

INSURANCE

CHAPTER 226

SENATE BILL NO. 2287

(Senators Wardner, Anderson, Bell)
(Representatives Delzer, Kreidt, Nehring)

AN ACT to provide for an insurance commissioner study of lignite coal industry insurance; and to provide for a report to the legislative management.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. STUDY OF LIGNITE COAL INDUSTRY INSURANCE - REPORT TO THE LEGISLATIVE MANAGEMENT. During the 2021-22 interim, the insurance commissioner, in consultation with the North Dakota insurance reserve fund, shall study the availability, cost, and risks associated with insurance coverage in the lignite coal industry. The study must include consideration of whether the current insurance market adequately or appropriately calculates the risk factors specifically connected to the coal industry and whether there is a need for a state-based insurance product that insures against current risk factors at an appropriate cost. The insurance commissioner shall report its findings to the legislative management and implement any necessary recommendations by June 1, 2022.

Approved March 15, 2021

Filed March 15, 2021

CHAPTER 227

SENATE BILL NO. 2078

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

AN ACT to create and enact a new subsection to section 26.1-26.7-02 of the North Dakota Century Code, relating to the licensing of insurance producers; to amend and reenact subsection 2 of section 26.1-02.1-01, subdivision c of subsection 1 of section 26.1-26-13.3, sections 26.1-26-33 and 26.1-26-42.1, subdivision c of subsection 1 of section 26.1-26.9-03, and subsection 2 of section 26.1-26.9-05 of the North Dakota Century Code, relating to the licensing of insurance producers; and to provide for a legislative management study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-02.1-01 of the North Dakota Century Code is amended and reenacted as follows:

2. "Business of insurance" means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or who are officers, directors, agents, producers, or employees of insurers, or who are other persons authorized to act on their behalf. The term does not include the activities of the North Dakota life and health insurance guaranty association or the North Dakota insurance guaranty association.

SECTION 2. AMENDMENT. Subdivision c of subsection 1 of section 26.1-26-13.3 of the North Dakota Century Code is amended and reenacted as follows:

- c. Has paid to the commissioner or the commissioner's designee the fees set forth in section 26.1-01-07; and

SECTION 3. AMENDMENT. Section 26.1-26-33 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-33. Notification of address change - Duty of licensee.

Every licensee shall notify the commissioner of any change in the licensee's residential or business address or legal name within thirty days of the change. Notification may occur through the insurance producer database maintained by the national association of insurance producers, its affiliates, or subsidiaries. Any licensee who ceases to maintain residency in this state shall deliver the insurance license to the commissioner by personal delivery or by mail within thirty days after terminating residency.

SECTION 4. AMENDMENT. Section 26.1-26-42.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-26-42.1. Revocation of nonresident license.

Notwithstanding the provisions of subsection 13 of section 26.1-26-42, any nonresident license issued pursuant to this chapter may be suspended or revoked

without notice and hearing to the licensee and without proceeding in conformity with chapter 28-32, upon evidence ~~in the form of a certified copy that the authority which issued the resident license to~~ the North Dakota nonresident licensee has been revoked or suspended the resident license. This evidence may be in the form of a certified copy or through the insurance producer database maintained by the national association of insurance producers, its affiliates, or subsidiaries.

SECTION 5. A new subsection to section 26.1-26.7-02 of the North Dakota Century Code is created and enacted as follows:

A vendor, and the vendor's employees or authorized representatives, are exempt from the continuing education requirements of section 26.1-26-31.1.

SECTION 6. AMENDMENT. Subdivision c of subsection 1 of section 26.1-26.9-03 of the North Dakota Century Code is amended and reenacted as follows:

- c. Provide the actual terms of the self-service storage insurance coverage, or summarize the material terms of the insurance coverage, including:
 - (1) The identity of the insurer;
 - (2) The identity of the supervising entity, if any;
 - (3) The amount of any applicable deductible and how the deductible is to be paid;
 - (4) Benefits of the coverage; and
 - (5) Key terms and conditions of the coverage.

SECTION 7. AMENDMENT. Subsection 2 of section 26.1-26.9-05 of the North Dakota Century Code is amended and reenacted as follows:

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

SECTION 8. LEGISLATIVE MANAGEMENT STUDY - WRITTEN CONSENT FOR CERTAIN INSURANCE PRODUCERS. During the 2021-22 interim, the legislative management shall consider studying the process for obtaining written consent under the provisions of the Violent Crime Control and Law Enforcement Act of 1994 codified at 18 U.S.C. Section 1033 [Pub. L. 103-322] for individuals otherwise excluded from licensure as insurance producers. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

Approved April 16, 2021

Filed April 16, 2021

CHAPTER 228

HOUSE BILL NO. 1092

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

AN ACT to create and enact three new sections to chapter 26.1-02.1 of the North Dakota Century Code, relating to civil and administrative remedies used to combat insurance fraud; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-02.1 of the North Dakota Century Code is created and enacted as follows:

Administrative penalty and enforcement.

1. Upon a showing by a preponderance of evidence that a violation of this chapter occurred, and with the consent of the county state's attorney, the commissioner may impose an administrative penalty not to exceed ten thousand dollars for each fraudulent insurance act. Assessment of the administrative penalty must be determined by the nature, circumstances, extent, and gravity of the fraudulent insurance act or acts, any prior history of such act or acts, the degree of culpability, and such other matters as justice may require. The commissioner shall determine the administrative penalty, such as fines, restitution, or both.
2. In the event of nonpayment of the administrative penalty after all rights of appeal have been waived or exhausted, the commissioner may bring a civil action in district court for the collection of the administrative penalty and any other expenses incurred, including interest, attorney's fees, and costs, in the following manner:
 - a. A summons and complaint must be filed in the district court of Burleigh County setting forth that administrative action was taken against the defendant in accordance with this chapter, that the defendant either voluntarily entered a consent order that called for the payment of a specified monetary penalty, or in the alternative, that after proper notice and hearing, the defendant was determined to be in violation of this chapter and that by order of the commissioner a specified monetary penalty had been assessed against the defendant, that all rights of appeal have been waived or exhausted, and that payment in full has not been made in accordance with the terms of the consent order or other order of the commissioner. The insurance department shall attach to the complaint a certified copy of that consent order or other order of the commissioner.
 - b. The court shall enter judgment in favor of the department for the amount specified in the complaint if the department establishes:
 - (1) The defendant is the same person against which the consent order or other order of the commissioner applies; and

- (2) Payment in full has not been made by or on behalf of the defendant according to the terms of the consent or other order of the commissioner.
- c. Except as otherwise provided in this section the North Dakota Rules of Civil Procedure govern the civil proceedings.
3. A person that is found to have committed a fraudulent insurance act and assessed an administrative penalty or a person that violated an order of the commissioner pursuant to a hearing or consent order in relation to an administrative penalty associated with a fraudulent insurance act, may be liable for expenses incurred by the insurance department at the discretion of the commissioner. The assessment for costs may not exceed fifteen percent of each penalty assessed under this section.
4. The commissioner may order restitution to the insurer or self-insured employer of any insurance proceeds paid pursuant to a fraudulent insurance act. Restitution ordered must be paid by the owing party to the insurance regulatory trust fund under section 26.1-01-07.1 and from that fund be paid to the victim insurer or self-insured employee.
5. The expenses or administrative penalties collected by the commissioner under this chapter are appropriated to the insurance department in accordance with this section and section 26.1-01-07.1. All such moneys that are deposited in the insurance regulatory trust fund under this chapter may be appropriated for use in the education and enforcement of insurance fraud, except funds ordered as restitution to a victim. Restitution funds must be reallocated to the victim. In the discretion of the department, the department may pay a reward drawn from the assessed administrative penalty to an individual who reports to the insurance department an incident of fraudulent insurance act that results in either an admission or finding of fraud. The reward may not exceed the lesser of the assessed administrative penalty or twenty-five thousand dollars. In order to be eligible to receive a reward under this subsection, a reporting individual shall sign a written complaint that subjects the person to the sanctions of section 26.1-02.1. Persons required to report fraudulent insurance acts under subsection 1 of section 26.1-02.1-06 are not eligible to receive a reward pursuant to this subsection.
6. The insurance department may collect moneys for use by the department for fraud education and enforcement purposes.
- a. The following amounts must be deposited in the insurance regulatory trust fund for use by the department for fraud education and enforcement purposes, all sums received from:
- (1) Fines assessed in accordance with this chapter; and
- (2) Assessment of department costs under subsection 3.
- b. The moneys received under this subsection are reserved for the use by the insurance department to defray the expenses of the department in the performance of the various functions and duties associated with fraud enforcement, fund specialized training of department personnel tasked with working within fraud enforcement, and provide the funding for

specialized equipment, specialized technology, and insurance fraud public service and prevention campaigns and rewards.

- c. The moneys deposited for this purpose are subject to the provisions of section 26.1-01-07.1.

SECTION 2. A new section to chapter 26.1-02.1 of the North Dakota Century Code is created and enacted as follows:

Consent orders.

A person may enter a consent order by which such person, without admitting the conduct alleged, consents to the imposition of an administrative penalty and when so requested agrees to cease and desist the acts or omissions alleged in the complaint.

SECTION 3. A new section to chapter 26.1-02.1 of the North Dakota Century Code is created and enacted as follows:

Criminal prosecution.

The imposition of a fine or other sanction under this chapter does not preclude prosecution for a violation of a criminal law of the state.

Approved March 9, 2021

Filed March 10, 2021

CHAPTER 229

SENATE BILL NO. 2075

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

AN ACT to create and enact chapter 26.1-02.2 of the North Dakota Century Code, relating to insurance data and security; and to provide for a legislative management study.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-02.2 of the North Dakota Century Code is created and enacted as follows:

26.1-02.2-01 Definitions.

As used in this chapter:

1. "Authorized individual" means an individual known to and screened by the licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and the licensee's information systems.
2. "Commissioner" means the insurance commissioner.
3. "Consumer" means an individual, including an applicant, policyholder, insured, beneficiary, claimant, and certificate holder, who is a resident of this state and whose nonpublic information is in a licensee's possession, custody, or control.
4. "Cybersecurity event" means an event resulting in unauthorized access to, disruption, or misuse of, an information system or nonpublic information stored on the information system. The term does not include:
 - a. The unauthorized acquisition of encrypted nonpublic information if the encryption, process, or key is not also acquired, released, or used without authorization; or
 - b. An event the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.
5. "Department" means the insurance department.
6. "Encrypted" means the transformation of data into a form that results in a low probability of assigning meaning without the use of a protective process or key.
7. "Information security program" means the administrative, technical, and physical safeguards a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of, or otherwise handle nonpublic information.

8. "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic nonpublic information, as well as any specialized system, including industrial or process controls systems, telephone switching, private branch exchange systems, and environmental control systems.
9. "Licensee" means any person licensed, authorized to operate, registered, or required to be licensed, authorized, or registered pursuant to the insurance laws of this state. The term does not include a purchasing group or a risk retention group chartered and licensed in another state or a licensee that is acting as an assuming insurer that is domiciled in another state or jurisdiction.
10. "Multi-factor authentication" means authentication through verification of at least two of the following types of authentication factors:
 - a. Knowledge factors, including a password;
 - b. Possession factors, including a token or text message on a mobile phone;
or
 - c. Inherence factors, including a biometric characteristic.
11. "Nonpublic information" means electronic information that is not publicly available information and is:
 - a. Any information concerning a consumer which can be used to identify the consumer because of name, number, personal mark, or other identifier in combination with any one or more of the following data elements:
 - (1) Social security number;
 - (2) Driver's license number or nondriver identification card number;
 - (3) Financial account number or credit or debit card number;
 - (4) Any security code, access code, or password that would permit access to a consumer's financial account; or
 - (5) Biometric records.
 - b. Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer which can be used to identify a particular consumer and relates to:
 - (1) The past, present, or future physical, mental, or behavioral health or condition of any consumer or a member of the consumer's family;
 - (2) The provision of health care to any consumer; or
 - (3) Payment for the provision of health care to any consumer.
12. "Person" means any individual or any nongovernmental entity, including any nongovernmental partnership, corporation, branch, agency, or association.

13. "Publicly available information" means any information a licensee has a reasonable basis to believe is lawfully made available to the general public from: federal, state, or local government records; widely distributed media; or disclosures to the general public which are required to be made by federal, state, or local law. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:
 - a. The information is of the type available to the general public; and
 - b. Whether a consumer can direct the information not be made available to the general public and, if so, that the consumer has not done so.
14. "Risk assessment" means the risk assessment that each licensee is required to conduct under section 26.1-02.2-03.
15. "Third-party service provider" means a person, not otherwise defined as a licensee, that contracts with a licensee to maintain, process, store, or otherwise is permitted access to nonpublic information through its provision of services to the licensee.

26.1-02.2-02. Exclusive regulation.

Notwithstanding any other provision of law, this chapter establishes the exclusive state standards applicable to licensees for data security, the investigation of a cybersecurity event, and notification to the commissioner.

26.1-02.2-03. Information security program.

1. Commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including the licensee's use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control, each licensee shall develop, implement, and maintain a comprehensive written information security program based on the licensee's risk assessment that contains administrative, technical, and physical safeguards for the protection of nonpublic information and the licensee's information system.
2. A licensee's information security program must be designed to:
 - a. Protect the security and confidentiality of nonpublic information and the security of the information system;
 - b. Protect against any threats or hazards to the security or integrity of nonpublic information and the information system;
 - c. Protect against unauthorized access to or use of nonpublic information, and minimize the likelihood of harm to any consumer; and
 - d. Define and periodically re-evaluate a schedule for retention of nonpublic information and a mechanism for destruction if no longer needed.
3. The licensee shall:

- a. Designate one or more employees, an affiliate, or an outside vendor designated to act on behalf of the licensee which is responsible for the information security program;
 - b. Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration, or destruction of nonpublic information, including the security of information systems and nonpublic information accessible to, or held by, third-party service providers;
 - c. Assess the likelihood and potential damage of any threats, taking into consideration the sensitivity of the nonpublic information;
 - d. Assess the sufficiency of policies, procedures, information systems, and other safeguards in place to manage any threats, including consideration of threats in each relevant area of the licensee's operations, including:
 - (1) Employee training and management;
 - (2) Information systems, including network and software design, as well as information classification, governance, processing, storage, transmission, and disposal; and
 - (3) Detecting, preventing, and responding to attacks, intrusions, or other systems failures; and
 - e. Implement information safeguards to manage the threats identified in the licensee's ongoing assessment and assess the effectiveness of the safeguards' key controls, systems, and procedures on an annual basis.
4. Based on the licensee's risk assessment, the licensee shall:
- a. Design the information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including the licensee's use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody, or control.
 - b. Determine which security measures as provided under this subdivision are appropriate and implement the security measures:
 - (1) Place access controls on information systems, including controls to authenticate and permit access only to an authorized individual to protect against the unauthorized acquisition of nonpublic information;
 - (2) Identify and manage the data, personnel, devices, systems, and facilities that enable the organization to achieve business purposes in accordance with the business' relative importance to business objectives and the organization's risk strategy;
 - (3) Restrict physical access to nonpublic information only to an authorized individual;
 - (4) Protect by encryption or other appropriate means, all nonpublic information while being transmitted over an external network and all

- nonpublic information stored on a laptop computer or other portable computing or storage device or media;
- (5) Adopt secure development practices for in-house developed applications utilized by the licensee;
 - (6) Modify the information system in accordance with the licensee's information security program;
 - (7) Utilize effective controls, which may include multi-factor authentication procedures for employees accessing nonpublic information;
 - (8) Regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems;
 - (9) Include audit trails within the information security program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee;
 - (10) Implement measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, including fire and water damage or other catastrophes or technological failures; and
 - (11) Develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format.
- c. Include cybersecurity risks in the licensee's enterprise risk management process.
 - d. Stay informed regarding emerging threats or vulnerabilities and use reasonable security measures if sharing information relative to the character of the sharing and the type of information shared.
 - e. Provide cybersecurity awareness training to the licensee's personnel which is updated as necessary to reflect risks identified by the licensee in the risk assessment.
5. If the licensee has a board of directors, the board or an appropriate committee of the board at a minimum shall:
- a. Require the licensee's executive management or the licensee's delegates to develop, implement, and maintain the licensee's information security program.
 - b. Require the licensee's executive management or the licensee's delegates to report the following information in writing on an annual basis:
 - (1) The overall status of the information security program and the licensee's compliance with the provisions of this chapter; and
 - (2) Material matters related to the information security program, addressing issues, including risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, cybersecurity events, or violations, and management's

responses and recommendations for changes in the information security program.

- c. If executive management delegates any responsibilities under this section, the executive management delegates shall oversee the development, implementation, and maintenance of the licensee's information security program prepared by the delegate and shall receive a report from the delegate complying with the requirements of the report to the board of directors.
6. A licensee shall exercise due diligence in selecting its third-party service provider; and a licensee shall require a third-party service provider to implement appropriate administrative, technical, and physical measures to protect and secure the information systems and nonpublic information accessible to, or held by, the third-party service provider.
7. The licensee shall monitor, evaluate, and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to information, and the licensee's own changing business arrangements, including mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to information systems.
8. As part of the licensee's information security program, a licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity, or availability of nonpublic information in the licensee's possession. The incident response plan must include the licensee's plan to recover the licensee's information systems and restore continuous functionality of any aspect of the licensee's business or operations.
9. A licensee's incident response plan must address:

 - (1) The internal process for responding to a cybersecurity event;
 - (2) The goals of the incident response plan;
 - (3) The definition of clear roles, responsibilities, and levels of decisionmaking authority;
 - (4) External and internal communications and information sharing;
 - (5) Identification of requirements for the remediation of any identified weaknesses in information systems and associated controls;
 - (6) Documentation and reporting regarding cybersecurity events and related incident response activities; and
 - (7) The evaluation and revision as necessary of the incident response plan following a cybersecurity event.
10. Annually, an insurer domiciled in this state shall submit to the commissioner, a written statement by April fifteenth, certifying the insurer is in compliance with the requirements set forth in this section. An insurer shall maintain for examination by the department all records, schedules, and data supporting

this certificate for a period of five years. To the extent an insurer has identified areas, systems, or processes that require material improvement, updating, or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address the areas, systems, or processes. The documentation must be available for inspection by the commissioner.

26.1-02.2-04. Investigation of a cybersecurity event.

1. If a licensee learns a cybersecurity event has or may have occurred, the licensee, an outside vendor, or service provider designated to act on behalf of the licensee, shall conduct a prompt investigation.
2. During the investigation, the licensee or an outside vendor or service provider designated to act on behalf of the licensee, at a minimum shall:
 - a. Determine whether a cybersecurity event has occurred;
 - b. Assess the nature and scope of the cybersecurity event;
 - c. Identify any nonpublic information that may have been involved in the cybersecurity event; and
 - d. Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release, or use of nonpublic information in the licensee's possession, custody, or control.
3. If a licensee learns a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, the licensee shall complete the requirements provided under subsection 2 or confirm and document that the third-party service provider has completed the requirements.
4. The licensee shall maintain records concerning all cybersecurity events for a period of at least five years from the date of the cybersecurity event and shall produce the records upon demand of the commissioner.

26.1-02.2-05. Notification of a cybersecurity event.

1. A licensee shall notify the commissioner as promptly as possible, but no later than three business days from a determination that a cybersecurity event involving nonpublic information that is in the possession of a licensee has occurred if:
 - a. This state is the licensee's state of domicile, in the case of an insurer, or this state is the licensee's home state, in the case of a producer as defined in chapter 26.1-26, and the cybersecurity event has a reasonable likelihood of materially harming a consumer residing in this state or reasonable likelihood of materially harming any material part of the normal operations of the licensee; or
 - b. The licensee reasonably believes the nonpublic information involved is of two hundred fifty or more consumers residing in this state and is:
 - (1) A cybersecurity event impacting the licensee for which notice is required to be provided to any government body, self-regulatory

agency, or any other supervisory body pursuant to any state or federal law; or

(2) A cybersecurity event that has a reasonable likelihood of materially harming any consumer residing in this state or materially harming any part of the normal operations of the licensee.

2. The licensee shall provide the notice required under this section in electronic form as directed by the commissioner. The licensee shall update and supplement the initial and any subsequent notifications to the commissioner regarding material changes to previously provided information relating to the cybersecurity event. The licensee's notice required under this section must include:
 - a. The date of the cybersecurity event;
 - b. Description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of third-party service providers, if any;
 - c. How the cybersecurity event was discovered;
 - d. Whether any lost, stolen, or breached information has been recovered and if so, how;
 - e. The identity of the source of the cybersecurity event;
 - f. Whether the licensee has filed a police report or has notified any regulatory, government, or law enforcement agencies and, if so, when the notification was provided;
 - g. Description of the specific types of information acquired without authorization. Specific types of information means particular data elements, including medical information, financial information, or any other information allowing identification of the consumer;
 - h. The period during which the information system was compromised by the cybersecurity event;
 - i. The total number of consumers in this state affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the commissioner and update the estimate with a subsequent report to the commissioner pursuant to this section;
 - j. The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
 - k. Description of efforts being undertaken to remediate the situation that permitted the cybersecurity event to occur;
 - l. A copy of the licensee's privacy policy and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the cybersecurity event; and

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- m. Name of a contact person that is both familiar with the cybersecurity event and authorized to act for the licensee.
3. The licensee shall comply with chapter 51-30, as applicable, and provide a copy of the notice sent to consumers to the commissioner, when a licensee is required to notify the commissioner under subsection 1.
4. In the case of a cybersecurity event in a system maintained by a third-party service provider, of which the licensee has become aware, the licensee shall treat the event in accordance with subsection 1 unless the third-party service provider provides the notice required under chapter 26.1-02.2 to the commissioner.
- a. The computation of licensee's deadlines under this subsection begin on the day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.
- b. Nothing in this chapter prevents or abrogates an agreement between a licensee and another licensee, a third-party service provider, or any other party to fulfill any of the investigation requirements imposed under section 26.1-02.2-04 or notice requirements imposed under subsection 1.
5. If a cybersecurity event involving nonpublic information that is used by a licensee that is acting as an assuming insurer or in the possession, custody, or control of a licensee that is acting as an assuming insurer and that does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify the insurer's affected ceding insurers and the commissioner of the insurer's state of domicile within three business days of making the determination that a cybersecurity event has occurred. The ceding insurer that has a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under chapter 51-30 and any other notification requirements relating to a cybersecurity event imposed under subsection 1.
6. If a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a third-party service provider of a licensee that is an assuming insurer, the assuming insurer shall notify the insurer's affected ceding insurers and the commissioner of the insurer's state of domicile within three business days of receiving notice from its third-party service provider that a cybersecurity event has occurred. The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under chapter 51-30 and any other notification requirements relating to a cybersecurity event imposed under subsection 1.
7. Any licensee acting as assuming insurer does not have any other notice obligations relating to a cybersecurity event or other data breach under this section or any other law of this state.
8. If a cybersecurity event involving nonpublic information that is in the possession, custody, or control of a licensee that is an insurer or the insurer's third-party service provider for which a consumer accessed the insurer's services through an independent insurance producer, and for which consumer notice is required by chapter 51-30, the insurer shall notify the producers of

record of all affected consumers of the cybersecurity event no later than the time at which notice is provided to the affected consumers. The insurer is excused from the obligation imposed under this subsection for any producers that are not authorized by law or contract to sell, solicit, or negotiate on behalf of the insurer, and those instances in which the insurer does not have the current producer of record information for an individual consumer.

26.1-02.2-06. Power of commissioner.

1. The commissioner may examine and investigate the affairs of any licensee to determine whether the licensee has been or is engaged in any conduct in violation of this chapter. This power is in addition to the powers the commissioner has under chapter 26.1-03. Any investigation or examination must be conducted pursuant to chapter 26.1-03.
2. If the commissioner has reason to believe a licensee has been or is engaged in conduct in this state which violates this chapter, the commissioner may take action that is necessary or appropriate to enforce the provisions of this chapter.

26.1-02.2-07. Confidentiality.

1. Any documents, materials, or other information in the control or possession of the department which are furnished by a licensee, or an employee or agent thereof acting on behalf of a licensee pursuant to this chapter, or that are obtained by the commissioner in an investigation or examination pursuant to section 26.1-02.2-06 are confidential, not subject to chapter 44-04, not subject to subpoena, and are not subject to discovery or admissible in evidence in any private civil action. The commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties. The commissioner may not otherwise make the documents, materials, or other information public without the prior written consent of the licensee.
2. The commissioner or any person that received documents, materials, or other information while acting under the authority of the commissioner may not be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection 1.
3. In order to assist in the performance of the commissioner's duties the commissioner:
 - a. May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection 1, with other state, federal, and international regulatory agencies, with the national association of insurance commissioners, its affiliates or subsidiaries, and with state, federal, and international law enforcement authorities, provided the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information;
 - b. May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the national association of insurance commissioners, its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or

- privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information;
- c. May share documents, materials, or other information subject to this section, with a third-party consultant or vendor provided the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information; and
 - d. May enter agreements governing sharing and use of information consistent with this subsection.
4. A waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information does not occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection 3.
5. Documents, materials, or other information in the possession or control of the national association of insurance commissioners or a third-party consultant or vendor pursuant to this chapter are confidential, not subject to chapter 44-04, not subject to subpoena, and not subject to discovery or admissible in evidence in any private civil action.

26.1-02.2-08. Exceptions.

1. The following exceptions apply to this chapter:
- a. A licensee with less than five million dollars in gross revenue or less than ten million dollars in year-end assets is exempt from section 26.1-02.2-03.
 - b. During the period beginning on August 1, 2021, and ending on July 31, 2023, a licensee with fewer than fifty employees, including independent contractors and employees of affiliated companies having access to nonpublic information used by the licensee or in the licensee's possession, custody, or control, is exempt from section 26.1-02.2-03.
 - c. After July 31, 2023, a licensee with fewer than twenty-five employees, including independent contractors and employees of affiliated companies having access to nonpublic information used by the licensee or in the licensee's possession, custody, or control is exempt from section 26.1-02.2-03.
 - d. A licensee that is subject to and governed by the privacy, security, and breach notification rules issued by the United States department of health and human services, title 45, Code of Federal Regulations, parts 160 and 164, established pursuant to the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191], and the federal Health Information Technology for Economic and Clinical Health Act [Pub. L. 111-5], and which maintains nonpublic information concerning a consumer in the same manner as protected health information is deemed to comply with the requirements of this chapter except for the commissioner notification requirements under subsections 1 and 2 of section 26.1-02.2-05.
 - e. An employee, agent, representative, or designee of a licensee, that also is a licensee, is exempt from section 26.1-02.2-03 and is not required to

develop an information security program to the extent the employee, agent, representative, or designee is covered by the information security program of the other licensee.

