million dollars. In case of a fractional percentage the next higher whole percent must be used in such computation.

The commissioner shall submit not later than December thirty-first of each odd-numbered year, all data concerning premiums written and losses incurred during the previous biennium ending July thirty-first to the insurance services office so that the experience of the fund may be included in the computation of rates to apply to the classes of business written by the fund.

SECTION 6. AMENDMENT. Section 26.1-22-15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-15. Collection of premiums and assessments. The commissioner, as soon as possible after providing for ~~the~~ insurance ~~of~~ coverage against any indirect loss or loss of property belonging to the state, a political subdivision, an international peace garden, or a winter show, shall certify to the ~~board or officer in charge of the property~~ insured the amount of premium or assessment due ~~from the state, state industry, political subdivision, an international peace garden, or a winter show~~. The certificate must give the name~~, location, and description~~ of the ~~property~~ insured, the amount of insurance written thereon, and the amount of the premium or assessment, and if applicable, the location and description of the insured property. The proper officer shall remit to the commissioner the amount of the premium or assessment within sixty days after the date of the certification. The commissioner shall deposit the premiums and assessments with the state treasurer to the credit of the fund. If the premiums or assessments are not paid within sixty days after the date on which they are certified, they shall bear interest at the rate of six percent per annum and collection thereof may be enforced by appropriate action. The attorney general and the state's attorney of the ~~several counties~~ relevant county shall bring appropriate actions to enforce the collections of the premium and assessment upon request of the commissioner. Payment of the premiums or assessments certified pursuant to this section may be made by any state department, officer, board, institution, or agency and by any political subdivision, out of any available funds, notwithstanding that no specific appropriation or tax levy has been made therefor.

* SECTION 7. AMENDMENT. Section 26.1-22-17 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-17. Loss - How paid. All losses occasioned by the ~~hazards provided for by~~ perils insured against under this chapter must be paid out of the fund in an amount not exceeding the amount of the insurance upon any particular risk. The loss upon any building or property insured in the fund,

* NOTE: Section 26.1-22-17 was also amended by section 4 of House Bill No. 1217, chapter 311.

whether totally destroyed or partially damaged by reason of the ~~hazards~~ perils, must be adjusted by the commissioner or a duly authorized adjuster or adjusting company. Immediately upon the happening or occasion of any such loss or damage, the ~~officer, board, or agency having charge or control of the property destroyed or damaged~~ insured shall notify the commissioner ~~by telegram or in writing, giving the~~. The notification must be in the manner required by the commissioner and must provide a description of the property, the amount of insurance carried, the probable amount of loss or damage, and the probable cause of loss or damage. The ~~officer, board, or agency having control of the damaged property~~ insured may not disturb the property except as provided in the policy until the commissioner or the commissioner's agent has adjusted the loss or has given notice that the information on which the adjustment is to be made has been secured. Allowances for loss and damage ~~to insured property~~ must be paid out of the fund upon warrants drawn by the office of management and budget upon the state treasurer against the fund after the submission of a voucher prepared by the commissioner to the office of management and budget specifying the amount to be paid and the payee to whom the warrants must be drawn. However, if at any time due to a catastrophe or disaster, or a succession of catastrophes or disasters, the reserve balance has been depleted below two million dollars, the commissioner may, with the approval of the industrial commission, issue premium anticipation certificates in an amount sufficient to bring the reserve balance up to two million dollars. The premium anticipation certificates must be issued for a period of from ten to twenty years, as determined by the commissioner with the approval of the industrial commission, and the interest and principal must be paid and retired by assessments levied on all policies in force with the fund. To retire these premium anticipation certificates, the commissioner shall levy a special assessment ~~against all property insured~~ on every policy in force with the fund; however, the total of all assessments and premiums provided for in section 26.1-22-14 may not exceed the full bureau rate. Any state department may invest its funds in the purchase of the premium anticipation certificates.

SECTION 8. AMENDMENT. Section 26.1-22-18 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-18. Arbitration of loss. In case an agreement as to the amount of loss ~~sustained by any building or property~~ insured against under this chapter cannot be arrived at between the commissioner or the commissioner's representative and the person or board representing the state, political subdivision, an international peace garden, or a winter show owning the building or property, the loss may be arbitrated as provided by law.

