INSURANCE

CHAPTER 259

SENATE BILL NO. 2067

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

INTERNATIONAL INSURANCE REGULATOR DOCUMENT SHARING

AN ACT to amend and reenact section 26.1-03-11.3 of the North Dakota Century Code, relating to sharing of confidential documents with international insurance regulators.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-11.3 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-11.3. Confidentiality. The commissioner shall maintain, as confidential, any confidential documents or information received from the national association of insurance commissioners or state ~~or~~, federal, or international regulatory or law enforcement officials of this state and other states or jurisdictions. The information may not be disclosed by the department and is exempt from section 44-04-18. The commissioner may share information that is confidential under the laws of this state with the national association of insurance commissioners and with state ~~or~~, federal, or international regulatory or law enforcement officials from this state and other states or jurisdictions providing that the officials are required, under their law, to maintain its confidentiality.

Approved April 5, 2007
Filed April 5, 2007

CHAPTER 260

HOUSE BILL NO. 1155

(Representative Price)
(Senator J. Lee)

CHAND COVERAGE

AN ACT to amend and reenact sections 26.1-08-01 and 26.1-08-02.1, subdivisions h and j of subsection 2 of section 26.1-08-02.2, sections 26.1-08-06, 26.1-08-07, and 26.1-08-09, subsection 6 of section 26.1-08-10, subsections 3 and 4 of section 26.1-08-11, sections 26.1-08-12 and 26.1-08-13, and subsection 28 of section 26.1-36.3-01 of the North Dakota Century Code, relating to the comprehensive health association of North Dakota and to a definition applicable to small employer employee health insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-08-01 of the North Dakota Century Code is amended and reenacted as follows:

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

1. "Association" means the comprehensive health association of North Dakota.

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

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

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

5. "~~Credible~~ Church plan" means a plan as defined under section 3(33) of the federal Employee Retirement Income Security Act of 1974.

6. "Creditable coverage" ~~means, with respect to an individual, coverage of the individual provided under:~~

   ~~a. A group health plan;~~

   ~~b. Health insurance;~~

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

   ~~d. Title XIX of the federal Social Security Act [42 U.S.C. 1396 et seq.], relating to grants to states for medical assistance programs, with the exception of coverage consisting solely of benefits under~~

~~section 1928 of the federal Social Security Act [Pub. L. 103-66; 107-637; 42 U.S.C. 1396s],~~ ~~relating to the program for distribution of pediatric vaccines;~~

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

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

~~g. A state health benefits risk pool;~~

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

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

~~j. A benefit plan under section 5(e) of the federal Peace Corps Act [Pub. L. 87-293; 75 Stat. 613; 22 U.S.C. 2504(e)]~~ has the same meaning as "qualifying previous coverage" as defined under section 26.1-36.3-01.

~~6.~~ 7. "Eligible individual" means an individual eligible for association benefit plan coverage as specified under section 26.1-08-12.

~~7.~~ 8. "Governmental plan" has the same meaning as provided under section 3(32) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] and as may be provided under any federal governmental plan.

~~8.~~ 9. "Group health plan" has the same meaning as employee welfare benefit plan as provided under section 3(1) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] to the extent that the plan provides medical care, and including items and service paid for as medical care to employees or the employees' dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

~~9.~~ 10. "Health insurance coverage" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care. ~~The term~~

a. Health insurance coverage does not include any one or more of the following:

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

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

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

~~d.~~ (4) Workforce safety and insurance or similar insurance;

~~e.~~ (5) Automobile medical payment insurance;

~~f.~~ (6) Credit-only insurance;

~~g.~~ (7) Coverage for onsite medical clinics; and

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

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

(1) Limited scope dental or vision benefits;

~~j.~~ (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of this care; and

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

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

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

~~m.~~ (2) Hospital indemnity or other fixed indemnity insurance~~;~~.

~~n. Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 1395ss(g)(1)];~~

~~o.~~ d. Health insurance coverage does not include the following if offered as a separate policy, certificate, or contract of insurance:

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

~~p.~~ (2) Similar supplemental coverage provided under a group health plan.

~~10.~~ 11. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, health maintenance organization, and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.

~~11.~~ 12. "Lead carrier" means the insurance company selected by the board to administer the association benefit plans.

~~12.~~ 13. "Medicare" means coverage under both parts A and B of title XVIII of the federal Social Security Act [Pub. L. 89-97; 79 Stat. 291; 42 U.S.C. 1395 et seq.].

~~13.~~ 14. "Participating member" means any ~~insurance company~~ insurer that is licensed ~~or authorized to do business~~ in this state which has an annual earned premium volume of ~~accident and~~ health insurance ~~contracts~~ coverage, including medicare supplemental health insurances as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 1395ss(g)(1)], derived from or on behalf of residents in the previous calendar year of at least one hundred thousand dollars.

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

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

~~a. Limited to disability or income protection coverage;~~

~~b. Automobile medical payment coverage;~~

~~c. Supplemental to liability insurance;~~

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

~~e. Credit accident and health insurance.~~

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

~~17.~~ 15. "Resident" means an individual who has been a legal resident of this state for a minimum of one hundred eighty-three days, determined by applying section 54-01-26. However, for a federally defined eligible individual as defined under subdivision b of subsection 5 of section 26.1-08-12, there is no minimum ~~length of~~ residency requirement. The board may waive the residency requirement upon a showing of good cause.

~~18.~~ 16. "Significant break in coverage" means a period of sixty-three or more consecutive days during all of which the individual does not have ~~any credible~~ creditable coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

~~19.~~ 17. "Trade adjustment assistance, pension benefit guarantee corporation individual" means an individual who is certified as eligible for federal trade adjustment assistance or federal pension benefit guarantee corporation assistance as provided by the federal Trade Adjustment Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933], the spouse of such an individual, or a dependent of such an individual as provided under the federal Internal Revenue Code.

SECTION 2. AMENDMENT. Section 26.1-08-02.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-02.1. Board of directors.

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

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

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

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

SECTION 3. AMENDMENT. Subdivisions h and j of subsection 2 of section 26.1-08-02.2 of the North Dakota Century Code are amended and reenacted as follows:

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

j. Exempt, by a two-thirds majority vote, an applicant from the preexisting condition provisions of subsection ~~10~~ 13 of section 26.1-08-12 when required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life; and

SECTION 4. AMENDMENT. Section 26.1-08-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-06. Comprehensive benefit plan.

1. ~~A plan of health coverage is a qualified comprehensive plan if it otherwise meets the requirements established by chapters 26.1-36 and 26.1-36.4 and the other laws of the state.~~

~~2.~~ The benefit plan must offer comprehensive health care coverage to every eligible individual. The coverage to be issued by the association, its schedule of benefits, exclusions, and other limitations must be established by the lead carrier and subject to the approval of the board.

~~3.~~ 2. In establishing the benefit plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate. Benefit levels, deductibles, coinsurance factors, copayments, exclusions, and limitations may be applied as determined to be generally reflective of health insurance coverage provided in the state.

~~4.~~ 3. The coverage may include deductibles of not less than five hundred dollars per individual per benefit period.

~~5.~~ 4. The coverage must include a limitation of not less than three thousand dollars per individual on the total annual out-of-pocket expenses for services covered under this subsection.

~~6.~~ 5. Any coverage or combination of coverages through the association may not exceed a lifetime maximum benefit of one million dollars for an individual.

~~7.~~ 6. The coverage may include cost-containment measures and requirements, including preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost-effective.

~~8.~~ 7. The coverage may include preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

~~9.~~ 8. Coverage must include oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

~~10.~~ 9. Coverage must include substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.

~~11.~~ 10. Covered expenses must include, at the option of the eligible individual, professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

~~12.~~ 11. The coverage must include organ transplants as approved by the board.

~~13.~~ 12. The association must be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under an association benefit plan must be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workforce safety and insurance coverage, automobile medical payment or liability insurance whether provided on the basis of fault or no fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. The association must have a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this subsection.

SECTION 5. AMENDMENT. Section 26.1-08-07 of the North Dakota Century Code is amended and reenacted as follows:

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

SECTION 6. AMENDMENT. Section 26.1-08-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-09. Participating members.

1. There is established a comprehensive health association with participating ~~membership consisting of those insurance companies, licensed or authorized to do business in this state, with an annual premium volume of accident and health insurance contracts, derived from or on behalf of residents in the previous calendar year, of at least one hundred thousand dollars, as determined by the commissioner~~ members.

2. All participating members shall maintain their membership in the association, as a condition for writing policies in this state.

3. Each participating member of the association ~~which is liable for state income tax or state premium tax~~ shall share the losses due to claims and administrative expenses of the association. The difference between the total claims expense of the association and the benefit plan premiums received is the liability of the participating members. Such participating members shall share in the excess costs of the association in an amount equal to the ratio of a participating member's total annual premium volume for ~~accident and~~ health insurance received from or on behalf of state residents, to the total ~~accident and~~ health insurance premium volume received by all of the participating members as determined by the lead carrier and approved by the board. For determining the liability of participating members, health insurance coverage includes medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 1395ss(g)(1)] but does not include federal employees health benefits plans or medicare part C plans.

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

SECTION 7. AMENDMENT. Subsection 6 of section 26.1-08-10 of the North Dakota Century Code is amended and reenacted as follows:

6. The lead carrier shall:

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

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

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

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

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

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

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

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

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

   j. Determine and collect assessments.

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

SECTION 8. AMENDMENT. Subsections 3 and 4 of section 26.1-08-11 of the North Dakota Century Code are amended and reenacted as follows:

3. All licensed accident and health insurance producers may engage in the selling or marketing of ~~qualified~~ association benefit plans. The lead carrier shall pay ~~an insurance producer's~~ a referral fee to each licensed accident and health insurance ~~insurance~~ producer who refers an applicant to the association plan, if the applicant is accepted. The

referral fees must be paid to the lead carrier from moneys received as premiums for the association benefit plan.

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

SECTION 9. AMENDMENT. Section 26.1-08-12 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-12. Eligibility.

1. The association must be open for enrollment by eligible individuals. Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must:

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

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

   c. Provide the name, address, and age of spouse and children, if any.

   d. Provide a designation of coverage desired.