2. If a licensee ceases to qualify for an exception, the licensee has one hundred eighty days to comply with this chapter.

26.1-02.2-09. Penalties.

In the case of a violation of this chapter, a licensee may be penalized in accordance with section 26.1-01-03.3.

26.1-02.2-10. Rules and regulations.

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

26.1-02.2-11. Implementation dates.

A licensee shall implement:

1. Subsections 1, 2, 3, 4, 5, 8, and 9 of section 26.1-02.2-03 no later than August 1, 2022; and
2. Subsections 6 and 7 of section 26.1-02.2-03 no later than August 1, 2023.

SECTION 2. LEGISLATIVE MANAGEMENT STUDY - CYBER VULNERABILITIES OF ENTITIES LICENSED BY THE INSURANCE DEPARTMENT. During the 2021-22 interim, the legislative management shall consider, with the assistance of the insurance department, studying the North Dakota laws and practice of insurers making property and casualty insurance policies and related information available to insureds by electronic means; the feasibility and desirability of prohibiting insurers from restricting the conditions in which insureds may access such information, including through software and agents of their choosing; and the extent to which insurers conducting business in this state have sought to limit access to policies and related information made available to insureds, whether such restrictions restrain competition in the marketplace, balance with an analysis of the impact of such access on potential cyber breaches, and loss of trade secret or proprietary information resulting from third-party usage and software applications, and how the two competing considerations can be safely and fairly reconciled. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-eighth legislative assembly.

Approved March 22, 2021

Filed March 23, 2021

CHAPTER 230

HOUSE BILL NO. 1062

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

AN ACT to create and enact a new subsection to section 26.1-30-19 of the North Dakota Century Code, relating to the confidentiality of insurance filings; and to amend and reenact section 26.1-03-10, subdivision a of subsection 5 of section 26.1-03-19.4, and subsection 6 of section 26.1-03-19.4 of the North Dakota Century Code, relating to insurance company records held by the insurance commissioner.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-03-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-10. Publication of abstract of annual statement and certificate of authority.

An insurance company, at the time it submits its annual statement for filing, shall submit an abstract of the annual statement for publication upon the form prescribed by the commissioner. The abstract of the annual statement of each company, other than a state or county mutual insurance company, must be published at least three times in one newspaper of general circulation, designated by the commissioner, printed and published in each judicial district in this state in which the company has an agency. The abstract of the annual statement of each state or county mutual insurance company must be published once in a newspaper published in the county in which the company has its principal place of business, the newspaper to be designated by the members of the company at their annual meeting. The certificate of authority issued by the commissioner to authorize the company to do business within this state must be published in connection with the publication of the abstract of its annual statement. The fees for publication are those provided under section 46-05-03. Proof of publication must be filed with the commissioner within four months after the filing of the annual statement. The commissioner shall provide abstracts, in a convenient form, on the commissioner's website.

¹⁵⁰ **SECTION 2. AMENDMENT.** Subdivision a of subsection 5 of section 26.1-03-19.4 of the North Dakota Century Code is amended and reenacted as follows:

- a. Upon the adoption of a ~~financial~~ examination report under subdivision a of subsection 3, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of fifteen days except to the extent provided in subsection 2. Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

¹⁵⁰ Section 26.1-03-19.4 was also amended by section 3 of House Bill No. 1062, chapter 230.

¹⁵¹ **SECTION 3. AMENDMENT.** Subsection 6 of section 26.1-03-19.4 of the North Dakota Century Code is amended and reenacted as follows:

6. a. All 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 a ~~financial~~ examination made under this chapter, or in the course of analysis by the commissioner of the financial condition or market conduct of the company, must be given confidential treatment and are not subject to subpoena and may not be made public by the commissioner or any other person, except to the extent provided in subsection 5. Access also may ~~also~~ be granted to the national association of insurance commissioners. The parties must agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.
- b. ~~For purposes of any other examination other than financial examinations required or authorized by law, all preliminary data, drafts, notes, impressions, memoranda, working papers, and work product generated by the commissioner or the person making an examination or inspection are confidential and not open for public inspection until the commissioner releases a final report concerning the examination or inspection or upon a declaration by the commissioner that the material is nonconfidential. If a declaration of nonconfidentiality is requested by any person and denied, the commissioner, in the denial, shall state the reason for the confidentiality and the date, as can best be reasonably determined at the time, when it will be made public.~~

SECTION 4. A new subsection to section 26.1-30-19 of the North Dakota Century Code is created and enacted as follows:

A filing and any supporting information is not open to public inspection or subject to the provisions of chapter 44-04 unless the filing is approved by the commissioner.

Approved March 9, 2021

Filed March 10, 2021

¹⁵¹ Section 26.1-03-19.4 was also amended by section 2 of House Bill No. 1062, chapter 230.

CHAPTER 231

SENATE BILL NO. 2077

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

AN ACT to amend and reenact sections 18-04-04 and 26.1-03-11 of the North Dakota Century Code, relating to the imposition of a monetary penalty on insurance companies failing to report certain data to the insurance commissioner; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 18-04-04 of the North Dakota Century Code is amended and reenacted as follows:

18-04-04. Insurance companies to report fire, allied lines, homeowner's multiple peril, farmowner's multiple peril, and commercial multiple peril insurance premium collections - Form furnished by insurance commissioner.

1. The insurance commissioner, when the commissioner forwards to an insurance company which is issuing policies for fire, allied lines, homeowner's multiple peril, farmowner's multiple peril, and commercial multiple peril insurance in this state the form to be used in submitting its annual statement, shall forward a form containing the names of all cities and all rural fire protection districts or rural fire departments entitled to benefits under the provisions of this chapter. Every insurance company issuing policies for fire, allied lines, homeowner's multiple peril, farmowner's multiple peril, and commercial multiple peril insurance within this state shall complete such form by showing ~~thereon on the form~~ the amount of all premiums received by ~~the insurance company~~ upon such policies issued on property within the corporate limits of each city shown on ~~such~~ the form and on property within the boundaries of each rural fire protection district shown on ~~such~~ the form or property within the boundaries of each rural fire department as certified by the state fire marshal during the year ending on the preceding thirty-first day of December and shall file the ~~same~~ form as a part of ~~its~~ the insurance company's annual statement.
2. An insurance company failing to report fire, allied lines, homeowner's multiple peril, farmowner's multiple peril, and commercial multiple peril insurance premium collections on or before March first, on forms prescribed by the insurance commissioner, is subject to the monetary penalties prescribed in section 26.1-03-11.

SECTION 2. AMENDMENT. Section 26.1-03-11 of the North Dakota Century Code is amended and reenacted as follows:

26.1-03-11. Fire companies to report statistical data - Failure to report - Exceptions to reporting requirements - Penalty.

Each insurance company issuing fire insurance policies covering property in this state shall annually shall report information setting forth the amount of earned

premiums in this state for policies covering insured property located in this state and the amount of claims incurred. This information is not to include personal lines or farm property insurance. This information must be reported on a form prescribed by the commissioner. The company shall file the form with the commissioner or shall certify to the commissioner that the information has been reported directly to an advisory organization upon whose filings the majority of the fire insurance rates for North Dakota are based. The form or certification must accompany the annual statement required under section 26.1-03-07. ~~The commissioner shall forward information filed under this section to the advisory organization upon whose filings a majority of the fire insurance rates for North Dakota are based. Each advisory organization filing pursuant to chapter 26.1-25 shall use this information in its filing. The commissioner shall revoke the certificate of authority of an insurance company failing to file the information required by this section.~~An insurance company that fails to furnish the form on or before March first is subject to a penalty of one hundred dollars per day. The commissioner may revoke or suspend the certificate of authority of an insurance company that fails to file the form required in this section. If satisfied the delay was excusable, the insurance commissioner may waive, and if paid, issue a premium tax credit in an amount up to fifty percent of the penalty and interest. The insurance commissioner shall deposit in the insurance tax distribution fund monetary penalties collected under this section.

Approved April 21, 2021

Filed April 22, 2021

CHAPTER 232

HOUSE BILL NO. 1087

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

AN ACT to create and enact two new sections to chapter 26.1-36.7 of the North Dakota Century Code, relating to third-party reinsurance; to amend and reenact sections 26.1-03-17, 26.1-36.7-01, 26.1-36.7-02, 26.1-36.7-03, 26.1-36.7-04, 26.1-36.7-05, 26.1-36.7-06, 26.1-36.7-07, 26.1-36.7-08, 26.1-36.7-09, and 26.1-36.7-10 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies and the establishment of an invisible reinsurance pool for the individual health insurance market; to provide for a study; to provide a penalty; to provide an appropriation; to provide a continuing appropriation; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

26.1-03-17. Commissioner to collect premium tax - Insurance companies generally - Computation - Credits - Penalty - Estimated tax. (~~Effective through December 31, 2021~~)

1. Before issuing the annual certificate required by law, the commissioner shall collect from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except fraternal benefit and benevolent societies, doing business in this state, a tax on the gross amount of premiums, assessments, membership fees, subscriber fees, policy fees, service fees collected by any third-party administrator providing administrative services to a group that is self-insured for health care benefits, and finance and service charges received in this state during the preceding calendar year, at the rate of two percent with respect to life insurance, one and three-fourths percent with respect to accident and health insurance, and one and three-fourths percent with respect to all other lines of insurance. This tax does not apply to considerations for annuities. The total tax is payable on or before March first following the year for which the tax is assessable. If the due date falls on a Saturday or legal holiday, the tax is payable on the next succeeding business day. Collections from this tax must be deposited in the insurance tax distribution fund under section 18-04-04.1 but not in an amount exceeding one-half of the biennial amount appropriated for distribution under section 18-04-05 and chapter 23-46 in any fiscal year. Collections from this tax exceeding the sum of the amount deposited in the insurance tax distribution fund must be deposited in the general fund in the state treasury.
2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member

may be liable for the year in which the assessment was paid, a credit against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

3. Any company failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of one hundred dollars plus twenty-five dollars per day, excepting the first day after the tax became due. Any company failing to file the appropriate tax statement required by rule if the tax is zero is subject to a penalty of twenty-five dollars per day for each day's neglect not to exceed five hundred dollars. The commissioner, if satisfied that the delay was excusable, may waive, and if paid, issue a premium tax credit for all or any part of the penalty and interest.
4. Every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except fraternal benefit or benevolent societies, doing business in this state required to pay premium taxes in this state shall make and file a statement of estimated premium taxes. The statement and payment must be made on a quarterly basis as prescribed by the commissioner. Failure of a company to make payments of at least one-fourth of the total tax paid during the previous calendar year, or eighty percent of the actual tax for the quarter being reported of the current calendar year, shall subject the company to the penalty and interest provided in subsection 3.
5. If an amount of tax, penalty, or interest has been paid which was not due under the provisions of this section, a refund may be issued to the taxpayer who made the erroneous payment. The refund is allowed as a credit against any tax due or to become due under this section or as a cash refund, at the discretion of the commissioner. The taxpayer who made the erroneous payment shall present a claim for refund to the commissioner not later than two years after the due date of the return for the period for which the erroneous payment was made.
6. In lieu of the tax required by subsection 1, the commissioner shall collect from each entity subject to this section an annual filing fee in the amount of two hundred dollars, provided the total tax liability of the entity pursuant to subsection 1 is less than two hundred dollars. No annual filing fee is due or may be collected from an entity if its total tax liability pursuant to subsection 1 is in excess of two hundred dollars. The annual filing fee may be reduced by any credits available pursuant to subsections 2 and 5. Failure of a company to pay the two hundred dollar filing fee subjects the company to the penalty as provided in subsection 3.

26.1-03-17. Commissioner to collect premium tax -- Insurance companies generally -- Computation -- Credits -- Penalty -- Estimated tax. (Effective after December 31, 2021)

1. Before issuing the annual certificate required by law, the commissioner shall collect from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except fraternal benefit and benevolent societies, doing business in this state, a tax on the gross amount of premiums, assessments, membership fees, subscriber fees, policy fees, service fees collected by any third-party administrator providing administrative services to a group that is self-insured for health care benefits, and finance and service charges received in this state during the preceding calendar year, at the rate of two percent with respect to life insurance, one and three-fourths percent with respect to accident and health insurance, and one and three-fourths percent with respect to all other lines of insurance. This tax does not apply to considerations for annuities. The total tax is payable on or before March first following the year for which the tax is assessable. If the due date falls on a Saturday or legal holiday, the tax is payable on the next succeeding business day. Collections from this tax must be deposited in the insurance tax distribution fund under section 18-04-04.1 but not in an amount exceeding one-half of the biennial amount appropriated for distribution under section 18-04-05 and chapter 23-46 in any fiscal year. Collections from this tax exceeding the sum of the amount deposited in the insurance tax distribution fund must be deposited in the general fund in the state treasury.
2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit as provided under section 26.1-38-1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18-1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.
3. Any company failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of one hundred dollars plus twenty-five dollars per day, excepting the first day after the tax became due. Any company failing to file the appropriate tax statement required by rule if the tax is zero is subject to a penalty of twenty-five dollars per day for each day's neglect not to exceed five hundred dollars. The commissioner, if satisfied that the delay was excusable, may waive, and if paid, issue a premium tax credit for all or any part of the penalty and interest.
4. Every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except fraternal benefit or benevolent societies, doing business in this state required to pay premium taxes in this state shall make and file a

statement of estimated premium taxes. The statement and payment must be made on a quarterly basis as prescribed by the commissioner. Failure of a company to make payments of at least one-fourth of the total tax paid during the previous calendar year, or eighty percent of the actual tax for the quarter being reported of the current calendar year, shall subject the company to the penalty and interest provided in subsection 3.