Approved March 27, 1991
Filed March 28, 1991

CHAPTER 314

HOUSE BILL NO. 1264
(Tollefson, Wald, Whalen)

COMMERCIAL INSURANCE AUDITS

AN ACT to amend and reenact section 26.1-24-10 of the North Dakota Century Code, relating to insurance audits by insurers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-24-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-24-10. Insurer's audit to determine premium - Time limitation. An insurer providing commercial ~~multiple peril~~ insurance may conduct an audit to determine the premium due or to be refunded only within one hundred eighty days after the expiration date of the policy unless the insured agrees in writing to extend that period of time. During the period allowed to conduct the audit, the insurer may not estimate the amount of premium to be refunded to or paid by the insured.

Approved March 18, 1991
Filed March 19, 1991

CHAPTER 315

HOUSE BILL NO. 1522
(Payne, Whalen)

INSURANCE AGENT LICENSE REVOCATION

AN ACT to amend and reenact subsections 11, 12, and 13 of section 26.1-26-42 of the North Dakota Century Code, relating to grounds for revocation of an insurance agent's license.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsections 11, 12, and 13 of section 26.1-26-42 of the North Dakota Century Code are amended and reenacted as follows:

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

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.

Approved April 2, 1991
Filed April 4, 1991

CHAPTER 316

HOUSE BILL NO. 1477
(DeMers, Svedjan, Clayburgh)

HEALTH CARE SERVICE REVIEW

AN ACT to provide for utilization review of health care services; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Purpose. The purpose of this Act is to:

1. Promote the delivery of quality health care in a cost-effective manner;

2. Assure that utilization review agents adhere to reasonable standards for conducting utilization review;

3. Foster greater coordination and cooperation between health care providers and utilization review agents;

4. Improve communications and knowledge of benefits among all parties concerned before expenses are incurred; and

5. Ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable laws.

SECTION 2. Definitions. For purposes of this Act, unless the context requires otherwise:

1. "Commissioner" means the commissioner of insurance.

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

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

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

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

   a. An agency of the federal government; or

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

SECTION 3. Certification. A utilization review agent may not conduct utilization review in this state unless the utilization review agent has certified to the commissioner in writing that the agent is in compliance with section 4 of this Act. Certification must be made annually on or before March first of each calendar year. In addition, a certification review agent must file the following information:

1. The name, address, telephone number, and normal business hours of the utilization review agent;

2. The name and telephone number of a person for the commissioner to contact; and

3. A description of the appeal procedures for utilization review determinations.

Any material changes in the information filed in accordance with this section must be filed with the commissioner within thirty days of the change.

SECTION 4. Minimum standards of utilization review agents. All utilization review agents must meet the following minimum standards:

1. Notification of a determination by the utilization review agent must be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of the request for determination and the receipt of all information necessary to complete the review.

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

3. Any notification of a determination not to certify an admission or service or procedure must include the principal reason for the determination and the procedures to initiate an appeal of the determination.

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

   a. On appeal, all determinations not to certify an admission, service, or procedure as being necessary or appropriate must be

made by a physician or, if appropriate, a licensed psychologist.

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

c. Utilization review agents shall provide for an expedited appeals process for emergency or life-threatening situations. Utilization review agents shall complete the adjudication of expedited appeals within forty-eight hours of the date the appeal is filed and the receipt of all information necessary to complete the appeal.

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

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

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

8. Physicians or psychologists making utilization review determinations shall have current licenses from a state licensing agency in the United States.

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

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

SECTION 5. Utilization review agent violations - Penalty. Whenever the commissioner has reason to believe that a utilization review agent subject to this Act has been or is engaged in conduct that violates section 3 or 4 of this Act, the commissioner shall notify the utilization review agent of the alleged violation. The utilization review agent has thirty days from the date the notice is received to respond to the alleged violation.

If the commissioner believes that the utilization review agent has violated this Act, or is not satisfied that the alleged violation has been corrected, the commissioner shall conduct a hearing on the alleged violation in accordance with chapter 28-32.