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

2. Within thirty days of receipt of the application, the lead carrier shall either reject the application for failing to comply with the requirements of this section or forward the eligible individual a notice of acceptance and billing information. ~~Insurance~~

3. At the option of the eligible individual, association coverage is effective ~~retroactive to the date of the application or the day following the date shown on the written rejection or refusal, if the applicant otherwise complies with this chapter~~:

   a. For an eligible individual applying under subsection 10 or 11, on the signature date of the application.

   b. For an eligible individual applying under subparagraph a of paragraph 1 of subdivision a of subsection 5 or under subparagraph a of paragraph 1 of subdivision c of subsection 5:

      (1) On the day following the date shown on the written evidence;

      (2) On the signature date of the application, if it is at least one day and less than one hundred eighty days following the date shown on the written evidence; or

      (3) On any date after the signature date of the application if the date is at least one day and less than one hundred eighty days following the date shown on the written evidence.

   c. For an eligible individual applying under subparagraph b or c of paragraph 1 of subdivision a of subsection 5 or under

subparagraph b or c of paragraph 1 of subdivision c of subsection 5:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application but less than one hundred eighty days following the date shown on the written evidence.

d. For an eligible individual applying under subdivision b or d of subsection 5:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application, but less than sixty-four days following termination of previous coverage.

e. For an eligible individual applying under subsection 6:

(1) On the signature date of the application; or

(2) On any date after the signature date of the application, but less than one hundred eighty days following the date shown on the written evidence from a medical professional.

~~3.~~ 4. An eligible individual may not purchase more than one policy from the association.

~~4.~~ 5. An individual may qualify to enroll in the association for benefit plan coverage as:

a. A ~~standard~~ traditional applicant:

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

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

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

(c) ~~Refusal by~~ Written evidence that an insurer has offered to issue comparable insurance ~~except~~ at ~~the~~ a rate exceeding the association benefit rate.

(2) Is not ~~eligible for~~ enrolled in health benefits with the state's medical assistance program.

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

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

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

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

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

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

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

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

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

(3) Is not ~~eligible for~~ enrolled in health benefits with the state's medical assistance program.

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

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

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

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

(c) ~~Refusal by~~ Written evidence that an insurer has offered to issue comparable insurance ~~except~~ at ~~the~~ a rate exceeding the association benefit rate.

(2) Is not ~~eligible for~~ enrolled in health benefits with the state's medical assistance program.

d. A Trade Adjustment Assistance Reform Act of 2002 applicant:

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

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

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

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

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

(e) Is not ~~an inmate or a resident of a public institution~~ imprisoned under federal, state, or local authority; and

(f) Does not have health insurance coverage through:

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

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

[3] A government plan.

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

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

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

including continuation or guaranteed issue, but who elects to obtain coverage under this subdivision.

~~5.~~ 6. The board and lead carrier shall develop a list of medical or health conditions for which an individual must be eligible for association coverage without applying for health insurance coverage under subdivisions a and c of subsection ~~4~~ 5. Individuals with written evidence of the existence or history of any medical or health conditions on the approved list may not be required to provide written evidence of rejection~~,~~ or refusal, a rate that exceeds the association rates, or substantially reduced coverage.

~~6.~~ 7. A rejection or refusal by an insurer offering only stop loss, excess of loss, or reinsurance coverage with respect to an applicant under subdivisions a and c of subsection 4 is not sufficient evidence to qualify.

~~7. An eligible individual~~

8. A traditional applicant, as specified under subdivision a of subsection 5, may have insurance coverage, other than the state's medical assistance program, with an additional commercial insurer; however, the association will reimburse eligible claim costs as payer of last resort.

9. An individual who is eligible for association coverage as specified under subdivision c of subsection 5 may not have more than one policy that is a supplement to part A or part B of medicare relating to health insurance for the aged and disabled. The individual may obtain association coverage as a traditional applicant as specified under subdivision a of subsection 5 which is concurrent with a supplement policy offered by a commercial carrier. However, the association will reimburse eligible claims as payer of last resort.

~~8.~~ 10. Each resident dependent of an individual who is eligible for association coverage is also eligible for association coverage.

~~9.~~ 11. Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition is also eligible for association coverage.

12. A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first thirty-one days following birth. Continued coverage through the association for the child will be provided if the association receives an application and the appropriate premium within thirty-one days following the birth.

~~10.~~ 13. Preexisting conditions.

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

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

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

d. A preexisting condition may not be imposed on an individual who is eligible under subdivision b or d of subsection ~~4~~ 5.

~~11.~~ 14. Waiting periods do not apply to an individual who:

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

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

~~c.~~ Has obtained coverage as a federally eligible individual as defined in subdivision b of subsection ~~4~~ 5.

~~d.~~ c. Has obtained coverage as an eligible person under subdivision a or c of subsection ~~4~~ 5, allowing for a reduction in waiting period days by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06 and provided the association application is made within sixty-three days of termination of the qualifying previous coverage.

~~e.~~ d. Has obtained coverage as an eligible individual under subdivision d of subsection ~~4~~ 5.

~~12.~~ 15. An individual is not eligible for coverage through the association if:

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

b. The individual has previously terminated association coverage unless twelve months have lapsed since such termination. This limitation does not apply to an applicant who is a federally defined eligible individual as defined under subdivision b of subsection 5.

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

d. The individual is ~~an inmate or resident of a public institution~~ imprisoned under federal, state, or local authority. This limitation does not apply to an applicant who is a federally defined eligible individual as defined under subdivision b of subsection 5.

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

~~13.~~ 16. A period of ~~credible~~ creditable coverage is not counted with respect to the enrollment of an individual who seeks coverage under this chapter if after such period and before the enrollment date, the individual experiences a significant break in coverage which is more than sixty-three days.

SECTION 10. AMENDMENT. Section 26.1-08-13 of the North Dakota Century Code is amended and reenacted as follows:

26.1-08-13. Termination of coverage. The coverage of an individual who ceases to meet the eligibility requirements of this chapter may be terminated at the end of the policy period for which the necessary premiums have been paid. Coverage under this chapter terminates:

1. Upon request of the covered individual.

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

3. When the one million dollar lifetime maximum benefit amount has been reached.

4. If the covered individual ~~qualifies for~~ is enrolled in health benefits under the state's medical assistance program.

5. If the covered individual ~~physically resides outside this state for more than one hundred eighty-two days of each calendar year~~ is no longer a legal resident of this state, except for an individual who is absent from the state for a verifiable medical or other reason as determined by the board.

6. At the option of the plan, thirty days after the plan makes an inquiry concerning the individual's eligibility or place of residence to which the individual does not reply.

SECTION 11. AMENDMENT. Subsection 28 of section 26.1-36.3-01 of the North Dakota Century Code is amended and reenacted as follows:

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

a. A group health benefit plan;

b. A health benefit plan;

c. Medicare;

d. Medicaid;

e. Civilian health and medical program for uniformed services;

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

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

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

i. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; ~~and~~

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

k. A state's children's health insurance program funded through title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].

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

Approved April 9, 2007
Filed April 10, 2007

CHAPTER 261

SENATE BILL NO. 2171

(Senators Tollefson, Klein)
(Representative Ruby)

COUNTY MUTUAL INSURANCE COMPANY OFFICE LOCATION

AN ACT to amend and reenact subsection 1 of section 26.1-13-12 of the North Dakota Century Code, relating to the location of a county mutual insurance company's principal office.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

1. The principal office of the company must be located within the ~~limits of the county or counties in which the incorporators reside~~ company's approved territory of operation.

Approved April 5, 2007
Filed April 5, 2007

CHAPTER 262

HOUSE BILL NO. 1274

(Representatives Carlson, Dahl, Price)
(Senators Holmberg, Krebsbach, Oehlke)

NONPROFIT MUTUAL INSURANCE COMPANY DIVIDEND PAYMENTS

AN ACT to amend and reenact subsection 3 of section 26.1-17-33.1 of the North Dakota Century Code, relating to the payment of dividends by a nonprofit mutual insurance company.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 26.1-17-33.1 of the North Dakota Century Code is amended and reenacted as follows:

3. The nonprofit corporation laws apply to the operation and control of a nonprofit mutual insurance company converted from a nonprofit health service corporation under this section and supersede any conflicting provisions in title 26.1 unless title 26.1 is more restrictive. Except as authorized in subsections 4 and 5, a nonprofit mutual insurance company may not sell, lease, transfer, or dispose of all or substantially all property or assets, and may not merge or consolidate with, or acquire, a stock insurance company or agency, for-profit subsidiary, or any other corporation. Except as provided in subsection 5, a nonprofit mutual insurance company may not ~~pay dividends or~~ issue stock.

Approved March 29, 2007
Filed March 30, 2007

CHAPTER 263

SENATE BILL NO. 2411

(Senators Warner, O'Connell)
(Representative S. Kelsh)

HOBBY BOILER OPERATOR LICENSING AND FEES

AN ACT to amend and reenact sections 26.1-22.1-09 and 26.1-22.1-14 of the North Dakota Century Code, relating to hobby boiler operator licensing and fees.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-22.1-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22.1-09. Inspection and certificate fees. Upon completion of inspection, the owner or user of a boiler shall pay to the commissioner fees or a combination of inspection and certificate fees. Inspection fees must be determined by the commissioner. Certificate fees are determined by section 26.1-22.1-10. The commissioner must determine and may annually adjust a fee scale for the internal inspections of power boilers, internal inspections of low pressure heating boilers, external inspections of all boilers, and inspection of boilers used exclusively for exhibition purposes.

Not more than one hundred fifty dollars may be charged or collected for any one inspection of a boiler except for special inspections made upon request. Not more than seventy-five dollars may be charged or collected for any one inspection of a steam traction engine except for special inspections made upon request. All other inspections made by the chief boiler inspector, including shop inspections and reviews and special inspections when requested by the owner or user of a boiler, must be charged at a rate not to exceed three hundred fifty dollars per day or two hundred dollars per half day of four hours or less, plus payment for mileage, meals, and hotel expenses as allowed by sections 44-08-04 and 54-06-09, except that the mileage rate for a state-owned vehicle will be the actual amount incurred by the commissioner. The annual fee for the issuance of a reciprocal commission card for a special inspector is twenty-five dollars and the annual fee for the issuance of a welder-qualified card is ten dollars. The fee for taking an examination for a hobby boiler operating license is twenty-five dollars and the fee for a hobby boiler operating license is twenty-five dollars. A hobby boiler operating license issued under this section is valid for six years.