5. If an amount of tax, penalty, or interest has been paid which was not due under the provisions of this section, a refund may be issued to the taxpayer who made the erroneous payment. The refund is allowed as a credit against any tax due or to become due under this section or as a cash refund, at the discretion of the commissioner. The taxpayer who made the erroneous payment shall present a claim for refund to the commissioner not later than two years after the due date of the return for the period for which the erroneous payment was made.
6. In lieu of the tax required by subsection 1, the commissioner shall collect from each entity subject to this section an annual filing fee in the amount of two hundred dollars, provided the total tax liability of the entity pursuant to subsection 1 is less than two hundred dollars. No annual filing fee is due or may be collected from an entity if its total tax liability pursuant to subsection 1 is in excess of two hundred dollars. The annual filing fee may be reduced by any credits available pursuant to subsections 2 and 5. Failure of a company to pay the two hundred dollar filing fee subjects the company to the penalty as provided in subsection 3.

¹⁵² **SECTION 2. AMENDMENT.** Section 26.1-36.7-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-01. Definitions. (Effective through December 31, 2024)

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

1. "Association" means the reinsurance association of North Dakota.
2. "Board" means the board of directors of the reinsurance association of North Dakota.
3. "Earned group health benefit plan premiums" means premium owed to an insurer for a period of time during which the insurer has been liable to cover claims for an insured pursuant to the terms of a group health benefit plan issued by the insurer.
4. "Future losses" means reserves for claims incurred but not reported.
5. "Group health benefit plan" means a health benefit plan offered through an employer, or an association of employers, to more than one individual employee.
6. "Health benefit plan" means any hospital and medical expense-incurred policy or certificate, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement

¹⁵² Section 26.1-36.7-01 was also amended by section 2 of Senate Bill No. 2073, chapter 239.

that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care.

- a. "Health benefit plan" does not include any one or more of the following:
- (1) Coverage only for accident or disability income insurance, or any combination of the two;
 - (2) Coverage issued as a supplement to liability insurance;
 - (3) Liability insurance, including general liability insurance and automobile liability insurance;
 - (4) Workforce safety and insurance or similar workers' compensation insurance;
 - (5) Automobile medical payment insurance;
 - (6) Credit-only insurance;
 - (7) Coverage for onsite medical clinics;
 - (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - (9) Self-funded plans.
- b. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:
- (1) Limited scope dental or vision benefits;
 - (2) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination of this care; and
 - (3) Other similar limited benefits specified under federal regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].
- c. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; and any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:
- (1) Coverage only for specified disease or illness; and
 - (2) Hospital indemnity or other fixed indemnity insurance.
- d. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

- (1) Medicare supplement health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 13295ss(g)(1)];
 - (2) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and
 - (3) Similar supplemental coverage provided under a group health plan.
7. "Individual health benefit plan" means a health benefit plan offered to individuals, other than in connection with a group health benefit plan. The term does not include short-term limited-duration health insurance as defined by section 26.1-36-49.
 8. "Insured" means an individual who is insured by a health benefit plan.
 9. "Insurer" means an entity authorized to write health benefit plans or that provides health benefit plans in the state. The term includes an insurance company as defined in section 26.1-02-01, a nonprofit health service organization, a fraternal benefit society, and a health maintenance organization.
 10. "Member insurer" means an insurer that offers individual health benefit plans and is actively marketing individual health benefit plans in this state.

SECTION 3. AMENDMENT. Section 26.1-36.7-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-02. Waiver proposal and application. (~~Effective through December 31, 2024~~)

1. The commissioner may develop a proposal for an innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.].
2. On behalf of the state, in accordance with the proposal developed under subsection 1, the commissioner may submit an application to the United States department of health and human services and to the United States secretary of the treasury. The commissioner may implement any federally approved waiver.
3. The commissioner may develop an amendment for an innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.].

SECTION 4. AMENDMENT. Section 26.1-36.7-03 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-03. Reinsurance association of North Dakota. (~~Effective through December 31, 2024~~)

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

2. The association may begin operation on either:
 - a. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the state's innovation waiver application has been approved by the federal government pursuant to section 1332 of the federal Patient Protection and Affordable Care Act [Pub L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.]; or
 - b. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the Patient Protection and Affordable Care Act [Pub. L. 111-148] has been repealed, amended, or finally adjudicated by a court of law with jurisdiction over North Dakota as invalid or in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.
3. If the federal funding associated with an approved innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.] is terminated or otherwise discontinued, the commissioner may cease or suspend operations of the reinsurance association of North Dakota beginning on the January first following the date the commissioner notifies the board that federal funding has been terminated or otherwise discontinued.

SECTION 5. AMENDMENT. Section 26.1-36.7-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-04. Board of directors. (~~Effective through December 31, 2021~~)

1. The association is governed by the board of directors of the reinsurance association of North Dakota.
2. The board consists of the state health officer, one senator appointed by the majority leader of the senate of the legislative assembly, one representative appointed by the speaker of the house of representatives of the legislative assembly, one individual from each of the four insurers of the association with the highest annual market share as determined by annual market share reports of health benefit plans provided by the commissioner annually, and two nonvoting members from the insurance department appointed by the commissioner.
3. Members of the board may be reimbursed from the moneys of the association for expenses incurred by the members due to their service as board members, but may not otherwise be compensated by the association for board services.
4. The costs of conducting the meetings of the association and the board are borne by the association.
5. For cause, the commissioner may remove any board member representing one of the four insurers.

SECTION 6. AMENDMENT. Section 26.1-36.7-05 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-05. Powers and duties of commissioner and board. (~~Effective through December 31, 2021~~)

1. The commissioner shall:
 - a. Perform all functions necessary for the association to carry out the purposes of this chapter; and
 - b. Approve any assessments to the insurers writing or otherwise issuing group health benefit plans. A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment.
2. The board shall:
 - a. Formulate general policies to advance the purposes of this chapter;
 - b. Schedule and approve independent biennial audits in order to:
 - (1) Ensure claims are being processed appropriately and only include services covered by the individual health benefit plan for the contracted rates; and
 - (2) Verify that the assessment base is accurate and that the appropriate percentage was used to calculate the assessment;
 - c. Approve bylaws and operating rules; and
 - d. Provide for other matters as may be necessary and proper for the execution of the commissioner's and board's powers, duties, and obligations.
3. The commissioner and the members of the board are not liable for any obligations of the association.

SECTION 7. AMENDMENT. Section 26.1-36.7-06 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-06. Assessments against insurers. (~~Effective through December 31, 2024~~)

1. For the purpose of providing the funds necessary to carry out the purposes of the association under this chapter, the commissioner shall assess insurers writing or otherwise issuing group health benefit plans based on the insurer's group health benefit plan premium written in this state. The assessment must be paid quarterly within forty-five days of the end of the previous quarter on all earned group health benefit plan premiums for the previous calendar quarter. An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due.
2. An insurer writing less than one hundred thousand dollars, annually, in group health benefit plan premium is exempt from the assessments.
3. The commissioner may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the commissioner. The commissioner may use any reasonable method of estimating an insurer's group health benefit plan premium if the specific number is not reported to the commissioner.

- 3-4. Any federal funding obtained by the association must be used to reduce the assessments of insurers writing or otherwise issuing group health benefit plans pursuant to this section.
- 4-5. Before April second of each year, the association shall determine and report to the board the association's net gains or net losses for the previous calendar year.
- 5-6. Before April sixteenth of each year, the association shall provide an estimate to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.
- 6-7. Before May second of each year, the board may provide a recommendation to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.
- 7-8. An insurer may apply to the commissioner for a deferral of all or part of an assessment imposed by the association under this section. The commissioner may defer all or part of the assessment if the commissioner determines the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited from reinsuring any person through the association until such time as the insurer pays the assessments.
- 8-9. The board shall use any surplus, including any interest earned on the surplus, to:
- a. Offset future losses;
 - b. Reduce future assessments to insurers writing or otherwise issuing group health benefit plans; or
 - c. Pay off a line of credit issued pursuant to section 26.1-36.7-07.
- 9-10. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the commissioner may use any power granted to the commissioner by this title to collect any unpaid assessment.

SECTION 8. AMENDMENT. Section 26.1-36.7-07 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-07. Bank of North Dakota line of credit. (~~Effective through December 31, 2021~~)

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

association may access the line of credit to the extent necessary to provide reimbursements to member insurers as required by this chapter.

SECTION 9. AMENDMENT. Section 26.1-36.7-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-08. Reinsurance. (~~Effective through December 31, 2021~~)

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

SECTION 10. AMENDMENT. Section 26.1-36.7-09 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-09. Reimbursement of member insurer. (~~Effective through December 31, 2021~~)

For nongrandfathered individual health benefit plans issued or renewed after the November second preceding to the date the association begins operation, a member insurer may seek reimbursement from the association and the association shall reimburse the member insurer pursuant to the provisions of section 26.1-36.7-08 to the extent the claims incurred by the insured and submitted by the member insurer to the association are eligible for coverage and reimbursement according to the terms of insured's individual health benefit plan.

SECTION 11. AMENDMENT. Section 26.1-36.7-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.7-10. Rulemaking. (~~Effective through December 31, 2021~~)

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

SECTION 12. A new section to chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

Third-party reinsurance.

The association may use federal funding received under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.] to procure third-party reinsurance for the association's portion of eligible claims.

SECTION 13. A new section to chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

Federal funding - Administration of the association - Continuing appropriation.

Federal funding received by the association under the innovation waiver approved under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148; 119 Stat. 124; 42 U.S.C. 1801 et seq.] is appropriated to the insurance commissioner on a continuing basis for the purposes of this chapter.

SECTION 14. INSURANCE DEPARTMENT STUDY - COMBINING INDIVIDUAL MARKET AND SMALL GROUP MARKET FOR REINSURANCE. During the 2021-22 interim, the insurance department shall study ways the state may be able to establish an invisible reinsurance pool for the combination of the individual health insurance market with the small group health insurance market.

SECTION 15. APPROPRIATION. There is appropriated out of special funds derived from the reinsurance association of North Dakota, not otherwise appropriated, the sum of \$200,000, or so much of the sum as may be necessary, to the insurance commissioner for the purpose of a study relating to the establishment of an invisible reinsurance pool for the combination of the individual health insurance market with the small group health insurance market, and implementing the findings of the study, for the biennium beginning July 1, 2021, and ending June 30, 2023.

SECTION 16. EMERGENCY. This Act is declared to be an emergency measure.

Approved April 1, 2021

Filed April 1, 2021

CHAPTER 233

SENATE BILL NO. 2072

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

AN ACT to amend and reenact section 26.1-04-01, subsection 8 of section 26.1-04-03, section 26.1-25-16, and subdivision a of subsection 4 of section 26.1-36-09.8 of the North Dakota Century Code, relating to unfair trade practices and the use of rebates in the business of insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-04-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-04-01. Limitation on right to engage in trade.

An insurance company organized under this title may not deal or trade, directly or indirectly, in the buying or selling of any goods, wares, merchandise, or other commodities whatsoever, except such as may have been insured by the company and are claimed to be damaged by reason of the risk insured against or as allowed under this chapter.

SECTION 2. AMENDMENT. Subsection 8 of section 26.1-04-03 of the North Dakota Century Code is amended and reenacted as follows:

8. Rebates.

- a. Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity, or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the insurance or annuity any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatsoever not specified in the contract; or giving, selling, or purchasing, or offering to give, sell, or purchase as inducement to the insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.
- b. Subsection 7 or subdivision a of this subsection do not prohibit the following practices:
 - (1) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums are fair and

equitable to policyholders and for the best interests of the company and its policyholders;

- (2) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; and
 - (3) Readjusting the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for the policy year.
- c. Notwithstanding any other provision in this subsection, if the cost does not exceed an aggregate retail value of one hundred dollars per person per year, an insurance producer may give a gift, prize, promotional article, logo merchandise, meal, or entertainment activity directly or indirectly to a person in connection with marketing, promoting, or advertising the business. As used in this subdivision, "person" means the named insured, policy owner, or prospective client or the spouse of any of these individuals, but the term does not include a certificate holder, child, or employee of the named insured, policy owner, or prospective client. Subject to the limits of this subdivision, an insurance producer may give a gift card for specific merchandise or services such as a meal, gasoline, or car wash but may not give cash, a cash card, any form of currency, or any refund or discount in premium. An insurance producer may not condition the giving of a gift, prize, promotion article, logo merchandise, meal, or entertainment activity on obtaining a quote or a contract of insurance. Notwithstanding the limitation in this subdivision, an insurance producer may conduct raffles or drawings, if there is no financial cost to an entrant to participate, the drawing or raffle does not obligate a participant to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the commissioner, and the drawing or raffle is open to the public. The raffle or drawing must be offered in a manner that is not unfairly discriminatory and may not be contingent on the purchase, continued purchase, or renewal of a policy. Notwithstanding the limitation in this subdivision, an insurance producer may make a donation to a nonprofit organization that is exempt from federal taxation under Internal Revenue Code section 501(c)(3) [26 U.S.C. 501(c)(3)] in any amount as long as the donation is not given as an inducement to obtain a contract of insurance.
- d. The provisions in this subsection may not be construed as including within the definition of discrimination or rebates any of the following practices:
- (1) The offer or provision by an insurer or producer, by or through an employee, an affiliate, or a third-party representative, of value-added products or services at no or reduced cost if such products or services are not specified in the policy of insurance if the product or service:
 - (a) Relates to the insurance coverage and is designed to satisfy one or more of the following:

[1] Provide loss mitigation or loss control;

- [2] Reduce claims costs or claim settlement costs;
 - [3] Provide education about liability risk or risk of loss to persons or property;
 - [4] Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
 - [5] Enhance health;
 - [6] Enhance financial wellness through items such as education of financial planning services;
 - [7] Provide post-loss services;
 - [8] Incent behavioral changes to improve the health or reduce the risk of death or disability of an individual defined as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured, or applicant; or
 - [9] Assist in the administration of the employee or retiree benefit insurance coverage.
- (b) If offered by the insurer or producer, the insurer or producer, upon request, shall ensure the person is provided with contact information to assist the person with questions regarding the product or service.
- (c) Is based on documented objective criteria and offered in a manner not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced at the request of the commissioner.
- (d) Is reasonable in comparison to that person's premiums or insurance coverage for the policy class.
- (2) If an insurer or producer does not have sufficient evidence, but has a good-faith belief the product or service meets the criteria in paragraph 1 of subdivision d of subsection 8, the insurer or producer may provide the product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program for no longer than one year. An insurer or producer shall notify the department of the pilot or testing program offered to consumers in this state before launching and may proceed with the program unless the department objects within twenty-one days of notice.
- e. An insurer, producer, or representative of an insurer or producer may not offer or provide insurance as an inducement to the purchase of another policy or otherwise use of the words "free" or "no cost" or words of similar import in an advertisement.
- f. The commissioner may adopt regulations when implementing the permitted practices set forth in this subsection to ensure consumer protection. Consistent with applicable law, the topics addressed by the

regulations may include consumer data protections and privacy, consumer disclosure, and unfair discrimination.