If, after the hearing, the commissioner determines that the utilization review agent has engaged in violations of this Act, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon

the utilization review agent a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violations. The commissioner may also, at the commissioner's discretion, order:

1. Payment of a penalty of not more than ten thousand dollars for a violation that occurred with such frequency as to indicate a general business practice; or

2. Suspension or revocation of the authority to do business in this state as a utilization review agent if the utilization review agent knew that the act was in violation of this Act.

Approved April 8, 1991
Filed April 8, 1991

CHAPTER 317

HOUSE BILL NO. 1294
(Representative Goffe)
(Senator E. Hanson)

ANNUITY AND INSURANCE CANCELLATION RIGHTS

AN ACT to create and enact sections 26.1-34-01.1 and 26.1-36-02.1 of the North Dakota Century Code, relating to a "free-look" provision for annuity and accident and health policies and certificates.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-34-01.1 of the North Dakota Century Code is created and enacted as follows:

26.1-34-01.1. Annuity policies and certificates - Right to return. A person who purchases an annuity policy or certificate issued or delivered in this state may return the policy within twenty days of delivery to the purchaser. If a policy or certificate is returned, the purchaser is entitled to a refund of the premium, except in the sale of variable annuities where the purchaser is entitled to the value of the annuity plus all expense charges. Every annuity, policy, or certificate issued or delivered in this state must have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the purchaser may return the policy or certificate within twenty days of its delivery and have the premium, or such other amount as specified above, refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

SECTION 2. Section 26.1-36-02.1 of the North Dakota Century Code is created and enacted as follows:

26.1-36-02.1. Accident and health policies and certificates - Notice of free examination. Accident and health policies and certificates must have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the applicant may return the policy or certificate within ten days of its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

Approved March 20, 1991
Filed March 21, 1991

CHAPTER 318

HOUSE BILL NO. 1192
(Committee on Industry, Business and Labor)
(At the request of the Commissioner of Insurance)

CHARITABLE GIFT ANNUITIES

AN ACT to create and enact chapter 26.1-34.1 of the North Dakota Century Code, relating to creating an exemption that may be granted by the commissioner of insurance for the issuance of charitable gift annuities.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-34.1 of the North Dakota Century Code is created and enacted as follows:

26.1-34.1-01. Application for certificate of exemption to issue gift annuities. A domestic or foreign corporation organized and operated exclusively as, or for the purpose of aiding, an educational, religious, charitable, scientific, or philanthropic institution and which is organized as a nonprofit organization without profit to any person, may apply to the commissioner for a certificate of exemption to receive gifts of money or other property conditioned upon, or in return for, its agreement to pay an annuity to a donor or nominee or both. The corporation shall include with its application any documents or information the commissioner reasonably requires, including:

1. Its name, location, and organization;

2. Evidence that it possesses a current tax-exempt status under the laws of the United States;

3. A designation form appointing the commissioner as its attorney upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an annuitant or beneficiary arising out of any annuity contract;

4. A statement of the financial condition, management, and affairs of the organization including an accurate and complete financial statement consisting of a balance sheet and income and expense statement, showing the current financial condition of the corporation and sworn to by the officer of the corporation having the responsibility for preparing such statement; and

5. A filing fee of one hundred dollars coincident with its application.

26.1-34.1-02. Issuance of certificate of exemption to issue gift annuities. The commissioner shall issue a certificate of exemption if:

1. All requirements of this chapter have been met; and

2. The commissioner is satisfied that the corporation is in a position to competently execute its responsibilities relative to such annuity contracts.

26.1-34.1-03. Segregated account.

1. Every corporation possessing a certificate of exemption shall maintain a segregated account for all of its gift annuity liabilities.

2. The assets of the segregated account are not liable for any debts of the corporation other than those incurred pursuant to this chapter.