SECTION 2. AMENDMENT. Section 26.1-22.1-14 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22.1-14. Rules - Penalty for violation - Hearing. The commissioner shall adopt rules for the safe and proper installation, use, operation, and inspection of boilers and pressure vessels subject to this chapter. The commissioner shall adopt rules for the licensing of operators of hobby boilers used during parades, exhibitions, and threshing shows where the public is invited. A fee must be charged for an operating license, for a license renewal, and for an examination conducted to determine minimum competence. Individuals operating hobby boilers within this state as of July 1, 2007, are considered acceptable for a license without additional training or examination. An individual who is not a resident of this state and who

holds a boiler operator license or credential in another state or Canadian province is exempt from licensure as a hobby boiler operator in this state. The commissioner may not issue a certificate of inspection to any owner or user of a boiler who fails or refuses to comply with those rules. The commissioner shall revoke any certificate presently in force upon evidence that the owner or user of the boiler is failing or refusing to comply with the rules.

Any owner or user of a boiler may request a hearing before the commissioner within fifteen days from service of an order refusing or revoking a certificate of inspection. It is the burden of the owner or user to show cause why the certificate of inspection should not be refused or revoked. If no hearing is requested within the required period, the order of the commissioner becomes final and is not subject to further proceedings.

Approved April 13, 2007
Filed April 16, 2007

CHAPTER 264

SENATE BILL NO. 2296

(Senators Wanzek, Erbele, Grindberg)
(Representatives Dietrich, Ruby, Vigesaa)

INSURANCE DEFINITIONS AND RATE FILINGS

AN ACT to amend and reenact sections 26.1-25-02.1 and 26.1-25-04 of the North Dakota Century Code, relating to the definitions of noncompetitive market, insurance company rate filings, and policy forms.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-25-02.1 of the North Dakota Century Code is amended and reenacted 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. "Competitive market" means a commercial risk market that has not been found to be noncompetitive as provided for in section 26.1-25-04. All commercial risk markets except crop hail, farmowners, and medical malpractice insurance are presumed to be competitive.

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

~~5.~~ 6. "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.~~ 7. "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.

8. "Noncompetitive market" means the crop hail, farmowners, and medical malpractice insurance markets together with any other line of commercial risk insurance that has not been found by the commissioner to have a reasonable degree of competitiveness within the market considering:

a. Market concentration and changes in market concentration determined through the use of the herfindahl-hirschman index and the United States department of justice merger guidelines for an unconcentrated market;

b. The existence of financial and other barriers that prevent a company from entering the market;

c. The number of insurers or groups of affiliated insurers providing coverage in the market;

d. The extent to which any insurer or group of affiliated insurers controls the market;

e. Whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple insurance options in the market;

f. The availability of insurance coverage to consumers in the markets by specific geographic area, by line of insurance, and by class of risk; and

g. The opportunities available in the market to acquire pricing and other consumer information.

A determination that a market is noncompetitive may not be based solely on the consideration of any one factor.

~~7.~~ 9. "Personal risk" means homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs.

~~8.~~ 10. "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.~~ 11. "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.~~ 12. "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.~~ 13. "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.~~ 14. "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.~~ 15. "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 2. 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 advisory organization making the filing.

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

c. The experience of other insurers or 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 an advisory organization, must be filed with the commissioner.

2. 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 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~~ subsections 5 and 6, 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 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 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~~ A 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~~ competitive market commercial risk rate filing, a private passenger automobile rate filing in which the average rate change is less than five percent, or a homeowner rate filing in which the average rate change is less than five percent 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 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. An insurer must file notice of a rate change for either a competitive market commercial risk product, a private passenger automobile rate filing in which the average rate change is less than five percent, or a homeowner rate filing in which the average rate change is less than five percent with the commissioner within thirty days after implementing the rate change. The exemption provided in subsection 5 for a private

passenger automobile or homeowner rate change filing is limited to no more that one filing per calendar year.

7. The commissioner after notice and hearing may determine by order that a commercial risk market is noncompetitive. A rate filing for a product in a noncompetitive commercial risk market is subject to the provisions of chapter 26.1-25. The commissioner's order finding that a commercial risk market is noncompetitive expires after two years.

8. 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 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.~~ 9. 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.~~ 10. 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~~ 8 or ~~7~~ 9.

~~9.~~ 11. 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 July 1, 1991, or decreases from those rates or premium charges filed by the advisory organization and subsequently approved after July 1, 1991.

Approved May 4, 2007
Filed May 4, 2007

CHAPTER 265

SENATE BILL NO. 2065

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

INSURANCE PRODUCER EDUCATION

AN ACT to amend and reenact subsection 1 of section 26.1-26-13.3 of the North Dakota Century Code, relating to elimination of mandatory prelicensing education requirements for insurance producers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-26-13.3 of the North Dakota Century Code is amended and reenacted as follows:

1. An individual applying for a resident insurance producer license shall make application to the commissioner on the uniform application and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner must find that the individual:

   a. Is at least eighteen years of age;

   b. Has not committed any act that is a ground for denial, suspension, or revocation set forth in section 26.1-26-42;

   c. ~~Has completed, within six months of the filing of the application for licensure, an approved prelicensing course of study for the lines of authority for which the individual has applied;~~

   ~~d.~~ Has paid the fees set forth in section 26.1-01-07; and

   ~~e.~~ d. Has successfully passed the examinations for the lines of authority for which the individual has applied.

Approved March 7, 2007
Filed March 8, 2007

CHAPTER 266

SENATE BILL NO. 2268

(Senators Klein, Hacker, Heitkamp)
(Representatives Ekstrom, N. Johnson, Keiser)

VIATICAL SETTLEMENT CONTRACTS

AN ACT to create and enact chapter 26.1-33.3 of the North Dakota Century Code, relating to viatical settlement contracts; to amend and reenact subdivision a of subsection 21 of section 10-04-02 of the North Dakota Century Code, relating to the definition of viatical settlement contract; to repeal chapter 26.1-33.2 of the North Dakota Century Code, relating to viatical settlement contracts; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subdivision a of subsection 21 of section 10-04-02 of the North Dakota Century Code is amended and reenacted as follows:

a. The assignment, transfer, sale, devise, or bequest of a death benefit, life insurance policy, or certificate of insurance by the viator to the viatical settlement provider pursuant to chapter ~~26.1-33.2~~ 26.1-33.3;

SECTION 2. Chapter 26.1-33.3 of the North Dakota Century Code is created and enacted as follows:

26.1-33.3-01. Definitions.

1. "Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public, in this state, for the purpose of creating an interest in or inducing a person to sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy pursuant to a viatical settlement contract.

2. "Business of viatical settlements" means an activity involved in, but not limited to, the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating, or in any other manner, acquiring an interest in a life insurance policy by means of a viatical settlement contract.

3. "Chronically ill" means:

   a. Being unable to perform at least two activities of daily living, such as eating, toileting, transferring, bathing, dressing, or continence;

   b. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

c. Having a level of disability similar to that described in subdivision a as determined by the secretary of health and human services.

4. a. "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but:

(1) Whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies; and

(2) Who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts.

b. "Financing entity" does not include a nonaccredited investor or a viatical settlement purchaser.

5. "Fraudulent viatical settlement act" includes:

a. Acts or omissions committed by any person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including:

(1) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, financing entity, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of or concerning a fact material to one or more of the following:

(a) An application for the issuance of a viatical settlement contract or insurance policy;

(b) The underwriting of a viatical settlement contract or insurance policy;

(c) A claim for payment or benefit pursuant to a viatical settlement contract or insurance policy;

(d) Premiums paid on an insurance policy;

(e) Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or insurance policy;

(f) The reinstatement or conversion of an insurance policy;

(g) The solicitation, offer, effectuation, or sale of a viatical settlement contract or insurance policy;

(h) The issuance of written evidence of a viatical settlement contract or insurance; or

(i) A financing transaction; and

(2) Employing any plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies;

b. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to:

(1) Remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

(2) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(3) Transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

(4) File with the commissioner or the equivalent chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the commissioner;

c. Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or any other person engaged in the business of viatical settlements or insurance;

d. Recklessly entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, if the person or the persons intended to defraud the policy's issuer, the viatical settlement provider or the viator. "Recklessly" means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct; or

e. Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

6. "Person" means a natural person or a legal entity, including an individual, partnership, limited liability company, association, trust, or corporation.

7. "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

8. "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the commissioner as if those records and files were maintained directly by the licensed viatical settlement provider.

9. "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide either directly or indirectly access to institutional capital markets:

   a. For a financing entity or licensed viatical settlement provider; or

   b. (1) In connection with a transaction in which the securities in the special purposes entity are acquired by the viator or by "qualified institutional buyers" as defined in rule 144 adopted under the Securities Act of 1933, as amended; or

      (2) The securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

10. "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in twenty-four months or less.

11. "Viatical settlement broker" means a person who working exclusively on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or one or more viatical settlement brokers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

12. a. "Viatical settlement contract" means a written agreement between a viator and a viatical settlement provider or any affiliate of the viatical settlement provider establishing the terms under which compensation or anything of value is or will be paid, which compensation or value is less than the expected death benefits of the policy, in return for the viator's present or future assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance.

b. "Viatical settlement contract" includes a premium finance loan made for a life insurance policy by a lender to a viator on, before, or after the date of issuance of the policy if:

(1) The loan proceeds are not used solely to pay:

(a) Premiums for the policy; or

(b) The costs of the loan, including interest, arrangement fees, utilization fees and similar fees closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(2) The viator or the insured receives on the date of the premium finance loan a guarantee of a future viatical settlement value of the policy; or

(3) The viator or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

c. "Viatical settlement contract" does not include:

(1) A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms;

(2) A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of the loan or, if there is a default on the loan and the policy is transferred, the further assignment of the policy by the lender, provided that the default itself is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(3) A loan made by a lender that does not violate chapter 26.1-20.1, provided that the premium finance loan is not described in subdivision b;

(4) An agreement in which all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(5) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(6) A bona fide business succession planning arrangement:

(a) Between one or more shareholders in a corporation or between a corporation and one or more of its

shareholders or one or more trusts established by its shareholders;

(b) Between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners; or

(c) Between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members;

(7) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(8) Any other contract, transaction, or arrangement exempted from the definition of viatical settlement contract by the commissioner based on a determination that the contract, transaction, or arrangement is not of the type intended to be regulated by this chapter.