SECTION 3. AMENDMENT. Section 26.1-25-16 of the North Dakota Century Code is amended and reenacted as follows:

26.1-25-16. Rebates prohibited - Exception.

1. No insurance producer may knowingly charge, demand, or receive a premium for any insurance policy except in accordance with this chapter. No insurer or employee of an insurer, and no broker or agent may pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in an insurance policy, or any special favor or advantage in the dividends or other benefits to accrue on the policy, or any valuable consideration or inducement whatever, not specified in the insurance policy, except to the extent provided for in applicable filing. No insured named in an insurance policy, nor any employee of the insured, may knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit, or reduction of premium, or any such special favor or advantage or valuable consideration or inducement. This section does not prohibit the payment of commissions or other compensation to licensed insurance producers, nor any insurer from allowing or returning to its participating policyholders, members, or subscribers dividends, savings, or unabsorbed premium deposits. As used in this section, "insurance" includes suretyship and "policy" includes bond.
2. Notwithstanding any other provision in this section, if the cost does not exceed an aggregate retail value of one hundred dollars per person per year, an insurance producer may give a gift, prize, promotional article, logo merchandise, meal, or entertainment activity directly or indirectly to a person in connection with marketing, promoting, or advertising the business. As used in this subsection, "person" means the named insured, policy owner, or prospective client or the spouse of any of these individuals, but the term does not include a certificate holder, child, or employee of the named insured, policy owner, or prospective client. Subject to the limits of this subsection, an insurance producer may give a gift card for specific merchandise or services such as a meal, gasoline, or car wash but may not give cash, a cash card, any form of currency, or any refund or discount in premium. An insurance producer may not condition the giving of a gift, prize, promotional article, logo merchandise, meal, or entertainment activity on obtaining a quote or a contract of insurance. Notwithstanding the limitation in this subsection, an insurance producer may conduct raffles or drawings, if there is no financial cost to an entrant to participate, the drawing or raffle does not obligate a participant to purchase insurance, the prizes are not valued in excess of a reasonable amount determined by the commissioner, and the drawing or raffle is open to the public. The raffle or drawing must be offered in a manner that is not unfairly discriminatory and may not be contingent on the purchase, continued purchase, or renewal of a policy. Notwithstanding the limitation in this subsection, an insurance producer may make a donation to a nonprofit organization that is exempt from federal taxation under Internal Revenue Code section 501(c)(3) [26 U.S.C. 501(c)(3)] in any amount as long as the donation is not given as an inducement to obtain a contract of insurance.
3. The provisions in this section may not be construed as including within the definition of discrimination or rebates any of the following practices:

- a. The offer or provision by an insurer or producer, by or through an employee, an affiliate, or a third-party representative, of value-added products or services at no or reduced cost if the products or services are not specified in the policy of insurance if the product or service:
- (1) Relates to the insurance coverage and is designed to satisfy one or more of the following:
 - (a) Provide loss mitigation or loss control;
 - (b) Reduce claims costs or claim settlement costs;
 - (c) Provide education about liability risk or risk of loss to persons or property;
 - (d) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
 - (e) Enhance health;
 - (f) Enhance financial wellness through items such as education of financial planning services;
 - (g) Provide post-loss services;
 - (h) Incent behavioral changes to improve the health or reduce the risk of death or disability of an individual defined as policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured, or applicant; or
 - (i) Assist in the administration of the employee or retiree benefit insurance coverage.
 - (2) If offered by the insurer or producer, the insurer or producer, upon request, shall ensure the person is provided with contact information to assist the person with questions regarding the product or service.
 - (3) Is based on fair documented criteria and offered in a manner not unfairly discriminatory. The documented criteria must be maintained by the insurer or producer and produced at the request of the commissioner.
 - (4) Is reasonable in comparison to that person's premiums or insurance coverage for the policy class.
- b. If an insurer or producer does not have sufficient evidence, but has a good-faith belief the product or service meets the criteria in subdivision a, the provision by the insurer or producer of a product or service in a manner that is not unfairly discriminatory as part of a pilot or testing program no longer than one year. An insurer or producer shall notify the department of the pilot or testing program offered to consumers in this state before launching and may proceed with the program unless the department objects within twenty-one days of notice.

4. An insurer, producer, or representative of an insurer or producer may not offer or provide insurance as an inducement to the purchase of another policy or otherwise use of the words "free" or "no cost" or words of similar import in an advertisement.
5. The commissioner may adopt regulations when implementing the permitted practices set forth in this regulation to ensure consumer protection. Consistent with applicable law, the topics addressed by the regulations may include consumer data protections and privacy, consumer disclosure, and unfair discrimination.

SECTION 4. AMENDMENT. Subdivision a of subsection 4 of section 26.1-36-09.8 of the North Dakota Century Code is amended and reenacted as follows:

- a. Provide monetary payments ~~or rebates~~ to any insured person to request less than the minimum coverage required under this section;

Approved March 29, 2021

Filed March 30, 2021

CHAPTER 234

HOUSE BILL NO. 1093

(Appropriations Committee)
(At the request of the State Auditor)

AN ACT to amend and reenact section 26.1-21-08 of the North Dakota Century Code, relating to the audit of state bonding coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-21-08 of the North Dakota Century Code is amended and reenacted as follows:

26.1-21-08. Review of coverage by auditor.

When conducting an audit examination of a state agency or political subdivision, the auditor ~~shall~~may evaluate the blanket bond coverage and, if necessary, the auditor ~~shall~~may include recommendations for changes in the amount of that coverage in the auditor's report.

Approved April 12, 2021

Filed April 13, 2021

CHAPTER 235

HOUSE BILL NO. 1086

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

AN ACT to amend and reenact sections 26.1-22-02.1, 26.1-22-06.1, 26.1-22-10, 26.1-22-14, 26.1-22-15, and 26.1-22-19 of the North Dakota Century Code, relating to property insured by the state fire and tornado fund; to provide an effective date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-22-02.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-02.1. Insurance against indirect losses.

The commissioner shall provide, upon request of an entity insured with the fund, coverage by the fund for an indirect loss incurred because of a loss arising out of a peril insured against by the fund. The coverage provided by the fund shall be an amount that is subject to the underwriting guidelines adopted by the commissioner.

SECTION 2. AMENDMENT. Section 26.1-22-06.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-06.1. Replacement cost appraisal required on state-owned property.

Once every six years each state agency and institution shall obtain from the fund a replacement cost appraisal on all buildings and fixtures and permanent contents under its control which are insured at replacement cost. The fund shall determine the manner of conducting the appraisal. Annually, except for any year an appraisal is conducted, the agency or institution shall adjust the appraisal amount in the manner authorized by the fund.

SECTION 3. AMENDMENT. Section 26.1-22-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-10. Commissioner to provide insurance on buildings and personal property.

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

case of disagreement, by approval through arbitration. The commissioner may allow personal property to be insured on a blanket basis.

2. All buildings and the contents of the buildings owned by the state mill and elevator association, in lieu of coverage under this chapter, may, at the option of the industrial commission, be insured by private insurance companies licensed to do business in this state, against at least all the types of hazards insured against by the fund. If the industrial commission exercises the option provided in this section, the commission shall seek competitive sealed bids, shall invite the fund to submit a bid, and may reject any or all bids received.
3. All public buildings owned by a political subdivision, in lieu of coverage provided for in this section, may at the option of the governing body of the political subdivision be insured on the basis of competitive sealed bids, through the fund which must be invited to submit a sealed bid or private insurance companies licensed to do business in this state, against damage resulting from hazards, which include those types of hazards that may be insured against by the fund. The governing body may reject any or all such bids.
4. All public libraries owned by the state or political subdivisions may, in addition to the coverage provided for in this section, be covered against damage through vandalism. If this coverage cannot be extended to the public libraries situated within this state, the libraries may contract for this coverage with private insurance companies; provided, that this coverage meets the recommendations of the insurance code of the American library association.

SECTION 4. AMENDMENT. Section 26.1-22-14 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-14. Assessments and reporting of premiums and losses.

1. If the reserve balance is less than twelve million dollars, the commissioner shall determine the amount of money necessary to bring the reserve balance up to twelve million dollars. The commissioner then shall ~~then~~ levy an assessment against every policy in force with the fund.
2. The assessment must be computed as follows:
 - a. ~~The eighty percent or ninety percent coinsurance rate established by the insurance services office for each insured property for which that rate may be applicable, and the full rate established for policies providing coverage against indirect losses and for properties to which the eighty percent or ninety percent coinsurance rate is not applicable under the rules of the insurance services office,~~ must be applied to the amount of insurance provided in each policy and the result of the application of the rate to the amount of insurance sets the tentative assessment to be made against the policy.
 - b. The total of all tentative assessments must then be ascertained.
 - c. The percentage of the assessment necessary to restore the reserve balance to the sum of twelve million dollars must then be computed and collected on each policy; provided, that until the reserve balance reaches twelve million dollars, the assessment must be in an amount determined by the commissioner but may not exceed sixty percent of the rates set by

the insurance services office for insured property unless the reserve balance is depleted below three million dollars.

- d. In case of a fractional percentage the next higher whole percent must be used in such computation.

~~The commissioner shall submit, not later than December thirty-first of every five-year period, all data concerning premiums written and losses incurred during the previous five-year period ending June thirtieth to the insurance services office so that the experience of the fund may be included in the computation of rates to apply to the classes of business written by the fund.~~

SECTION 5. AMENDMENT. Section 26.1-22-15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-15. Collection of premiums and assessments.

The commissioner, as soon as possible after providing for insurance coverage against any indirect loss or loss of property belonging to the state, a political subdivision, an international peace garden, or a winter show, shall certify to the insured the amount of premium or assessment due. The certificate must give the name of the insured, the amount of insurance written thereon, and the amount of the premium or assessment, and if applicable, the location and description of the insured property. The proper officer shall remit to the commissioner the amount of the premium or assessment within sixty days after the date of the certification. The commissioner shall deposit the premiums and assessments with the state treasurer to the credit of the fund. If the premiums or assessments are not paid within sixty days after the date on which they are certified, ~~they shall bear interest at the rate of six percent per annum and collection thereof may be enforced by appropriate action.~~ The attorney general and the state's attorney of the relevant county shall bring appropriate actions to enforce the collections of the premium and assessment upon request of the commissioner. An enforcement judgment obtained under this section must include a rate of six percent interest per annum. Payment of the premiums or assessments certified pursuant to this section may be made by any state department, officer, board, institution, or agency and by any political subdivision, out of any available funds, notwithstanding that no specific appropriation or tax levy has been made therefor.

SECTION 6. AMENDMENT. Section 26.1-22-19 of the North Dakota Century Code is amended and reenacted as follows:

26.1-22-19. Repair or replacement of destroyed buildings.

If the commissioner and the insured agree that the fund shall repair or replace the building destroyed or damaged, no repairs, rebuilding, or replacement may be undertaken by the commissioner or any employees of the commissioner, ~~but if they are deemed necessary or proper in any case, they must be performed by independent contractors.~~ The cost of any repairs, rebuilding, or replacements may not exceed the amount of the insurance carried upon the particular risk.

SECTION 7. EFFECTIVE DATE. This Act becomes effective on July 1, 2021.

SECTION 8. EMERGENCY. This Act is declared to be an emergency measure.

Approved March 9, 2021

Filed March 10, 2021

CHAPTER 236

SENATE BILL NO. 2076

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

AN ACT to amend and reenact section 26.1-31.2-01 of the North Dakota Century Code, relating to reinsurance credit of insurers.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-31.2-01 of the North Dakota Century Code is amended and reenacted as follows:

26.1-31.2-01. Credit allowed a domestic ceding insurer.