3. The segregated account must be adequate to meet the future payments under all outstanding annuity agreements.

26.1-34.1-04. Contents of annuity contract or policy form. Each charitable annuity contract or policy form used or issued by the corporation must include at least the following information:

1. The value of the property to be transferred;

2. The amount of the periodic annuity benefits to be paid;

3. The manner in which and the intervals at which payment is to be made;

4. The age of the person during whose life payment is to be made; and

5. The reasonable value as of the date of the agreement of the benefits thereby created.

26.1-34.1-05. Continued compliance. The commissioner may require that a corporation possessing a certificate of exemption submit periodically any report the commissioner determines to be desirable or necessary to ascertain compliance with requirements of this chapter. The commissioner, whenever the commissioner determines it to be expedient, may make or cause to be made an examination of the assets and liabilities and other affairs of the corporation as the same pertains to annuity agreements entered into pursuant to this chapter. The reasonable expenses incurred for any such examination must be fixed and paid in accordance with section 26.1-03-20.

26.1-34.1-06. Grounds for denial, revocation, or suspension of certificate of exemption. The commissioner may refuse to grant, or may revoke or suspend, a certificate of exemption if the commissioner finds that the corporation does not meet or continue to meet the requirements of this chapter or that the corporation has violated this chapter or chapter 26.1-04.

26.1-34.1-07. Other applicable code provisions. Except as prescribed in this chapter, the corporation is otherwise exempt from the provisions of this code and other insurance laws.

Approved March 20, 1991
Filed March 21, 1991

CHAPTER 319

HOUSE BILL NO. 1042
(Legislative Council)
(Interim Industry and Business Committee)

BASIC HEALTH INSURANCE COVERAGE

AN ACT to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to providing basic health insurance coverage for individuals and certain employers; to provide for reports to the legislative council; and to provide an expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Basic health insurance coverage - Exception to required coverages. An insurance company, a nonprofit health service corporation, or a health maintenance organization may deliver, issue, execute, or renew a basic health insurance policy, health service contract, or evidence of coverage on an individual basis or an employer group, blanket, franchise, or association basis for employers with fewer than twenty-five employees. The basic policy, contract, or evidence of coverage is not subject to sections 26.1-36-08, 26.1-36-09, 26.1-36-09.1, 26.1-36-09.3, 26.1-36-12.1, and 43-13-31. The insurance company, nonprofit health service corporation, or health maintenance organization shall make the coverages required under those sections available at the option of the individual or employer and may charge an additional premium for each coverage provided. The basic policy, contract, or agreement authorized under this section is not available to an individual or employer unless that individual or employer has not had any health insurance coverage in force for at least twelve months preceding the date of application for the basic policy, contract, or agreement.

SECTION 2. COMMISSIONER'S REPORT ON BASIC HEALTH INSURANCE COVERAGE. The commissioner shall collect data from insurance companies, nonprofit health service corporations, and health maintenance organizations relating to coverage provided under section 1 of this Act. The data must include the number of groups and individuals purchasing coverage, the number of insureds, subscribers, members, and their dependents, under coverage, and the rates and rate increases or decreases for the coverage. The commissioner shall assemble a written report concerning this data and shall submit the report to the legislative council during the 1991-92 and 1993-94 interims. The commissioner shall submit a final report along with the commissioner's recommendation regarding the advisability of continuing the coverage provided under section 1 of this Act to the legislative council during the 1995-96 interim.

SECTION 3. EXPIRATION DATE. This Act is effective through June 30, 1997, and after that date is ineffective.

Approved March 18, 1991
Filed March 19, 1991

CHAPTER 320

HOUSE BILL NO. 1491
(Representatives Svedjan, Gilmore, Rydell)
(Senator Graba)

HEALTH INSURANCE CONTESTED CLAIM NOTICE

AN ACT to amend and reenact section 26.1-36-37.1 of the North Dakota Century Code, relating to health insurance proof of loss forms and claim payment time limits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-37.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-37.1. Standard health insurance proof of loss form - Claim payment time limits. The commissioner shall prescribe by rule a standard health insurance proof of loss and claim form ~~to be supplied by every insurer and health service corporation upon request~~ for use in filing proof of loss and a claim. After receipt of a health insurance proof of loss form, the insurer shall, within fifteen business days, pay the claim or that portion of the claim that is not contested, deny the claim, or make an initial request for additional information. If a claim or a portion of a claim is contested, the insured or the insured's assignee must be notified in writing that the claim is contested and the reasons for the contest. Nothing in this notification precludes the insurer from denying the claim in whole or in part, for other reasons at a later date. Within fifteen business days of the receipt of ~~additional~~ the information initially requested, the insurer shall pay or deny the claim.