13. "Viatical settlement investment agent" means a person who is an appointed or contracted agent of a licensed viatical settlement provider who solicits or arranges the funding for the purchase of a viatical settlement by a viatical settlement purchaser and who is acting on behalf of a viatical settlement provider. A viatical settlement investment agent is an agent as defined in section 10-04-02.

a. A viatical settlement investment agent shall not have any contact directly or indirectly with the viator or insured or have knowledge of the identity of the viator or insured.

b. A viatical settlement investment agent is deemed to represent the viatical settlement provider of whom the viatical settlement investment agent is an appointed or contracted agent.

14. a. "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract with a viator resident in this state.

b. "Viatical settlement provider" does not include:

(1) A bank, savings bank, savings and loan association, or credit union;

(2) A licensed lending institution or premium finance company making premium finance loans and exempted by the commissioner from the licensing requirement under the premium finance laws, that takes an assignment of a life insurance policy solely as collateral for a loan;

(3) The issuer of the life insurance policy;

(4) An authorized or eligible insurer that provides stop-loss coverage or financial guaranty insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

(5) A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

(6) A financing entity;

(7) A special purpose entity;

(8) A related provider trust;

(9) A viatical settlement purchaser; or

(10) Any other person that the commissioner determines is not the type of person intended to be covered by the definition of viatical settlement provider.

15. "Viatical settlement purchase agreement" means a contract or agreement, entered into by a viatical settlement purchaser, to which the viator is not a party, to purchase a life insurance policy or an interest in a life insurance policy, that is entered into for the purpose of deriving an economic benefit. A viatical settlement purchase agreement is a viatical settlement contract as defined in section 10-04-02.

16. a. "Viatical settlement purchaser" means a person who provides a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy that has been or will be the subject of a viatical settlement contract, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit.

b. "Viatical settlement purchaser" does not include:

(1) A licensee under this chapter;

(2) An accredited investor or qualified institutional buyer as defined, respectively, in rule 501(a) or rule 144A adopted under the Federal Securities Act of 1933, as amended;

(3) A financing entity;

(4) A special purpose entity; or

(5) A related provider trust.

17. "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

18. a. "Viator" means the owner of a life insurance policy or a certificate holder under a group policy who resides in this state and enters or seeks to enter into a viatical settlement contract. For the purposes of this chapter, a viator shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed. If there is more than one viator on a single policy and the viators are residents of different states, the transactions shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all the viators.

b. "Viator" does not include:

(1) A licensee under this chapter;

(2) Qualified institutional buyer as defined, respectively, in rule 144A adopted under the Federal Securities Act of 1933, as amended;

(3) A financing entity;

(4) A special purpose entity; or

(5) A related provider trust.

26.1-33.3-02. License and bond requirements.

1. a. A person shall not operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the commissioner of the state of residence of the viator. A person may not operate as a viatical settlement broker without first obtaining an insurance producer license from the commissioner.

b. The insurer that issued the policy being viaticated shall not be responsible for any act or omission of a viatical settlement broker or viatical settlement provider arising out of or in connection with the viatical settlement transaction, unless the insurer receives compensation for the placement of a viatical settlement contract from the viatical settlement provider or viatical settlement broker in connection with the viatical settlement contract.

c. A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator, whose compensation is not paid directly or indirectly by the viatical settlement provider, may negotiate viatical settlement contracts on behalf of the viator without having to obtain a license as a viatical settlement broker.

2. Application for a viatical settlement provider or viatical settlement broker license shall be made to the commissioner by the applicant on a form prescribed by the commissioner, and these applications shall be accompanied by a two hundred fifty dollar fee for a provider license and a two hundred dollar fee for a broker license.

3. Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fee of one hundred dollars. Failure to pay the fees by the renewal date results in expiration of the license.

4. The applicant shall provide information on forms required by the commissioner. The commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees, and the commissioner may refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner or member thereof who may materially influence the applicant's conduct meets the standards of this chapter.

5. A license issued to a legal entity authorizes all partners, officers, members and designated employees to act as viatical settlement providers or viatical settlement brokers, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

6. Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and issue a license if the commissioner finds that the applicant:

   a. If a viatical settlement provider, has provided a detailed plan of operation;

   b. Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

   c. Has a good business reputation and has had experience, training or education so as to be qualified in the business for which the license is applied for;

   d. (1) If a viatical settlement provider, has demonstrated evidence of financial responsibility in a format prescribed by the commissioner through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or a deposit of cash, certificates of deposit or securities or any combination thereof in the amount of one hundred fifty thousand dollars.

   (2) If a viatical settlement broker, has demonstrated evidence of financial responsibility in a format prescribed by the commissioner through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or a deposit of cash, certificates of deposit, or securities or any combination thereof in the amount of one hundred fifty thousand dollars.

   (3) The commissioner shall accept, as evidence of financial responsibility, proof that financial instruments in accordance with the requirements in this section have been filed with one or more states where the applicant is licensed as a viatical settlement provider or viatical settlement broker.

(4) The commissioner may ask for evidence of financial responsibility at any time the commissioner deems necessary.

(5) Any surety bond issued pursuant to this subdivision shall specifically authorize recovery by the commissioner on behalf of any person in this state who sustained damages as the result of erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices by the viatical settlement provider or viatical settlement broker.

e. If a legal entity, provides a certificate of good standing from the state of its domicile; and

f. If a viatical settlement provider or viatical settlement broker, has provided an antifraud plan that meets the requirements of subsection 7 of section 26.1-33.3-13.

7. The commissioner shall not issue a license to a nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the commissioner or the applicant has filed with the commissioner, the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

8. A viatical settlement provider or viatical settlement broker shall provide to the commissioner new or revised information about officers, ten percent or more stockholders, partners, directors, members, or designated employees within thirty days of the change.

26.1-33.3-03. License revocation and denial.

1. The commissioner may refuse to issue, suspend, revoke or refuse to renew the license of a viatical settlement provider or viatical settlement broker if the commissioner finds that:

a. There was any material misrepresentation in the application for the license;

b. The licensee or any officer, partner, member, or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

c. The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

d. The licensee or any officer, partner, member or key management personnel has been found guilty of, or has pleaded guilty or nolo contendre to, any felony, or to misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

e. The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to this chapter;

f. The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract;

g. The licensee no longer meets the requirements for initial licensure;

h. The viatical settlement provider has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state, viatical settlement purchaser, an accredited investor or qualified institutional buyer as defined respectively in rule 501(a) or rule 144A promulgated under the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

i. The licensee or any officer, partner, member, or key management personnel has violated any provision of this chapter.

2. The commissioner may suspend, revoke or refuse to renew the license of a viatical settlement broker if the commissioner finds that the viatical settlement broker has violated the provisions of this chapter or has otherwise engaged in bad faith conduct with one or more viators.

3. If the commissioner denies a license application or suspends, revokes or refuses to renew the license of a viatical settlement provider or viatical settlement broker pursuant to this chapter the commissioner shall conduct a hearing in accordance with chapter 28-32.

26.1-33.3-04. Approval of viatical settlement contracts and disclosure statements. A person shall not use a viatical settlement contract form or provide to a viator a disclosure statement from in this state unless first filed with and approved by the commissioner. The commissioner shall disapprove a viatical settlement contract form or disclosure statement form if in the commissioner's opinion, the contract or provisions contained therein fail to meet the requirement of sections 26.1-33.3-07, 26.1-33.3-09, and 26.1-33.3-12, and subsection 2 of section 26.1-33.3-13 or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the viator.

26.1-33.3-05. Reporting requirements and privacy.

1. Each viatical settlement provider shall file with the commissioner on or before March first of each year an annual statement containing such information as the commissioner may prescribed by regulation. Such information shall be limited to only those transactions where the viator is a resident of this state. Individual transaction data regarding the business of viatical settlements or data that could compromise the privacy of personal, financial, and health information of the viator or insured shall be filed with the commissioner on a confidential basis.

2. Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose that identity as an insured, or the insured's financial or medical information to any other person unless the disclosure:

a. Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

b. Is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to the requirements of subsection 3 of section 26.1-33.3-13;

c. Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

d. Is necessary to permit a financing entity, related provider trust or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

e. Is necessary to allow the viatical settlement provider or viatical settlement broker or their authorized representatives to make contacts for the purpose of determining health status; or

f. Is required to purchase stop-loss coverage or financial guaranty insurance.

26.1-33.3-06. Examination or investigations.

1. Authority, scope and scheduling of examinations.

a. (1) The commissioner may conduct an examination under this chapter of a licensee as often as the commissioner deems appropriate after considering the factors set forth in this subdivision.

(2) In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider such matters as the consumer complaints, results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, report of independent certified pubic accountants, and other relevant criteria as determined by the commissioner.

b. For purposes of completing an examination of a licensee under this chapter, the commissioner may examine or investigate any person, or the business of any person, in so far as the examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the licensee.

c. In lieu of an examination under this chapter of any foreign or alien licensee licensed in this state, the commissioner may accept an examination report on the licensee as prepared by the commissioner for the licensee's state of domicile or port-of-entry state.

d. As far as practical, the examination of a foreign or alien insurer shall be made in cooperation with the insurance supervisory officials of other states in which the insurer transacts business.

2. Record retention requirement.

a. A person required to be licensed by this chapter shall for five years retain copies of all:

(1) Proposed, offered or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later;

(2) Checks, drafts or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date the transaction; and

(3) Other records and documents related to the requirements of this chapter.

b. The section does not relieve a person of the obligation to produce these documents to the commissioner after the retention period has expired if the person has retained the documents.

c. Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

3. Conduct of examinations.

a. Upon determining that an examination should be conducted, the commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the examiners handbook adopted by the national association of insurance commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

b. Every licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to this title and chapter 28-32.

c. The commissioner shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

d. When making an examination under this chapter, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

e. Nothing contained in this chapter shall be construed to limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

f. Nothing contained in this chapter shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may deem appropriate.

4. Examination reports.

a. Examination reports shall be comprised of only facts appearing upon the books, records or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agent or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

b. No later than sixty days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

c. If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions provided by law.

5. Confidentiality of examination information.

a. Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the commissioner, unless required by law.

b. Except as otherwise provided in this chapter, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this chapter, or in the course of analysis or investigation by the commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to section 44-04-18 and section 6 of article XI of the Constitution of North Dakota shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

c. Documents, materials or other information, including all working papers, and copies thereof, in the possession or control of the national association of insurance commissioners and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:

(1) Created, produced, or obtained by or disclosed to the national association of insurance commissioners and its affiliates and subsidiaries in the course of assisting an examination made under this chapter, or assisting a commissioner in the analysis or investigation of the financial condition or market conduct of a licensee; or

(2) Disclosed to the national association of insurance commissioners and its affiliates and subsidiaries under subdivision d by a commissioner.