1. Credit for reinsurance must be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection ~~1~~, 2, 3, 4, 5, ~~or 6~~, 7, or 8. Credit will be allowed under subsection ~~1~~, 2, ~~or 3~~, or 4 only with respect to cessions of a kind or class of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit must be allowed under subsection ~~3~~~~—or 4~~ or 5 only if the applicable requirements of subsection ~~7~~9 have been satisfied.
- ~~4-2.~~ Credit must be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.
- ~~2-3.~~ Credit must be allowed when the reinsurance is ceded to an assuming insurer which is accredited by the commissioner as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer:
 - a. Shall file with the commissioner evidence of its submission to this state's jurisdiction;
 - b. Shall submit to this state's authority to examine its books and records;
 - c. Must be licensed to transact insurance or reinsurance in at least one state, or, in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;
 - d. Annually, shall file with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and
 - e. Shall demonstrate to the satisfaction of the commissioner the assuming insurer has adequate financial capacity to meet the assuming insurer's reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this

requirement as of the time of application the assuming insurer maintains a surplus as regards policyholders in an amount which is not less than twenty million dollars and the assuming insurer's accreditation has not been denied by the commissioner within ninety days after submission of its application.

- ~~3-4.~~ a. Credit must be allowed when the reinsurance is ceded to an assuming insurer domiciled in, or in the case of a United States branch of an alien assuming insurer, is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:
- (1) Maintains a surplus as regards policyholders in an amount not less than twenty million dollars; and
 - (2) Submits to the authority of this state to examine its books and records.
- b. The requirement of subdivision a does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.
- ~~4-5.~~ a. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in subsection 2 of section 26.1-31.2-03, for the payment of valid claims of its United States ceding insurers, their assigns, and successors in interest. To enable the commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers. The assuming insurer shall submit to examination of the insurer's books and records by the commissioner and bear the expense of examination.
- b. (1) Credit for reinsurance may not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:
- (a) The commissioner of the state in which the trust is domiciled; or
 - (b) The commissioner of another state who, pursuant to the terms of the trust instrument, accepted principal regulatory oversight of the trust.
- (2) The form of the trust and any trust amendments also must be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to the trust's assets in the trust's trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer are subject to examination as determined by the commissioner.

- (3) The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February twenty-eighth of each year the trustee of the trust shall report to the commissioner in writing the balance of the trust and listing of the trust's investments at the preceding year-end and shall certify the date of termination of the trust, if so planned, or certify the trust will not expire before the following December thirty-first.
- c. The following requirements apply to the following categories of assuming insurer:
- (1) The trust fund for a single assuming insurer must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and, in addition, the assuming insurer shall maintain a trustee surplus of not less than twenty million dollars, except as provided in paragraph 2.
 - (2) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.
 - (3) (a) In the case of a group, including incorporated and individual unincorporated underwriters:
 - [1] For reinsurance ceded under a reinsurance agreement with an inception, amendment, or renewal date after December 31, 1992, the trust must consist of a trustee account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group;
 - [2] For reinsurance ceded under a reinsurance agreement with an inception date before January 1, 1993, and not amended or renewed after that date, notwithstanding the other provisions of this chapter, the trust must consist of a trustee account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

- [3] In addition to these trusts, the group shall maintain a trustee surplus of one hundred million dollars which must be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.
- (b) The incorporated members of the group may not be engaged in any business other than underwriting as a member of the group and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.
 - (c) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements prepared by independent public accountants of each underwriter member of the group.
- (4) In the case of a group of incorporated underwriters under common administration, the group:
- (a) Must have continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation;
 - (b) Shall maintain aggregate policyholders' surplus of at least ten billion dollars;
 - (c) Shall maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;
 - (d) Shall maintain a joint trustee surplus of which one hundred million dollars must be held jointly for the benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and
 - (e) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, shall make available to the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.
- 5-6. Credit must be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the commissioner as a reinsurer in this state and secures the assuming insurer's obligations in accordance with the requirements of this subsection.
- a. In order to be eligible for certification, the assuming insurer shall meet the following requirements:

- (1) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to subdivision c;
 - (2) The assuming insurer shall maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to rule;
 - (3) The assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner pursuant to rule;
 - (4) The assuming insurer shall agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state, and agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final United States judgment;
 - (5) The assuming insurer shall agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis; and
 - (6) The assuming insurer shall satisfy any other requirements for certification deemed relevant by the commissioner.
- b. An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of subdivision a:
- (1) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and the association's members which must include a joint central fund that may be applied to any unsatisfied obligation of the association or any of the association's members, in an amount determined by the commissioner to provide adequate protection;
 - (2) The incorporated members of the association may not be engaged in any business other than underwriting as a member of the association and are subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and
 - (3) Within ninety days after the association's financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.
- c. The commissioner shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such

jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

- (1) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner has determined the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner.
 - (2) A list of qualified jurisdictions must be published through the national association of insurance commissioner committee process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified which does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.
 - (3) United States jurisdictions that meet the requirement for accreditation under the national association of insurance commissioners financial standards and accreditation program must be recognized as qualified jurisdictions.
 - (4) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, in lieu of revocation, the commissioner may suspend the reinsurer's certification indefinitely.
- d. The commissioner shall assign a rating to each certified reinsurer. Giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the commissioner pursuant to rule. The commissioner shall publish a list of all certified reinsurers and the reinsurer's ratings.
- e. A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with the certified reinsurer's rating, as specified in rules adopted by the commissioner.
- (1) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with the provisions of section 26.1-31.2-02 or in a multibeneficiary trust in accordance with subsection 45, except as otherwise provided in this subsection.
 - (2) If a certified reinsurer maintains a trust to fully secure the certified reinsurer's obligations subject to subsection 45, and chooses to secure

the certified reinsurer's obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for the certified reinsurer's obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for the certified reinsurer's obligations subject to subsection 45. As a condition to the grant of certification under subsection 56, the certified reinsurer must have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

- (3) The minimum trusteed surplus requirements provided in subsection 45 are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust must maintain a minimum trusteed surplus of ten million dollars.
- (4) With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and may impose further reductions in allowable credit upon finding there is a material risk the certified reinsurer's obligations will not be paid in full when due.
- (5) For purposes of this subsection, a certified reinsurer whose certification has been terminated for any reason must be treated as a certified reinsurer required to secure one hundred percent of the certified reinsurer's obligations.
 - (a) As used in this subsection, "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.
 - (b) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.
- f. If an applicant for certification has been certified as a reinsurer in a national association of insurance commissioners accredited jurisdiction, the commissioner may defer to that jurisdiction's certification, and may defer to the rating assigned by that jurisdiction, and such assuming insurer must be considered to be a certified reinsurer in this state.
- g. A certified reinsurer that ceases to assume new business in this state may request to maintain the certified reinsurer's certification in inactive status in order to continue to qualify for a reduction in security for the certified reinsurer's in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

6-7. a. Credit must be allowed if the reinsurance is ceded to an assuming insurer meeting each of the following conditions:

- (1) The assuming insurer must have the assuming insurer's head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. A "reciprocal jurisdiction" is a jurisdiction that meets one of the following:
 - (a) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. As used in this subsection, a "covered agreement" is an agreement entered pursuant to the federal Dodd-Frank Wall Street Reform and Consumer Protection Act [31 U.S.C. 313 and 314] which is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering a reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;
 - (b) A United States jurisdiction that meets the requirements for accreditation under the national association of insurance commissioners financial standards and accreditation program recognized by the commissioner; or
 - (c) A qualified jurisdiction, as determined by the commissioner pursuant to subdivision c of subsection 6, which is not otherwise described in subdivision a or b of subsection 6 and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by rules adopted by the commissioner.
- (2) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of the assuming insurer's domiciliary jurisdiction, in an amount in compliance with rules adopted by the commissioner. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, the assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in the domiciliary jurisdiction of the assuming insurer, and a central fund containing a balance in compliance with rules adopted by the commissioner.
- (3) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, in compliance with rules adopted by the commissioner. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, the assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction in which the assuming insurer has the assuming insurer's head office or is domiciled, as applicable, and is also licensed.

- (4) The assuming insurer shall agree and provide adequate assurance to the commissioner, in a form in compliance with rules adopted by the commissioner, as follows:
- (a) The assuming insurer shall provide prompt written notice and explanation to the commissioner if the assuming insurer falls below the minimum requirements set forth in paragraph 2 or 3, or if any regulatory action is taken against the assuming insurer for serious noncompliance with applicable law;
 - (b) The assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require consent for service of process be provided to the commissioner and included in each reinsurance agreement. This subparagraph does not limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;
 - (c) The assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or the ceding insurer's legal successor, which have been declared enforceable in the jurisdiction in which the judgment was obtained;
 - (d) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which the final judgment was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by the ceding insurer's legal successor on behalf of the ceding insurer's resolution estate; and
 - (e) The assuming insurer shall confirm the assuming insurer is not presently participating in any solvent scheme of arrangement that involves this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to one hundred percent of the assuming insurer's liabilities to the ceding insurer, if the assuming insurer enters such a solvent scheme of arrangement. Such security must be in a form consistent with the provisions of subsection 6 and section 26.1-31.2-02 and as specified by the commissioner by rule.
- (5) The assuming insurer or the assuming insurer's legal successor shall provide, if requested by the commissioner, on behalf of the assuming insurer and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner by regulation.
- (6) The assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth by the commissioner by rule.

- (7) The assuming insurer's supervisory authority shall confirm to the commissioner on an annual basis, as of the preceding December thirty-first or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in paragraphs 2 and 3.
- (8) This subdivision does not preclude an assuming insurer from providing the commissioner with information on a voluntary basis.
- b. The commissioner shall create timely and publish a list of reciprocal jurisdictions.
- (1) A list of reciprocal jurisdictions is published through the national association of insurance commissioners committee process. The commissioner's list must include any reciprocal jurisdiction as defined under subparagraphs a and b of paragraph 1 of subdivision a, and must consider any other reciprocal jurisdiction included on the national association of insurance commissioners' list. The commissioner may approve a jurisdiction that does not appear on the national association of insurance commissioners' list of reciprocal jurisdictions in accordance with criteria to be set by rules adopted by the commissioner.
- (2) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set by rules adopted by the commissioner, except that the commissioner may not remove from the list a reciprocal jurisdiction as defined under subparagraphs a and b of paragraph 1 of subdivision a. Upon removal of a reciprocal jurisdiction from this list credit for reinsurance ceded to an assuming insurer that has the assuming insurer's home office or is domiciled in that jurisdiction must be allowed, if otherwise allowed pursuant to chapter 26.1-31.2.
- c. The commissioner timely shall create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions must be granted credit in accordance with this subsection. The commissioner may add an assuming insurer to the list if a national association of insurance commissioners accredited jurisdiction has added the assuming insurer to a list of the assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under paragraph 4 of subdivision a and complies with any additional requirements the commissioner may impose by rule, except to the extent the requirements conflict with an applicable covered agreement.
- d. If the commissioner determines an assuming insurer no longer meets one or more of the requirements under this subsection, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth by rule.
- (1) While an assuming insurer's eligibility is suspended, a reinsurance agreement issued, amended, or renewed after the effective date of the suspension does not qualify for credit except to the extent the

assuming insurer's obligations under the contract are secured in accordance with section 26.1-31.2-02.

- (2) If an assuming insurer's eligibility is revoked, credit for reinsurance may not be granted after the effective date of the revocation with respect to any reinsurance agreements entered by the assuming insurer, including reinsurance agreements entered before the date of revocation, except to the extent the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of section 26.1-31.2-02.
- e. If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or the ceding insurer's representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring the assuming insurer post security for all outstanding ceded liabilities.
- f. This subsection does not limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter.
- g. Credit may be taken under this subsection only for reinsurance agreements entered, amended, or renewed on or after the effective date of this Act, and only with respect to losses incurred and reserves reported on or after the later of the date on which the assuming insurer has met all eligibility requirements pursuant to subdivision a and the effective date of the new reinsurance agreement, amendment, or renewal.

 - (1) This subdivision does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of this chapter.
 - (2) This subsection does not authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.
 - (3) This subsection does not limit or in any way alter the capacity of parties to any reinsurance agreement to renegotiate the agreement.
8. Credit must be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection 4, 2, 3, 4, or 5, 6, or 7 but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.
- 7-9. a. If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by subsections 34 and 45 may not be allowed unless the assuming insurer agrees in the reinsurance agreements:

 - (1) In the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to

the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(2) To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

b. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

8-10. If the assuming insurer does not meet the requirements of subsection 4, 2, or 3, 4, or 8, the credit permitted by subsection 45 or 56 may not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

a. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because the trust fund contains an amount less than the amount required by subdivision c of subsection 45, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

b. The assets must be distributed by and claims must be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled which are applicable to the liquidation of domestic insurers.

c. If the commissioner with regulatory oversight determines the assets of the trust fund or any part of this trust fund are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part of the assets must be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

d. The grantor shall waive any right otherwise available to the grantor under United States law that is inconsistent with this provision.