Approved March 20, 1991
Filed March 21, 1991

CHAPTER 321

HOUSE BILL NO. 1539
(Gabrielson)

SMALL EMPLOYER INSURANCE COVERAGE

AN ACT relating to health insurance coverage to small employers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. As used in this Act, unless the context otherwise requires:

1. "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with section 3 of this Act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

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

3. "Carrier" means any person who provides health insurance in this state. The term includes an insurance company, a nonprofit health service corporation, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to regulation by the commissioner.

4. "Case characteristics" include demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. The term does not include claim experience, health status, and duration of coverage since issue.

5. "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

   a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

      (1) Are marketed and sold through individuals and organizations that are not participating in the marketing

or sale of other distinct groupings of small employers for such small employer carrier;

(2) Have been acquired from another small employer carrier as a distinct grouping of plans;

(3) Are provided through an association with membership of not less than ten small employers which has been formed for purposes other than obtaining insurance; or

(4) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in paragraph 1 of subdivision a of subsection 1 of section 3 of this Act.

b. A small employer carrier may establish no more than two additional groupings under each grouping in subdivision a on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

c. The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

6. "Commissioner" means the commissioner of insurance.

7. "Health benefit plan" or "plan" means any hospital or medical expense incurred policy or certificate, health service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, credit, dental, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

8. "Index rate" means for each class of business for small employers with similar case characteristics the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

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

10. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

11. "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business who, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees. In determining the number of eligible employees, companies that are affiliated

companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

12. "Small employer carrier" means any carrier that offers health benefit plans covering the employees of a small employer.

SECTION 2. Health insurance plans subject to Act. Except as provided in this section, this Act applies to any health benefit plan that provides coverage to one or more employees of a small employer. This Act does not apply to individual health insurance policies that are subject to policy form and premium rate approval by the commissioner.

SECTION 3. Restrictions relating to premium rates.

1. Premium rates for health benefit plans subject to this Act are subject to the following:

   a. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than twenty percent. This subdivision does not apply to a class of business if:

      (1) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claim experience or health status;

      (2) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

      (3) The class of business is currently available for purchase.

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

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

      (1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

      (2) An adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the

small employer as determined from the carrier's rate manual for the class of business; and

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

d. In the case of health benefit plans issued before the effective date of this Act, a premium rate for a rating period may exceed the ranges described in subdivisions a and b of subsection 1 for a period of five years following the effective date of this Act. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

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

2. This section does not affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

3. A small employer carrier may not involuntarily transfer a small employer into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

SECTION 4. Renewability of coverage.

1. Except as provided in subsection 2, a health benefit plan subject to this Act must be renewable to all eligible employees and dependents at the option of the small employer, except for the following reasons:

a. Nonpayment of required premiums;

b. Fraud or misrepresentation of the small employer, or with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or the individual's representative;

c. Noncompliance with plan provisions;

d. The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

e. The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

2. A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least ninety days before termination of coverage. A carrier that exercises its right to cease to renew all plans in a class of business may not:

a. Establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the commissioner; or

b. Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status, or duration of coverage.

SECTION 5. Disclosure of rating practices and renewability provisions. Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers, the following:

1. The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer;

2. The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, that affect changes in premium rates;

3. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

4. The provisions relating to renewability of coverage.

SECTION 6. Maintenance of records.

1. Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

2. Each small employer carrier shall file, by March first of each year, with the commissioner an actuarial certification that the carrier is in compliance with this section and that the rating

methods of the carrier are actuarially sound. A copy of the certification must be retained by the carrier at its principal place of business.

3. A small employer carrier shall make the information and documentation described in subsection 1 available to the commissioner upon request. The information is considered proprietary and trade secret information. The commissioner may not disclose the information except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

SECTION 7. Discretion of the commissioner. The commissioner may suspend all or any part of section 3 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

SECTION 8. Applicability of the Act. This Act applies to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after the effective date of this Act. For purposes of this section, the date a plan is continued is the first rating period that commences after the effective date of this Act.