(3) For the purposes of subdivision b, this chapter includes the law of another state or jurisdiction that is substantially similar to this chapter.

d. Neither the commissioner nor any person that received the documents, material, or other information while acting under the authority of the commissioner, including the national association of insurance commissioners and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision a.

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

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subdivision a, with other state, federal and international regulatory agencies, with the

national association of insurance commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication, or other information;

(2) May receive documents, materials, communications, or information, including otherwise confidential and privileged documents, materials or information, from the national association of insurance commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement official of other foreign or domestic jurisdiction, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) May enter into agreements governing sharing and use of information consistent with this subsection.

f. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subdivision d.

g. A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

h. Nothing contained in this chapter shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time or to the national association of insurance commissioners, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this chapter.

6. Conflict of interest.

a. An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This section shall not be construed to automatically preclude an examiner from being:

(1) A viator;

(2) An insured in a viaticated insurance policy; or

(3) A beneficiary in an insurance policy that is proposed to be viaticated.

b. Notwithstanding the requirements of this clause, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

7. Cost of examinations. The expenses incurred in conducting any examination must be paid by the licensee or applicant.

8. Immunity from liability.

a. No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this chapter.

b. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this chapter, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This subdivision does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision a.

c. A person identified in subdivision a or b shall be entitled to an award of attorney's fees and costs if the person is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

9. Investigative authority of the commissioner. The commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

26.1-33.3-07. Disclosure to viator.

1. With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the following disclosures no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker, and shall provide the following information:

a. There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.

b. That a viatical settlement broker represents exclusively the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interest of the viator.

c. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.

d. Proceeds of the viatical settlement could be subject to the claims of creditors.

e. Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

f. The viator has the right to rescind a viatical settlement contract before the earlier of sixty calendar days after the date upon which the viatical settlement contract is executed by all parties or thirty calendar days after the viatical settlement proceeds have been delivered to the escrow agent by or on behalf of the settlement provider, as provided in subsection 6 of section 26.1-33.3-09. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given, and the viator repays all proceeds and any premiums, loans, and loan interest paid on account of the viatical settlement provider within the rescission period. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment by the viator or the viator's estate of all viatical settlement proceeds and any premiums, loans, and loan interest the viatical settlement within sixty days of the insured's death.

g. Funds will be sent to the viator by the later of the expiration of the rescission period or within three business days after the viatical settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

h. Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.

i. Disclosure to a viator shall include distribution of a brochure describing the process of viatical settlements. The national association of insurance commissioner's form for the brochure shall be used unless another form is developed or approved by the commissioner.

j. The disclosure document shall contain the following language: "All medical, financial or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

k. Following execution of a viatical contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in this chapter. This contact shall be limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less. All such contacts shall be made only by a viatical settlement provider licensed in the state in which the viator resided at the time of the viatical settlement, or by the authorized representative of a duly licensed viatical settlement provider.

2. A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

a. The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

b. The document shall include the name, business address, and telephone number of the viatical settlement provider;

c. Any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement purchaser;

d. If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives under the policy and shall be advised to consult with the viator's insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement;

e. State the dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate. If known, the viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract; and

f. Provide the name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

3. A viatical settlement broker shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

a. The name, business address, and telephone number of the viatical settlement broker;

b. A full, complete, and accurate description of all offers, counteroffers, acceptances and rejections relating to the proposed viatical settlement contract;

c. A written disclosure of any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contracts;

d. The amount and method of calculating the broker's compensation, which term "compensation" includes anything of value paid or given to a viatical settlement broker for the placement of a policy; and

e. If any portion of the viatical settlement broker's compensation, as defined in subdivision c, is taken from a proposed viatical settlement offer, the broker shall disclose the total amount of the viatical settlement offer and the percentage of the viatical settlement offer comprised by the viatical settlement broker's compensation.

4. If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within twenty days after the change.

5. A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures prior to the date the viatical settlement purchase agreement is signed by all parties. The disclosures shall be conspicuously displayed in any viatical purchase contract or in a separate document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosure to the viatical settlement purchaser:

a. The purchaser will receive no returns, such as dividends and interest, until the insured dies and a death claim payment is made.

b. The actual annual rate of return on a viatical settlement contract is dependent upon an accurate projection of the insured's life expectancy, and the actual date of the insured's death. An annual "guaranteed" rate of return is not determinable.

c. The viaticated life insurance contract should not be considered a liquid purchase since it is impossible to predict the exact timing of its maturity and the funds probably are not available until the death of the insured. There is no established secondary market for resale of these products by the purchaser.

d. The purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical investment.

e. The purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement. These payments may reduce the purchaser's return. If a party other than the purchaser is responsible for the payment, the name and address of that party also shall be disclosed.

f. The purchaser is responsible for payment of the insurance premiums or other costs related to the policy if the insured returns to health. Disclose the amount of such premiums, if applicable.

g. State the name, business address, and telephone number of the independent third party providing escrow services and the relationship to the broker.

h. The amount of any trust fees or other expenses to be charged to the viatical settlement purchaser shall be disclosed.

i. State whether the purchaser is entitled to a refund of all or part of the purchaser's investment under the settlement contract if the policy is later determined to be null and void.

j. Disclose that group policies may contain limitations or caps in the conversion rights, additional premiums may have to be paid if the policy is converted, name the party responsible for the payment of the additional premiums and, if a group policy is terminated and replaced by another group policy, state that there may be no right to convert the original coverage.

k. Disclose the risks associated with policy contestability including, but not limited to, the risk that the purchaser will have no claim or only a partial claim to death benefits should the insurer rescind the policy within the contestability period.

l. Disclose whether the purchaser will be the owner of the policy in addition to being the beneficiary, and if the purchaser is the beneficiary only and not also the owner, the special risks associated with that status, including, but not limited to, the risk that the beneficiary may be changed or the premium may not be paid.

m. Describe the experience and qualifications of the person who determines the life expectancy of the insured, such as in-house staff, independent physicians, and specialty firms that weigh medical and actuarial data; the information this projection is based on; and the relationship of the projection maker to the viatical settlement provider, if any.

n. Disclosure to an investor shall include distribution of a brochure describing the process of investment in viatical settlements. The national association of insurance commissioner's form for the brochure shall be used unless one is developed by the commissioner.

6. A viatical settlement provider or its viatical settlement investment agent shall provide the viatical settlement purchaser with at least the following disclosures no later than at the time of the assignment, transfer or sale of all or a portion of an insurance policy. The disclosures shall be contained in a document signed by the viatical settlement purchaser and viatical settlement provider or viatical settlement investment agent, and shall make the following disclosures to the viatical settlement purchaser:

a. Disclose all the life expectancy certifications obtained by the provider in the process of determining the price paid to the viator.

b. State whether premium payments or other costs related to the policy have been escrowed. If escrowed, state the date upon which the escrowed funds will be depleted and whether the purchaser will be responsible for payment of premiums thereafter and, if so, the amount of the premiums.

c. State whether premium payments or other costs related to the policy have been waived. If waived, disclose whether the investor will be responsible for payment of the premiums if the insurer that wrote the policy terminates the waiver after purchase and the amount of those premiums.

d. Disclose the type of policy offered or sold, such as whole life, term life, universal life or a group policy certificate, any additional benefits contained in the policy, and the current status of the policy.

e. If the policy is term insurance, disclose the special risks associated with term insurance including the purchaser's responsibility for additional premiums if the viator continues the term policy at the end of the current term.

f. State whether the policy is contestable.

g. State whether the insurer that wrote the policy has any additional rights that could negatively affect or extinguish the purchaser's rights under the viatical settlement contract, what these rights are, and under what conditions these rights are activated.

h. State the name and address of the person responsible for monitoring the insured's condition. Describe how often the monitoring of the insured's condition is done, how the date of death is determined, and how and when this information will be transmitted to the purchased.

7. The viatical settlement purchase agreement is voidable by the purchaser at any time within three days after the disclosures mandated by subsections 5 and 6 are received by the purchaser.

26.1-33.3-08. Disclosure to insurer. Prior to the initiation of a viatical settlement plan, viatical settlement transaction, or series of viatical settlement transactions, a viatical settlement broker or viatical settlement provider shall fully disclose all nonproprietary information to an insurer the details of the plan, transaction, or series of transactions, to which the viatical settlement broker or viatical settlement provider is a party, to originate, renew, continue, or finance a life insurance policy with the insurer for the purpose of engaging in the business of viatical settlements at any time prior to, or during the first five years after, issuance of the policy. Any disclosure required under this section must be in writing.

26.1-33.3-09. General rules.

1. a. A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(1) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(2) A document in which the insured consents to the release of the insured's medical records to a licensed viatical settlement provider, viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

b. Within twenty days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by subdivision c.

c. The viatical provider shall deliver a copy of the medical release required under paragraph 2 of subdivision a, a copy of the viator's application for the viatical settlement contract, the notice required under subdivision b, and a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction. The national association of insurance commissioner's form for verification of coverage shall be used unless another form is developed or approved by the commissioner.

d. The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within thirty calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on a national association of insurance commissioner's form or any other form approved by the commissioner. The insurer shall accept an original or facsimile or electronic copy of such request and any accompanying

authorization signed by the viator. Failure by the insurer to meet its obligations under this subsection shall be a violation of subsection 3 of section 26.1-33.3-10 and section 26.2-33.3-15.

e. Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that the viator has a full and complete understanding of the benefits of the life insurance policy, acknowledges that the viator is entering into the viatical settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

f. If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

2. All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

3. All viatical settlement contracts entered into in this state shall provide the viator with a right to rescind the contract before the earlier of sixty calendar days after the date upon which the viatical settlement contract is executed by all parties or thirty calendar days after the viatical settlement proceeds have been sent to the escrow agent by or on behalf of the viatical settlement provider as provided in subdivision 6 of section 26.1-33.3-09. Rescission by the viator may be conditioned upon the viator both giving notice and repaying to the viatical settlement provider within the rescission period all proceeds of the settlement and any premiums, loans, and loan interest paid by or on behalf of the viatical settlement provider in connection with or as a consequence of the viatical settlement. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser, which shall be paid within sixty calendar days of the death of the insured. In the event of any rescission, if the viatical settlement provider has paid commissions or other compensation to a viatical settlement broker in connection with the rescinded transaction, the viatical settlement broker shall refund all such commissions and compensation to the viatical settlement provider within five business days following receipt of written demand from the viatical settlement provider, which demand shall be accompanied by either the viator's notice of rescission if rescinded at the election of the viator, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

4. The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow

agent. Within three business days after the date the escrow agent receives the document, or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the federal deposit insurance corporation. Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or related provider trust or other designated representative of the viatical settlement provider. Upon the later to occur of the expiration of any then remaining rescission period or the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

5. Failure to tender consideration to the viator for the viatical settlement contract within the time set forth in the disclosure pursuant to subdivision g of subsection 1 of section 26.1-33.3-07 renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator. Funds shall be deemed sent by a viatical settlement provider to a viator as of the date that the escrow agent either releases funds for wire transfer to the viator or places a check for delivery to the viator via United States postal service or other nationally recognized delivery service.

6. Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or broker licensed in this state or its authorized representatives and shall be limited to once every three months for insureds with a life expectancy of more than one year, and to no more than once per month for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

26.1-33.3-10. Prohibited practices.

1. It is in violation of this chapter for any person to enter into a viatical settlement contract at any time prior to the application for or issuance of a policy which is the subject of a viatical settlement contract or within a five-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement provider or it is otherwise conclusively shown by the viatical settlement provider that one or more of the following conditions have been met within the five-year period:

   a. The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time

covered under the prior policy is at least sixty months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

b. The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the five-year period:

(1) The viator or insured is terminally or chronically ill;

(2) The viator's spouse dies or no remaining beneficiaries are then surviving;

(3) The viator divorces a spouse;

(4) The viator retires from full-time employment; or

(5) The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;

c. A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator in default, bankrupt, or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets; or

d. The viator enters into a viatical settlement contract more than two years after the date of issuance of a policy and, with respect to the policy, at all times prior to the date that is two years after policy issuance, the following conditions are met:

(1) Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed only to the extent of its net cash surrender value, provided by, or fully recourse liability incurred by, the insured or a person described in paragraph 4 of subdivision c of subsection 12 of section 26.1-33.3-01;

(2) There is no agreement or understanding with any other person to guarantee any such liability or to purchase, or stand ready to purchase, the policy, including through an assumption or forgiveness of the loan; and

(3) Neither the insured nor the policy has been evaluated for settlement in connection with the issuance of the policy.

2. Copies of the independent evidence described in subdivision b of subsection 1 and documents required by subsection 1 of section 26.1-33.3-09 shall be submitted to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation

from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

3. If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification described in and the independent evidence required by subdivision b of subsection 1 when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

4. A insurer may not require, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, that the viator, insured, viatical settlement provider, or viatical settlement broker sign any forms, disclosures, consent, or waiver form that has not been expressly approved by the commissioner for use in connection with viatical settlement contracts in this state.

5. Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within thirty calendar days with written acknowledgement confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary and shall not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this state.

26.1-33.3-11. Prohibited practices and conflicts of interest.

1. With respect to any viatical settlement contract or insurance policy, no viatical settlement broker knowingly shall solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, viatical settlement purchaser, financing entity, or related provider that is controlling, controlled by, or under common control with such viatical settlement broker.

2. With respect to any viatical settlement contract or insurance policy, no viatical settlement provider knowingly may enter into a viatical settlement contract with a viator, if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider or the viatical settlement purchaser, financing entity, or related provider trust that is involved in such viatical settlement contract.

3. A violation of subsection 1 or 2 shall be deemed a fraudulent viatical settlement act.

4. It is unlawful for an insurance company to engage in any transaction, act, or practice or course of business or dealing which restricts, limits, or impairs in any way the lawful transfer of ownership, change of beneficiary, or assignment of a policy to effectuate a viatical settlement contract.

26.1-33.3-12. Advertising for viatical settlements. Every viatical settlement licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the viatical settlement licensees, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the viatical settlement licensee. The commissioner may adopt rules to implement this section.

26.1-33.3-13. Fraud prevention and control.

1. Fraudulent viatical settlement acts, interference and participation of convicted felons prohibited.

   a. A person shall not commit a fraudulent viatical settlement act.

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

   c. A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

2. Fraud warning required.

   a. Viatical settlement contracts and applications for viatical settlements, regardless of the form of transmission, must contain the following statement or a substantially similar statement:

      "Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

   b. The lack of a statement as required in subdivision a does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

3. Mandatory reporting of fraudulent viatical settlement acts.

   a. Any person engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a fraudulent viatical settlement act is being, will be or has been committed shall provide to the commissioner such information as required by, and in a manner prescribed by, the commissioner.

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

4. Immunity from liability.

a. No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent viatical settlement acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(1) The commissioner or the commissioner's employees, agents or representatives;

(2) Federal, state or local law enforcement or regulatory officials or their employees, agents or representatives;

(3) A person involved in the prevention and detection of fraudulent viatical settlement acts or that person's agents, employees or representatives;

(4) The national association of insurance commissioners, national association of securities dealers, the North American securities administrators association, or their employees, agents or representatives, or other regulatory body overseeing life insurance, viatical settlements, securities or investment fraud; or

(5) The life insurer that issued the life insurance policy covering the life of the insured.

b. Subdivision a shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act, the party bringing the action shall plead specifically any allegation that subdivision a does not apply because the person filing the report or furnishing the information did so with actual malice.

c. A person furnishing information as identified in subdivision a shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated. However, such an award does not apply to any person furnishing information concerning that person's own fraudulent viatical settlement acts.

d. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subdivision a.

5. Confidentiality.

a. The documents and evidence provided pursuant to subsection 4 or obtained by the commissioner in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and

confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

b. Subdivision a does not prohibit release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(1) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(2) To federal, state or local law enforcement or regulator agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts or to the national association of insurance commissioners; or

(3) At the discretion of the commissioner, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

c. Release of documents and evidence under subdivision b does not abrogate or modify the privilege granted in subdivision a.

6. Other law enforcement or regulatory authority. This chapter shall not:

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

b. Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the insurance department; or

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

7. Viatical settlement antifraud initiatives.

a. Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent viatical settlement acts. At the discretion of the commissioner, the commissioner may order, or a licensee may request and the commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

b. Antifraud initiatives shall include:

(1) Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(2) An antifraud plan, which shall be submitted to the commissioner. The antifraud plan shall include, but not be limited to:

(a) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) A description of the procedures for reporting possible fraudulent viatical settlement acts to the commissioner;

(c) A description of the plan for antifraud education and training of underwriters and other personnel; and

(d) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

c. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

26.1-33.3-14. Injunctions - Civil remedies - Cease and desist - Penalty.

1. In addition to the penalties and other enforcement provisions of this chapter, if any person violates this chapter or any regulation implementing this chapter, the commissioner may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the commissioner determines are necessary to restrain the person from committing the violation.

2. Any person damaged by the acts of a person in violation of this chapter may bring a civil action against the person committing the violation in a court of competent jurisdiction.

3. The commissioner may issue, in accordance with this title and chapter 28-32, a cease and desist order upon a person that violates any provision of this chapter, any regulation or order adopted by the commissioner, or any written agreement entered into with the commissioner.

4. When the commissioner finds that an activity in violation of this chapter presents an immediate danger to the public that requires an immediate final order, the commissioner may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety days. If the commissioner begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective,

absent an order by a court of competent jurisdiction pursuant to this title and chapter 28-32.

5. In addition to the penalties and other enforcement provisions of this chapter, any person who violates this chapter is subject to civil penalties of up to fifty thousand dollars per violation. Imposition of civil penalties shall be pursuant to an order of the commissioner issued under this title and chapter 28-32. The commissioner's order may require a person found to be in violation of this chapter to make restitution to persons aggrieved by violations of this chapter.

6. A person convicted of a violation of this chapter by a court of competent jurisdiction is governed by chapter 12.1-32. A person convicted of a violation of this chapter shall be ordered to pay restitution to persons aggrieved by the violation of this chapter. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment.

7. Except for a fraudulent viatical settlement act committed by a viator, the enforcement provisions and penalties of this section shall not apply to a viator.

8. A person convicted of a violation of this chapter by a court of competent jurisdiction may be sentenced in accordance with subdivision a, b, c, or d based on the greater of the value of property, services, or other benefit wrongfully obtained or attempted to obtain; or the aggregate economic loss suffered by any person as a result of the violation. A person convicted of a fraudulent viatical settlement act must be ordered to pay restitution to persons aggrieved by the fraudulent viatical settlement act. Restitution must be ordered in addition to a fine or imprisonment but not in lieu of a fine or imprisonment. A fraudulent viatical settlement act is:

   a. A class A felony if the value of a viatical settlement contract is more than thirty-five thousand dollars;

   b. A class B felony if the value of a viatical settlement contract is more than two thousand five hundred dollars but not more than thirty-five thousand dollars;

   c. A class C felony if the value of a viatical settlement contract is more than five hundred dollars but not more than two thousand five hundred dollars; or

   d. A class A misdemeanor if the value of a viatical settlement contract is five hundred dollars or less.

   In any prosecution under this section under subdivisions a, b, c, and d, the value of the viatical settlement contracts within any six-month period may be aggregated and the defendant charged accordingly in applying in the provisions of this section; provided that when two or more offenses are committed by the same person in two or more counties, the accused may be prosecuted in any county in which one of the offenses was committed for all of the offenses aggregated under this section. The applicable statute of limitations provision shall not begin to run until the insurance company or law enforcement agency is aware of the

fraud, but in no event may the prosecution be commenced later than seven years after the act has occurred.

26.1-33.3-15. Unfair trade practices. A violation of this chapter, including the commission of a fraudulent viatical settlement act, shall be considered an unfair trade practice under section 26.1-04-03 subject to the penalties contained in that section.

26.1-33.3-16. Authority to promulgate regulations. The commissioner shall have the authority to:

1. Promulgate regulations implementing this chapter;

2. Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons who are terminally or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy insuring the life of a person that is chronically or terminally ill;

3. Establish appropriate licensing requirements, fees, and standards for continued licensure for viatical settlement providers and brokers;

4. Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

5. Adopt rules governing the relationship and responsibilities of both insurers and viatical settlement providers and viatical settlement brokers during the viatication of a life insurance policy or certificate.

26.1-33.3-17. Effective date. This chapter takes effect on August 1, 2007. A viatical settlement provider or viatical settlement broker transacting business in this state may continue to do so pending approval or disapproval of the provider or broker application for a license as long as the application is filed with the commissioner by August 1, 2007.