9-11. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

a. The commissioner shall give the reinsurer notice and opportunity for a hearing. The suspension or revocation may not take effect until after the commissioner's order on a hearing, unless:

(1) The reinsurer waives the reinsurer's right to a hearing;

- (2) The commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in the reinsurer's domiciliary jurisdiction or in the primary certifying state of the reinsurer under subdivision f of subsection 56; or
- (3) The commissioner finds an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.
- b. During the period of suspension of a reinsurer's accreditation or certification, a reinsurance contract issued or renewed after the effective date of the suspension does not qualify for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with section 26.1-31.2-02. If a reinsurer's accreditation or certification is revoked, credit for reinsurance may not be granted after the effective date of the revocation, except to the extent the reinsurer's obligations under the contract are secured in accordance with subdivision e of subsection 5 of section 26.1-31.2-02.
- 40-12. a. A ceding insurer shall take steps to manage the ceding insurer's reinsurance recoverables proportionate to the ceding insurer's own book of business. A domestic ceding insurer shall notify the commissioner within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceed fifty percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate the exposure is safely managed by the domestic ceding insurer.
- b. A ceding insurer shall take steps to diversify the ceding insurer's reinsurance program. A domestic ceding insurer shall notify the commissioner within thirty days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent of the ceding insurer's gross written premium in the prior calendar year, or after the ceding insurer's determined the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification must demonstrate the exposure is safely managed by the domestic ceding insurer.
- c. Credit for reinsurance ceded to a certified reinsurer is limited to reinsurance contracts entered or renewed on or after the effective date of the commissioner's certification of the assuming insurer.

Approved March 22, 2021

Filed March 23, 2021

CHAPTER 237

HOUSE BILL NO. 1153

(Representative Keiser)
(Senator Klein)

AN ACT to amend and reenact subsection 2 of section 26.1-34-02 of the North Dakota Century Code, relating to the interest rate used in determining the minimum nonforfeiture amount for an annuity.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-34-02 of the North Dakota Century Code is amended and reenacted as follows:

2. For an annuity contract issued after July 31, 2005:
 - a. The minimum nonforfeiture amount at any time at or before the commencement of any annuity payments must be equal to an accumulation up to such time at rates of interest, as provided under subdivision c, of the net considerations, as defined under subdivision b, paid before such time, decreased by the sum of:
 - (1) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as provided under subdivision c;
 - (2) An annual contract charge of fifty dollars, accumulated at rates of interest as provided under subdivision c;
 - (3) Any premium tax paid by the company for the contract, accumulated at rates of interest as provided under subdivision c; and
 - (4) The amount of any indebtedness to the company on the contract, including interest due and accrued.
 - b. The net considerations for a given contract year used to define the minimum nonforfeiture amount under subdivision a must be an amount equal to eighty-seven and one-half percent of the gross considerations credited to the contract during that contract year.
 - c. The interest rate used in determining minimum nonforfeiture amounts must be determined as the lesser of:
 - (1) Three percent per annum; or
 - (2) The five-year constant maturity rate reported by the federal reserve as of a date or average over a period, reduced by one hundred twenty-five basis points. The rate calculated under this paragraph may not be less than ~~one-fifteen~~ one-hundredths of one percent, must be specified in the contract, and must be determined no more than fifteen months before the contract issue date or redemption date.

- d. The interest rate used in determining minimum nonforfeiture amounts applies for an initial period and may be redetermined for additional periods. The redetermination date basis and period, if any, must be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.
- e. Notwithstanding subdivisions a, b, c, and d, during the period or term that a contract provides substantive participation in an equity indexed benefit, the contract may increase the reduction of one hundred twenty-five basis points under paragraph 2 of subdivision c by an amount not to exceed one hundred basis points, in order to reflect the value of the equity index benefit. The present value at the contract issue date, the present value at each redetermination date, or the additional reduction may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the reduction does not exceed the market value of the benefit. Lacking such a demonstration acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.
- f. The commissioner may adopt rules to implement the provisions of subdivision e and to provide further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts if the commissioner determines that adjustments are justified.

Approved March 23, 2021

Filed March 24, 2021

CHAPTER 238

HOUSE BILL NO. 1160

(Representative Keiser)
(Senator Klein)

AN ACT to amend and reenact sections 26.1-34.2-01.1, 26.1-34.2-02, 26.1-34.2-03, 26.1-34.2-03.1, 26.1-34.2-04, and 26.1-34.2-05 of the North Dakota Century Code, relating to annuity transaction practices; to provide a penalty; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-34.2-01.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-34.2-01.1. Scope.

~~This chapter applies to any sale or recommendation to purchase, exchange, or replace of an annuity made to a consumer by an insurance producer, or an insurer when no producer is involved, that results in the purchase, exchange, or replacement recommended. This chapter may not be construed to create or imply a private cause of action for a violation of this chapter or to subject a producer to civil liability under the best interest standard of care outlined in section 26.1-34.2-03 or under standards governing the conduct of a fiduciary or a fiduciary relationship.~~

SECTION 2. AMENDMENT. Section 26.1-34.2-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-34.2-02. Definitions.

1. "Annuity" means an annuity that is an insurance product under state law which 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. "~~Cash compensation~~" means a discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer or intermediary or directly from the consumer.
3. "Comparable standards":
 - a. With respect to a broker-dealer and registered representative of a broker-dealer, applicable federal securities and exchange commission and financial industry regulatory authority rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including Regulation Best Interest [17 CFR 240];

- a. A broker-dealer registered under federal or state securities laws or a registered representative of a broker-dealer;
- b. An investment adviser registered under federal or state securities laws or an investment adviser representative associated with the federal or state registered investment adviser; or
- c. A plan fiduciary under section 3(21) of the federal Employee Retirement Income Security Act of 1974 [29 CFR 2510.3-21] or fiduciary under section 4975(e)(3) of the Internal Revenue Code [26 U.S.C. 4975(e)(3)] as amended.
8. "Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.
- 4-9. "Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by producers.
10. "Material conflict of interest" means a financial interest of the producer in the sale of an annuity which a reasonable person would expect to influence the impartiality of a recommendation. The term does not include cash compensation or noncash compensation.
11. "Noncash compensation" means any form of compensation that is not cash compensation, including health insurance, office rent, office support, and retirement benefits.
12. "Nonguaranteed elements" means the premiums, credited interest rates, including a bonus, benefits, values, dividends, noninterest based credits, charges, or elements of formulas used to determine any of these which are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in the element's calculation.
13. "Producer" means an individual or entity required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, including annuities. The term includes an insurer if no producer is involved.
14. "Recommendation" means advice provided by an insurance producer, or an insurer when no producer is involved, to an individual consumer which results in a purchase, replacement, or exchange of an annuity in accordance with that advice; a producer to an individual consumer which was intended to result or results in a purchase, a replacement, or an exchange of an annuity in accordance with that advice. The term does not include general communication to the public, generalized customer services assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.
- 5-15. "Replacement" means a transaction in which a new policy or contract annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no whether or not a producer is involved, that by reason of the transaction, an existing annuity or other insurance policy or contract has been or is to be any of the following:

- a. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or otherwise terminated;
 - b. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
 - c. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
 - d. Reissued with any reduction in cash value; or
 - e. Used in a financed purchase.
6. ~~"Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:~~
- a. Age;
 - b. Annual income;
 - c. ~~Financial situation and needs, including the financial resources used for the funding of the annuity;~~
 - d. Financial experience;
 - e. Financial objectives;
 - f. Intended use of the annuity;
 - g. Financial time horizon;
 - h. ~~Existing assets, including investment and life insurance holdings;~~
 - i. Liquidity needs;
 - j. Liquid net worth;
 - k. Risk tolerance; and
 - l. Tax status.

SECTION 3. AMENDMENT. Section 26.1-34.2-03 of the North Dakota Century Code is amended and reenacted as follows:

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,~~

including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

- a. TheA producer, if making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest ahead of the consumer's interest. A producer has acted in the best interest of the consumer if the producer has satisfied the following obligations regarding care, disclosure, conflict of interest, and documentation:
 - a. (1) The producer, in making a recommendation, shall exercise reasonable diligence, care, and skill to:
 - (a) Know the consumer's financial situation, insurance needs, and financial objectives;
 - (b) Understand the available recommendation options after making a reasonable inquiry into options available to the producer;
 - (c) Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs, and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and
 - (d) Communicate the basis or bases of the recommendation.
 - (2) The requirements under this subdivision include making reasonable efforts to obtain consumer profile information from the consumer before the recommendation of an annuity.
 - (3) The requirements under this subdivision require a producer to consider the types of products the producer is authorized and licensed to recommend or sell which address the consumer's financial situation, insurance needs, and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. A producer must be held to standards applicable to producers with similar authority and licensure.
 - (4) The requirements under this subdivision do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this chapter.
 - (5) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits, and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs, and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

- (6) The requirements under this subdivision include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit, or other insurance-related features.
 - (7) The requirements under this subdivision apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any.
 - (8) The requirements under this subdivision do not mean the annuity with the lowest one-time or multiple occurrence compensation structure necessarily must be recommended.
 - (9) The requirements under this subdivision do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be owed separately under the terms of a fiduciary, consulting, investment advising, or financial planning agreement between the consumer and the producer.
 - (10) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

 - (a) The consumer will incur a surrender charge; be subject to the commencement of a new surrender period; lose existing benefits, such as death, living, or other contractual benefits; or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;
 - (b) The replacing product would benefit the consumer substantially in comparison to the replaced product over the life of the product; and
 - (c) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding sixty months.
 - (11) This chapter may not be construed to require a producer to obtain a license other than a producer license with the appropriate line of authority to sell, solicit, or negotiate insurance in this state, including a securities license, in order to fulfill the duties and obligations contained in this chapter; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.
- b. (1) Before the recommendation or sale of an annuity, the producer prominently shall disclose to the consumer on a form substantially similar to a model form designed by the insurance department:
- (a) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;
 - (b) An affirmative statement on whether the producer is licensed and authorized to sell the following products:

- [1] Fixed annuities;
 - [2] Fixed indexed annuities;
 - [3] Variable annuities;
 - [4] Life insurance;
 - [5] Mutual funds;
 - [6] Stocks and bonds; and
 - [7] Certificates of deposit;
- (c) An affirmative statement describing the insurers the producer is authorized, contracted, or appointed, or otherwise able to sell insurance products for, using the following descriptions:
- [1] One insurer;
 - [2] From two or more insurers; or
 - [3] From two or more insurers although primarily contracted with one insurer.
- (d) A description of the sources and types of cash compensation and noncash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary, or other producer or by fee as a result of a contract for advice or consulting services; and
- (e) A notice of the consumer's right to request additional information regarding cash compensation described in subparagraph d;
- (2) Upon request of the consumer or the consumer's designated representative, the producer shall disclose:
- (a) A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and
 - (b) Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages;
- (3) Before or at the time of the recommendation or sale of an annuity, the producer must have a reasonable basis to believe the consumer has been reasonably informed of various features of the annuity, such as the potential surrender period and surrender charge; potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity; mortality and expense fees; investment advisory fees; annual fees; potential charges for and features of riders or other options of the

annuity; limitations on interest returns; potential changes in nonguaranteed elements of the annuity; insurance and investment components; and market risk;

- b. ~~The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization, or death or living benefit;~~
 - c. ~~The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable, and in the case of an exchange or replacement, the transaction as a whole is suitable, for the particular consumer based on the consumer's suitability information; and~~
 - d. ~~In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable, including taking into consideration whether:~~
 - (1) ~~The consumer will incur a surrender charge; be subject to the commencement of a new surrender period; lose existing benefits, such as death, living, or other contractual benefits; or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;~~
 - (2) ~~The consumer would benefit from product enhancements and improvements; and~~
 - (3) ~~The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding thirty-six months.~~
2. ~~Before the execution of a purchase, replacement, 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 the consumer's suitability information.~~
3. ~~Except as permitted under subsection 4, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information.~~
4. c. A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.
- d. At the time of recommendation or sale the producer shall:
- (1) Make a written record of any recommendation and the basis for the recommendation subject to this chapter;
 - (2) Obtain a consumer-signed statement on a form substantially similar to a model form established by the insurance department:
 - (a) A customer's refusal to provide the consumer profile information, if any; and

- (b) A customer's understanding of the ramifications of not providing the customer's consumer profile information or providing insufficient consumer profile information; and
- (3) Obtain a consumer-signed statement on a form substantially similar to a model form established by the insurance department acknowledging the annuity transaction is not recommended if a customer decides to enter an annuity transaction that is not based on the producer's recommendation.
- e. A requirement applicable to a producer under this subsection applies to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.
2. a. ~~Except as provided under subdivision b, neither an insurance producer, nor an insurer, has any~~ does not have an obligation to a consumer under subsection 1 or 3 related to any annuity transaction if:
- (1) A recommendation was not made;
 - (2) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;
 - (3) A consumer refuses to provide relevant ~~suitability~~ consumer profile information and the annuity transaction is not recommended; or
 - (4) A consumer decides to enter an annuity transaction that is not based on a recommendation of the ~~insurer or the insurance~~ producer.
- b. An insurer's issuance of an annuity subject to subdivision a must be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.
5. ~~An insurance producer or, when no insurance producer is involved, the responsible insurer representative, at the time of sale shall:~~
- a. ~~Make a record of any recommendation subject to subsection 1;~~
 - b. ~~Obtain a customer signed statement documenting a customer's refusal to provide suitability information, if any; and~~
 - c. ~~Obtain a customer signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter an annuity transaction that is not based on the insurance producer's or insurer's recommendation.~~
- 6-3. a. Except as permitted under subdivision b, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer's

financial situation, insurance needs, and financial objectives based on the consumer's consumer profile information.