Approved March 20, 1991
Filed March 21, 1991

CHAPTER 322

SENATE BILL NO. 2555
(Senators Freborg, Naaden)
(Representative Wald)

NO-FAULT INSURANCE FUNERAL BENEFITS

AN ACT to amend and reenact subsection 2 of section 26.1-41-01 of the North Dakota Century Code, relating to basic no-fault insurance funeral benefits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-41-01 of the North Dakota Century Code is amended and reenacted as follows:

2. "Basic no-fault benefits" means benefits for economic loss resulting from accidental bodily injury. The maximum amount of basic no-fault benefits payable for all economic loss incurred and resulting from accidental bodily injury to any one person as the result of any one accident may not exceed thirty thousand dollars, regardless of the number of persons entitled to the benefits or the number of basic no-fault insurers obligated to pay the benefits. Basic no-fault benefits payable may not exceed one hundred fifty dollars per week per person prorated for any lesser period for work loss or survivors' income loss, or ~~one~~ three thousand five hundred dollars for funeral, cremation, and burial expenses.

Approved March 14, 1991
Filed March 15, 1991

CHAPTER 323

SENATE BILL NO. 2302
(Senator Peterson)
(Representative Soukup)

BUSES UNDER AUTO ACCIDENT REPARATIONS LAW

AN ACT to create and enact a new subdivision to subsection 4 of section 26.1-41-01 of the North Dakota Century Code, relating to the definition of bus with respect to automobile accident reparations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new subdivision to subsection 4 of section 26.1-41-01 of the North Dakota Century Code is created and enacted as follows:

Any motor vehicle owned by a political subdivision and operated as part of a public transit system in which all or a portion of the costs of operation are subsidized by the political subdivision or the federal government.

Approved March 11, 1991
Filed March 11, 1991

CHAPTER 324

SENATE BILL NO. 2089
(Lips)

AUTO ACCIDENT LOSS ALLOCATION

AN ACT to amend and reenact subsection 3 of section 26.1-41-13 and section 26.1-41-17 of the North Dakota Century Code, relating to the coordination of benefits under the Auto Accident Reparations Act and the equitable allocation of losses between insurance companies under the Auto Accident Reparations Act.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26.1-41-13 of the North Dakota Century Code is amended and reenacted as follows:

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

SECTION 2. AMENDMENT. Section 26.1-41-17 of the North Dakota Century Code is amended and reenacted as follows:

26.1-41-17. Equitable allocation of losses among insurers. A basic no-fault insurer may recover ~~basic~~ no-fault benefits paid to or for the benefit of an injured person from the motor vehicle liability insurer of a secured person if:

1. The injured person has sustained a serious injury; or

2. The injury results from an accident involving two or more motor vehicles, at least one of which is a motor vehicle weighing more than six thousand five hundred pounds [2,948.35 kilograms] unloaded.

The right of recovery and the amount thereof must be determined on the basis of tort law without regard to section 26.1-41-08 by agreement between the ~~basic no-fault~~ insurers involved, or, if they fail to agree, by binding

intercompany arbitration under procedures approved by the commissioner. The amount of recovery under this section may not exceed the limits of liability of the secured person's motor vehicle liability insurance policy or other security, reduced by the amount of the liability for tort claims against the secured person covered by the policy or other security.

Approved March 14, 1991
Filed March 15, 1991

CHAPTER 325

HOUSE BILL NO. 1084
(Wald)

CLAIMS AGAINST INSOLVENT INSURERS

AN ACT to amend and reenact subsection 3 of section 26.1-42-02 of the North Dakota Century Code, relating to the definition of covered claim under the Property and Casualty Insurance Guaranty Association Act.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26.1-42-02 of the North Dakota Century Code is amended and reenacted as follows:

3. "Covered claim" means an unpaid claim, including one for unearned premiums, within the coverage of an insurance policy to which this chapter applies issued by an insurer if the insurer becomes insolvent after July 1, 1971. The claimant or insured must be a resident of this state at the time of the insured event or the insured property must be permanently located in this state. "Covered claim" does not include any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. A reinsurer, insurer, insurance pool, or underwriting association that has paid a claim, and become subrogated to the amount of that claim, may assert that claim against the liquidator of the insolvent insurer, but not against the insured of the insolvent insurer.

Approved March 18, 1991
Filed March 19, 1991