SECTION 3. REPEAL. Chapter 26.1-33.2 of the North Dakota Century Code is repealed.

Approved April 9, 2007
Filed April 10, 2007

CHAPTER 267

SENATE BILL NO. 2155

(Senators Hacker, Andrist, Heitkamp)
(Representatives Gruchalla, N. Johnson, Vigesaa)

ANNUITY TRANSACTION SUITABILITY

AN ACT to create and enact chapter 26.1-34.2 of the North Dakota Century Code, relating to suitability in annuity transactions; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-34.2 of the North Dakota Century Code is created and enacted as follows:

26.1-34.2-01. Exemptions. Unless otherwise specifically included, this chapter does not apply to recommendations involving:

1. Direct response solicitations if there is no recommendation based on information collected from the consumer pursuant to this chapter; and

2. Contracts used to fund:

   a. An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act;

   b. A plan described by section 401(a), 401(k), 403(b), 408(k), or 408(p) of the Internal Revenue Code, as amended, if established or maintained by an employer;

   c. A government or church plan defined in section 414 of the Internal Revenue Code, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the Internal Revenue Code;

   d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

   e. Settlements of or assumptions of liabilities associated with personal injury litigation or a dispute or claim resolution process; or

   f. Formal prepaid funeral contracts.

26.1-34.2-02. Definitions.

1. "Annuity" means a fixed annuity or variable annuity that is individually solicited, whether the product is classified as an individual or group annuity.

2. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, including annuities.

3. "Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

4. "Recommendation" means advice provided by an insurance producer, or an insurer when no producer is involved, to an individual consumer that results in a purchase or exchange of an annuity in accordance with that advice.

26.1-34.2-03. Duties of insurers and insurance producers.

1. In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer when no producer is involved, must have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's financial situation and needs.

2. Before the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer when no producer is involved, shall make reasonable efforts to obtain information concerning:

   a. The consumer's financial status;

   b. The consumer's tax status;

   c. The consumer's investment objectives; and

   d. Other information used or considered to be reasonable by the insurance producer, or the insurer when no producer is involved, in making recommendations to the consumer.

3. a. Except as provided under subdivision b, neither an insurance producer nor an insurer when no producer is involved has an obligation to a consumer under subsection 1 related to a recommendation if a consumer:

      (1) Refuses to provide relevant information requested by the insurer or insurance producer;

      (2) Decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance producer; or

      (3) Fails to provide complete or accurate information.

   b. An insurer or insurance producer's recommendation subject to subdivision a must be reasonable under all the circumstances actually known to the insurer or insurance producer at the time of the recommendation.

4. a. An insurer shall ensure that a system to supervise recommendations that is reasonably designed to achieve compliance with this chapter is established and maintained by

complying with subdivisions c through e, or shall establish and maintain such a system, including:

(1) Maintaining written procedures; and

(2) Conducting periodic reviews of its records that are reasonably designed to assist in detecting and preventing violations of this chapter.

b. A general agent and independent agency shall adopt a system established by an insurer to supervise recommendations of its insurance producers that is reasonably designed to achieve compliance with this chapter, or shall establish and maintain such a system, including:

(1) Maintaining written procedures; and

(2) Conducting periodic reviews of records that are reasonably designed to assist in detecting and preventing violations of this chapter.

c. An insurer may contract with a third party, including a general agent or independent agency, to establish and maintain a system of supervision as required by subdivision a with respect to insurance producers under contract with or employed by the third party.

d. An insurer shall make reasonable inquiry to ensure that the third party contracting under subdivision c is performing the functions required under subdivision a and shall take action as is reasonable under the circumstances to enforce the contractual obligation to perform the functions. An insurer may comply with its obligation to make reasonable inquiry by doing all of the following:

(1) The insurer annually obtains a certification from a third-party senior manager who has responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions; and

(2) The insurer, based on reasonable selection criteria, periodically selects third parties contracting under subdivision c for a review to determine whether the third parties are performing the required functions. The insurer shall perform those procedures to conduct the review that are reasonable under the circumstances.

e. An insurer that contracts with a third party pursuant to subdivision c and that complies with the requirements to supervise in subdivision d has fulfilled its responsibilities under subdivision a.

f. An insurer, general agent, or independent agency is not required by subdivision a or b to:

(1) Review, or provide for review of, all insurance producer solicited transactions; or

(2) Include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer, general agent, or independent agency.

g. A general agent or independent agency contracting with an insurer pursuant to subdivision c shall promptly, when requested by the insurer pursuant to subdivision d, give a certification as described in subdivision d or give a clear statement that it is unable to meet the certification criteria.

h. A person may not provide a certification under paragraph 1 of subdivision d unless:

(1) The person is a senior manager with responsibility for the delegated functions; and

(2) The person has a reasonable basis for making the certification.

5. Compliance with the national association of securities dealers conduct rules pertaining to suitability satisfies the requirements under this section for the recommendation of variable annuities. However, nothing in this subsection limits the insurance commissioner's ability to enforce the provisions of this chapter.

26.1-34.2-04. Mitigation of responsibility - Penalty.

1. The commissioner may order:

a. An insurer to take reasonably appropriate corrective action for a consumer harmed by the insurer's, or by its insurance producer's, violation of this chapter;

b. An insurance producer to take reasonably appropriate corrective action for a consumer harmed by the insurance producer's violation of this chapter; and

c. A general agency or independent agency that employs or contracts with an insurance producer to sell, or solicit the sale of, annuities to consumers, to take reasonably appropriate corrective action for a consumer harmed by the insurance producer's violation of this chapter.

2. Any applicable penalty under section 26.1-01-03.3 for a violation of subsection 1 or 2 or subdivision b of subsection 3 of section 26.1-34.2-03 may be reduced or eliminated, according to a schedule adopted by the commissioner, if corrective action for the consumer was taken promptly after a violation was discovered.

26.1-34.2-05. Recordkeeping.

1. Insurers, general agents, independent agencies, and insurance producers shall maintain or be able to make available to the commissioner a record of the information collected from the consumer and other information used in making the recommendations that were

the basis for insurance transactions for ten years after the insurance transaction is completed by the insurer. An insurer is permitted, but is not required, to maintain documentation on behalf of an insurance producer.

2. Records required to be maintained by this chapter may be maintained in paper, photographic, microprocess, magnetic, mechanical, or electronic media, or by any process that accurately reproduces the actual document.

Approved April 12, 2007
Filed April 13, 2007

CHAPTER 268

SENATE BILL NO. 2318
(Senator Nething)

INSURANCE POLICY PROVISIONS

AN ACT to amend and reenact subsection 2 of section 26.1-36-04 of the North Dakota Century Code, relating to accident and health policy provisions.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-36-04 of the North Dakota Century Code is amended and reenacted as follows:

2. Except as provided in subsection 3, no accident and health insurance policy delivered or issued for delivery to any person in this state may contain provisions respecting the matters described in this subsection unless the provisions in the policy are not less favorable in any respect to the insured or the beneficiary.

   a. A provision that if the insured is injured or contracts sickness after having changed occupation to one classified by the insurer as more hazardous than that stated in the policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in the policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes occupation to one classified by the insurer as less hazardous than that stated in the policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of proof, whichever is the more recent. The provision must provide that the classification of occupational risk and the premium rates will be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time the policy was issued; but if the filing was not required, then the classification of occupational risk and the premium rates will be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

   b. A provision that if the age of the insured has been misstated, all amounts payable under the policy will be such as the premium paid would have purchased at the correct age.

   c. A provision that if an accident or health or accident and health policy or policies previously issued by the insurer to the insured are in force concurrently therewith, making the aggregate indemnity for the type of coverage or coverages, in excess of the maximum limit

of indemnity or indemnities, the excess insurance is void and all premiums paid for the excess will be returned to the insured or to the insured's estate. In lieu of this type of provision, the policy may provide that insurance effective at any one time on the insured under the policy and a like policy or policies in the insurer is limited to the one such policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

d. A provision that upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

e. Subject to chapter 26.1-36.4, a provision that the insurer may cancel the policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer, stating when, not less than five days thereafter, the cancellation is effective; and after the policy has been continued beyond its original term the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in the notice. The provision must provide that in the event of cancellation, the insurer will return promptly the unearned portion of any premium paid, and, if the insured cancels, the earned premium will be computed by the use of the short-rate table last filed in the state where the insured resided when the policy was issued. The provision must provide that if the insurer cancels, the earned premium shall be computed pro rata. The provision must provide that cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

f. A provision that any provision of the policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is amended to conform to the minimum requirements of such statutes.

g. A provision that the insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

h. A provision that the insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

i. ~~A provision that if, with respect to a person covered under the policy, benefits for allowable expense incurred during a claim determination period under the policy together with benefits for allowable expense during such period under all other valid coverage exceed the total of the person's allowable expense during such period, the insurer is liable only for such proportionate amount of the benefits for allowable expense under the policy during such period as (1) the total allowable expense during such period bears to (2) the total amount of benefits payable during such period for such expense under the policy and all other valid~~

~~coverage, without giving effect to this provision or to any "overinsurance provision" applying to such other valid coverage, less in both (1) and (2) any amount of benefits for allowable expense payable under other valid coverage which does not contain an overinsurance provision. The provision must provide that in no event does the provision operate to increase the amount of benefits for allowable expense payable under the policy with respect to a person covered under the policy above the amount which would have been paid in the absence of the provision. The provision must provide that the insurer may pay benefits to any insurer providing other valid coverage in the event of overpayment by such insurer, and any such payment discharges the liability of this insurer as fully as if the payment had been made directly to the insured, the insured's assignee, or the insured's beneficiary. The provision must provide that in the event that the insurer pays benefits to the insured, the insured's assignee, or the insured's beneficiary, in excess of the amount which would have been payable if the existence of other valid coverage had been disclosed, the insurer has a claim for relief against the insured, the insured's assignee, or the insured's beneficiary, to recover the amount which would not have been paid had there been a disclosure of the existence of the other valid coverage. The provision must provide that the amount of other valid coverage which is on a provision of service basis will be computed as the amount the services rendered would have cost in the absence of such coverage. The provision must provide that:~~

~~(1) "Allowable expense" means one hundred ten percent of any necessary, reasonable, and customary item of expense which is covered, in whole or in part, as a hospital, surgical, medical, or major medical expense under this policy or under any other valid coverage.~~

~~(2) "Claim determination period" with respect to any covered person means the initial period, as provided in the policy, but not less than thirty days and each successive period of a like number of days, during which allowable expense covered under the policy is incurred on account of such person. The first period begins on the date when the first expense is incurred, and successive periods begin when successive expense is incurred after expiration of a prior period.~~

~~Or, in lieu thereof:~~

~~"Claim determination period" with respect to any covered person means the number of days, as provided in the policy but not less than thirty days during which allowable expense covered under the policy is incurred on account of such person.~~

~~(3) "Overinsurance provision" means the provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage.~~

~~This type of provision may be inserted in all policies providing hospital, surgical, medical, or major medical benefits. The insurer~~

~~may make this provision applicable to either or both: other valid coverage with other insurers; and, except for individual policies individually underwritten, other valid coverage with the same insurer. The insurer shall include in the provision a definition of "other valid coverage". The definition may include hospital, surgical, medical, or major medical benefits provided by group, blanket, or franchise coverage, individual and family-type coverage, blue cross-blue shield coverage, and other prepayment plans, group practice, and individual practice plans, uninsured benefits provided by labor-management trusteed plans, or union welfare plans, or by employer or employee benefit organizations, benefits provided under governmental programs, workforce safety and insurance, or any coverage required or provided by any other statute, and medical payments under automobile liability and personal liability policies. Other valid coverage may not include payments made under third-party liability coverage as a result of a determination of negligence. The insurer may require, as part of the proof of claim, the information necessary to administer the provision.~~

~~j.~~ A provision that after the loss-of-time benefit of the policy has been payable for ninety days, such benefit will be adjusted, as provided below, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed a percentage of the insured's earned income as provided in the policy; provided, however, that if the information contained in the application discloses that the total amount of loss-of-time benefits under the policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded an alternative percentage of the insured's earned income as provided in the policy, at the time of the application, such higher percentage will be used in place of the original percentage provided. The provision must provide that the adjusted loss-of-time benefit under the policy for any month will be only such proportion of the loss-of-time benefit otherwise payable under the policy as (1) the product of the insured's earned income and the original percent, or, if higher, the alternative percentage, bears to (2) the total amount of loss-of-time benefits payable for such month under the policy and all other valid loss-of-time coverage on the insured, without giving effect to the "overinsurance provision" in this or any other coverage, less in both (1) and (2) any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an "overinsurance provision". The provision must provide that in making the computation, all benefits and earnings will be converted to a consistent basis weekly if the loss-of-time benefit of the policy is payable weekly, or monthly if the benefit is payable monthly, or otherwise, based upon the time period. If the numerator of the foregoing ratio is zero or is negative, no benefit is payable. The provision must provide that in no event does the provision operate to reduce the total combined amount of loss-of-time benefits for such month payable under the policy and all other valid loss-of-time coverage below the lesser of three hundred dollars and the total combined amount of loss-of-time benefits determined without giving effect to any "overinsurance provision", nor operate to increase the amount of benefits payable

under the policy above the amount which would have been paid in the absence of the provision, nor take into account or operate to reduce any benefit other than the loss-of-time benefit. The provision must provide that:

(1) "Earned income", except when otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences and the insured's average monthly earnings for a period of two years immediately preceding the commencement of the disability, and does not include any investment income or any other income not derived from the insured's vocational activities.

(2) "Overinsurance provision" includes this type of provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings.

This type of provision may be included only in a policy which provides a loss-of-time benefit which may be payable for at least fifty-two weeks, which is issued on the basis of selective underwriting of each individual application, and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits of the insured to the insured's earned income or to determine that such ratio does not exceed the percentage of earnings, not less than sixty percent, selected by the insurer and inserted in lieu of the blank factor above. The insurer may require, as part of the proof of claim, the information necessary to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of such other coverage must be excluded in computing the alternative percentage in the first sentence of the overinsurance provision. The policy must include a definition of "valid loss-of-time coverage" which may include coverage provided by governmental agencies and by organizations subject to regulation by insurance law and by insurance departments of this or any other state or of any other country or subdivision thereof, coverage provided for the insured pursuant to any disability benefits statute or any workforce safety and insurance or employer's liability statute, benefits provided by labor-management trusteed plans or union welfare plans or by employer or employee benefit organizations, or by salary continuance or pension programs, and any other coverage the inclusion of which may be approved.

Approved May 2, 2007
Filed May 3, 2007

CHAPTER 269

SENATE BILL NO. 2252

(Senators Mathern, Seymour)
(Representatives Price, Kerzman)

SUICIDE-RELATED HEALTH INSURANCE

AN ACT to create and enact section 26.1-36-09.12 of the North Dakota Century Code, relating to health insurance coverage for suicide-related medical services.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Section 26.1-36-09.12 of the North Dakota Century Code is created and enacted as follows:

26.1-36-09.12. Medical services related to suicide. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any hospital, surgical, medical, or major medical benefit policy on an individual, group, blanket franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury. The medical benefits provided for in this section are exempt from section 54-03-28.

Approved May 4, 2007
Filed May 4, 2007

CHAPTER 270

SENATE BILL NO. 2154

(Senators Klein, Andrist, Heitkamp)
(Representatives Ekstrom, Kasper, Ruby)

HEALTH INSURANCE LOSS RATIOS

AN ACT to amend and reenact section 26.1-36-37.2 of the North Dakota Century Code, relating to loss ratios.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36-37.2 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36-37.2. Loss ratios - Rules. For all policies providing hospital, surgical, medical, or major medical benefit, an insurance company, a nonprofit health service corporation, a fraternal benefit society, and any other entity providing a plan of health insurance or health benefit subject to state insurance regulation shall return benefits to group policyholders in the aggregate of not less than ~~seventy-five~~ seventy percent of premium received and to individual policyholders in the aggregate of not less than ~~sixty-five~~ fifty-five percent of premium received. The commissioner shall adopt rules to establish these minimum standards on the basis of incurred claims experienced and earned premiums for the entire period for which rates are computed to provide coverage in accordance with accepted actuarial principles and practices. This section does not apply to any contract or plan of insurance that provides exclusively for accident, disability income insurance, specified disease, hospital confinement indemnity, or other limited benefit health insurance.

Approved April 13, 2007
Filed April 16, 2007

CHAPTER 271

HOUSE BILL NO. 1037

(Legislative Council)
(Transportation Committee)

PROOF OF INSURANCE

AN ACT to create and enact a new section to chapter 26.1-40 of the North Dakota Century Code, relating to proof of insurance; to amend and reenact section 39-08-20 of the North Dakota Century Code, relating to the criminal procedure for driving without liability insurance; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Proof of insurance. An insurer who issues a policy shall provide proof of insurance to the insured in the form of written evidence of the policy's terms as to type, duration, and the vehicle covered by the policy.

[147] **SECTION 2. AMENDMENT.** Section 39-08-20 of the North Dakota Century Code is amended and reenacted as follows:

39-08-20. Driving without liability insurance prohibited - Penalty.

1. A person may not drive, or the owner may not cause or knowingly permit to be driven, a motor vehicle in this state without a valid policy of liability insurance in effect in order to respond in damages for liability arising out of the ownership, maintenance, or use of that motor vehicle in the amount required by chapter 39-16.1.

2. Upon being stopped by a law enforcement officer for the purpose of enforcing or investigating the possible violation of an ordinance or state law or during the investigation of an accident, the person driving the motor vehicle shall provide to the officer upon request satisfactory evidence of the policy required under this section. If unable to comply with the request, that person may be charged with a violation of this section if that person fails to submit satisfactory evidence of the policy to the officer or the officer's agency within twenty days of the date of the request. If that person produces satisfactory evidence of a valid policy of liability insurance in effect at the time of the alleged violation of this section to the officer, the officer's agency, or a court, that person may not be convicted or assessed any administration fee for violation of ~~this section~~ subsection 1.

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[147] Section 39-08-20 was also amended by section 1 of Senate Bill No. 2146, chapter 328.

3. Notwithstanding section 26.1-30-18, a person may be convicted for failure to have a valid policy of liability insurance in effect under this section if the time of acquisition of the policy was after the time of the alleged incidence of driving without liability insurance. If the time of acquisition of the policy comes into question, the driver or owner has the burden of establishing the time of acquisition. If the driver is not an owner of the motor vehicle, the driver does not violate this section if the driver provides the court with evidence identifying the owner of the motor vehicle and describing circumstances under which the owner caused or permitted the driver to drive the motor vehicle.

4. Violation of ~~this section~~ subsection 1 is a class B misdemeanor and the sentence imposed must include a fine of at least one hundred fifty dollars which may not be suspended. A person convicted for a second or subsequent violation of driving without liability insurance within ~~an eighteen-month~~ a three-year period must be fined at least three hundred dollars which may not be suspended. For a second or subsequent conviction for a violation of subsection 1 or equivalent ordinance, the court shall impound the motor vehicle number plates of the motor vehicle owned and operated by the person at the time of the violation until that person provides proof of insurance and a twenty dollar fee to the department. The person shall deliver the number plates to the court without delay at a time certain as ordered by the court following the conviction. The court shall deliver the number plates to the department. A person who does not provide the number plates to the court at the appropriate time is guilty of a class B misdemeanor.

~~2.~~ 5. Upon conviction for a violation of ~~this section~~ subsection 1 or equivalent ordinance, the person who has been convicted shall provide proof of motor vehicle liability insurance to the department in the form of a written or electronically transmitted certificate from an insurance carrier authorized to do business in this state. This proof must be provided for a period of three years and kept on file with the department. If the person fails to provide this information, the department shall suspend that person's driving privileges and may not issue or renew that person's operator's license unless that person provides proof of insurance.

~~3.~~ 6. A person who has been convicted for violation of ~~this section~~ subsection 1 or equivalent ordinance shall surrender that person's operator's license and purchase a duplicate operator's license with a notation requiring that person to keep proof of liability insurance on file with the department. The fee for this license is fifty dollars and the fee to remove this notation is fifty dollars.

~~4.~~ 7. When an insurance carrier has certified a motor vehicle liability policy, the insurance carrier shall notify the director no later than ten days after cancellation or termination of the certified insurance policy by filing a notice of cancellation or termination of the certified insurance policy; except that a policy subsequently procured and certified shall, on the effective date of its certification, terminate the insurance previously certified with respect to any motor vehicle designated in both certificates.

Approved March 5, 2007
Filed March 6, 2007