- b. An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and the insurer's ~~insurance~~ producers' compliance with this chapter, including the following:
- (1) The insurer shall establish and maintain reasonable procedures to inform the insurer's ~~insurance~~ producers of the requirements of this chapter and shall incorporate the requirements of this chapter into relevant ~~insurance~~ producer training manuals.
 - (2) The insurer shall establish and maintain standards for insurance producer product training and shall maintain reasonable procedures to require the insurer's ~~insurance~~ producers to comply with the requirements of section 26.1-34.2-03.1.
 - (3) The insurer shall provide product-specific training and training materials that explain all material features of the insurer's annuity products to the insurer's ~~insurance~~ producers.
 - (4) The insurer shall establish and maintain procedures for the review of each recommendation before issuance of an annuity which are designed to ensure that there is a reasonable basis to determine that a ~~recommendation is suitable~~the recommended annuity effectively would address the particular consumer's financial situation, insurance needs, and financial objectives. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means, including physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria.
 - (5) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not ~~suitable~~in compliance with this paragraph and paragraphs 1, 2, and 4. This may include confirmation of the consumer ~~suitability~~profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations, and programs of internal monitoring. This paragraph does not prevent an insurer from complying with this paragraph by applying sampling procedures or by confirming ~~suitability~~the consumer profile information or other required information under this section after issuance or delivery of the annuity.
 - (6) ~~Annually, the insurer shall provide a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any. The insurer shall establish and maintain reasonable procedures to assess, before or upon issuance or delivery of an annuity, whether a producer has provided to the customer the information required to be provided under this section.~~

- b. (7) The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information.
- (8) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and noncash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subdivision are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees as long as those benefits are not based on the volume of sales of a specific annuity within a limited period of time.
- (9) Annually, the insurer shall provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.
- c. (1) This subsection does not restrict an insurer from contracting for performance of a function, including maintenance of procedures, required under this subdivision a. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to section 26.1-34.2-04, regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with paragraph 2.
- (2) An insurer's supervision system under ~~subdivision a~~this subsection must include supervision of contractual performance under this subsection. This includes the following:
- (a) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and
- (b) Annually, obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.
- e-d. ~~An insurer is not required to include in the insurer's system of supervision an insurance;~~
- (1) ~~A producer's recommendations to consumers of products other than the annuities offered by the insurer; or~~
- (2) Include consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.
- 7.4. ~~An insurance~~A producer or an insurer may not dissuade, or attempt to dissuade, a consumer from:
- a. Responding truthfully to an insurer's request for confirmation of ~~suitability~~the consumer profile information;

- b. Filing a complaint; or
 - c. Cooperating with the investigation of a complaint.
- 8.5. a. ~~Sales Recommendations and sales of annuities made in compliance with the financial industry regulatory authority requirements pertaining to suitability and supervision of annuity transactions comparable standards must satisfy the requirements under this chapter. This subsection applies to financial industry regulatory authority broker-dealer recommendations and sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales made by financial professionals in compliance with business rules, controls, and procedures that satisfy a comparable standard even if the standard would not otherwise apply to the product or recommendation at issue. However, this subsection does not limit the insurance commissioner's ability to enforce, including investigate, this chapter. This subdivision does not limit the insurer's obligation to comply with subdivision a of subsection 3 although the insurer may base the insurer's analysis on information received from either the financial professional or the entity supervising the financial professional.~~
- b. For subdivision a to apply, an insurer shall:
 - (1) Monitor ~~relevant conduct of the financial industry regulatory authority member broker-dealer professional seeking to rely upon subdivision a or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment advisor registered under federal or state securities laws~~ using information collected in the normal course of an insurer's business; and
 - (2) Provide to the ~~entity responsible for supervising the financial industry regulatory authority member broker-dealer professional seeking to rely on subdivision a, such as the financial professional's broker-dealer or investment advisor registered under federal or state securities laws,~~ information and reports that are reasonably appropriate to assist the ~~financial industry regulatory authority member broker-dealer~~ the ~~entity~~ to maintain its supervision system.

SECTION 4. AMENDMENT. Section 26.1-34.2-03.1 of the North Dakota Century Code is amended and reenacted as follows:

26.1-34.2-03.1. Insurance producer ~~Producer~~ training.

1. ~~An insurance~~ A producer may not solicit the sale of an annuity product unless the ~~insurance~~ producer has adequate knowledge of the product to recommend the annuity and the ~~insurance~~ producer is in compliance with the insurer's standards for product training. ~~An insurance~~ A producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.
2. a. (1) ~~An insurance~~ A producer who engages in the sale of annuity products shall complete a one-time, four-hour training course.
 - (2) ~~An insurance producer who holds a life insurance line of authority on August 1, 2011, and who desires to sell annuities shall complete the requirements of this subsection within twelve months after August 1,~~

~~2011. An individual who obtains a life insurance line of authority on or after August 1, 2011, may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.~~

- b. The training required under this subsection must include information on the following topics:
- (1) The types of annuities and various classifications of annuities;
 - (2) Identification of the parties to an annuity;
 - (3) How fixed, variable, and indexed annuity contract provisions affect consumers;
 - (4) The application of income taxation of qualified and nonqualified annuities;
 - (5) The primary uses of annuities; and
 - (6) Appropriate standards of conduct, sales practices, replacement, and disclosure requirements.
- c. Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and may not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.
- d. A producer who has completed an annuity training course approved by the insurance department before the effective date of this Act, within six months after such date, shall complete either:
- (1) A new four-credit training course approved by the insurance department after the effective date of this Act; or
 - (2) An additional one-time, one-credit training course approved by the insurance department and provided by an insurance department-approved education provider on appropriate sales practices, replacement, and disclosure requirements under this chapter.
- e. Providers of annuity training shall issue certificates of completion.
- e-f. The satisfaction of the training requirements of another state which are substantially similar to the provisions of this subsection are deemed to satisfy the training requirements of this subsection in this state.
- f-g. The satisfaction of the components of the training requirements of a course with components substantially similar to the provisions of this subsection is deemed to satisfy the training requirements of this subsection in this state.
- h. An insurer shall verify that ~~an insurance~~the producer has completed the annuity training course required under this subsection before allowing the

producer to sell an annuity product for that insurer. An insurer may satisfy the insurer's responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports from a reasonably reliable commercial database vendor that has a reporting arrangement with insurance education providers.

SECTION 5. AMENDMENT. Section 26.1-34.2-04 of the North Dakota Century Code is amended and reenacted as follows:

26.1-34.2-04. ~~Mitigation of responsibility~~ Compliance mitigation - Enforceability - Penalty.

1. An insurer is responsible for compliance with this chapter. If a violation occurs, either because of the action or inaction of the insurer or the insurer's ~~insurance~~ producer, the commissioner may order:
 - a. An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this chapter by the insurer ~~insurer~~ or by the ~~insurer's insurance producer's violation of this chapter~~ producer;
 - b. A general agency, independent agency, or the ~~insurance~~ producer to take reasonably appropriate corrective action for any consumer harmed by the ~~insurance producer's violation of this chapter~~; and
 - c. Appropriate penalties and sanctions.
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~~ this chapter 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.
3. The authority to enforce compliance with this section is vested exclusively with the commissioner.

SECTION 6. AMENDMENT. Section 26.1-34.2-05 of the North Dakota Century Code is amended and reenacted as follows:

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, disclosures made to the consumer, including summaries of oral disclosures, 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.

SECTION 7. EFFECTIVE DATE. This Act becomes effective January 1, 2022.

Approved March 23, 2021

Filed March 24, 2021

CHAPTER 239

SENATE BILL NO. 2073

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

AN ACT to create and enact chapter 26.1-36.8 of the North Dakota Century Code, relating to short-term limited-duration health insurance plans; to amend and reenact section 26.1-36.4-02 and subsection 7 of section 26.1-36.7-01 of the North Dakota Century Code, relating to short-term limited-duration health insurance plans; and to repeal section 26.1-36-49 of the North Dakota Century Code, relating to short-term limited-duration health insurance plans.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-36.4-02 of the North Dakota Century Code is amended and reenacted as follows:

26.1-36.4-02. Definitions.

As used in this chapter, the definitions in section 26.1-36.3-01 apply, unless the context otherwise requires. In addition:

1. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, or health maintenance organization that provides a plan of health insurance or health benefits subject to state insurance regulation.
2. "Policy" means any health benefit plan as defined in section 26.1-36.3-01, whether offered on a group or individual basis. The term does not include an individual short-term limited-duration health insurance plan offered in the individual market plan or association short-term limited-duration plan as defined in section 26.1-36.8-01.
3. ~~"Short-term limited-duration health insurance plan", except as required by the Health Insurance Portability and Accountability Act of 1996, is defined by section 26.1-36-49.~~

¹⁵³ **SECTION 2. AMENDMENT.** Subsection 7 of section 26.1-36.7-01 of the North Dakota Century Code is amended and reenacted as follows:

7. "Individual health benefit plan" means a health benefit plan offered to individuals, other than in connection with a group health benefit plan. The term does not include an individual short-term limited-duration health insurance plan or association short-term limited-duration plan as defined by section 26.1-36-49 26.1-36.8-01.

SECTION 3. Chapter 26.1-36.8 of the North Dakota Century Code is created and enacted as follows:

¹⁵³ Section 26.1-36.7-01 was also amended by section 2 of House Bill No. 1087, chapter 232.

26.1-36.8-01. Definitions.

1. "Association" means a group that has a constitution and bylaws, has been organized and maintained in good faith for the purposes other than that of obtaining insurance, and insures at least twenty-five members of the association for the benefit of persons other than the association or officers or trustees of the association.
2. "Association short-term limited-duration plan" means health insurance coverage provided to an association which has an expiration date specified in the policy which is no longer than twelve months after the original effective date of the policy and, taking into account any renewals or extensions, has a duration of no more than thirty-six months in total.
3. "Essential health benefits" means benefits pursuant to section 1302 of the federal Patient Protection and Affordable Care Act [42 U.S.C. 18022] and title 45, Code of Federal Regulations, section 156.110.
4. "Individual short-term limited-duration plan" means health insurance coverage provided pursuant to an individual insurance policy which has an expiration date specified in the policy which is no longer than twelve months after the original effective date of the policy including renewals or extension.

26.1-36.8-02. Individual short-term limited-duration plans.

1. An insurer issuing an individual short-term limited-duration plan shall provide, at the insured's option, for renewal or continuation of coverage.
2. An insurer may not subject an insured to additional underwriting at renewal or continuation of coverage and the insured shall remain within the same risk class as of the original effective date of the policy.
3. An insurer shall provide a notice of termination of the individual short-term limited-duration plan to the insured at least fifteen days before renewal or end of the policy term.

26.1-36.8-03. Association short-term limited-duration insurance plans.

1. For purposes of this section an association short-term limited-duration insurance plan approved under section 26.1-30-19 before August 1, 2021, may maintain the current plan and is not required to comply with the requirements of this section.
2. An insurer issuing a policy or certificate under this section shall provide, at the insured's option, for renewal or continuation of coverage. The renewal or continuation of coverage period may not extend for more than thirty-six months from the original effective date of the policy.
3. An insurer may not subject an insured to additional underwriting at renewal or continuation of coverage. An insurer offering a short-term limited-duration health insurance plan may not rate an insured based on any factor other than:
 - a. Geographic areas;
 - b. Tobacco use;

- c. Family size;
 - d. Age; and
 - e. Gender.
4. At a minimum, an association short-term limited-duration plan must cover the following:
- a. Ambulatory patient services in accordance with the essential health benefits;
 - b. Emergency services in accordance with the essential health benefits;
 - c. Hospitalization in accordance with the essential health benefits;
 - d. Pregnancy, maternity, and newborn care in accordance with the essential health benefits;
 - e. Mental health and substance use disorder services in accordance with the essential health benefits;
 - f. Prescription drugs in accordance with the essential health benefits;
 - g. Rehabilitative and habilitative services and devices in accordance with the essential health benefits;
 - h. Laboratory services in accordance with the essential health benefits; and
 - i. Preventive and wellness services in accordance with the essential health benefits.
5. An insurer shall provide a notice of termination of the policy or certificate to the insured at least fifteen days before renewal or end of the policy term.

26.1-36.8-04. Marketing and sales of individual and association plans.

- 1. All marketing materials related to the offering or sale of an individual or association short-term limited-duration plan must be filed with and approved by the commissioner before the plan is offered for sale in this state.
- 2. Sale of an individual or association short-term limited-duration plan is only allowed through a licensed and properly appointed insurance producer. An insurance producer's signature and identification number must be included on the prospective insured's application.

SECTION 4. REPEAL. Section 26.1-36-49 of the North Dakota Century Code is repealed.

Approved March 29, 2021

Filed March 30, 2021

CHAPTER 240

SENATE BILL NO. 2074

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

AN ACT to amend and reenact subsection 1 of section 26.1-36.4-09 of the North Dakota Century Code, relating to health insurance utilization reports; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-36.4-09 of the North Dakota Century Code is amended and reenacted as follows:

1. Once each calendar year, any employer with fifty-one or more eligible employees, any employer investigating becoming part of a health plan, including a plan sponsored by an association or a multiple employer welfare arrangement, or any employer upon termination of health insurance coverage ~~for any employer~~, the employer is entitled to a report from the insurer or administrator of that employer's employee health plan which includes a:
 - a. ~~monthly accounting for the most recent twenty-four month period of the total number of insured or covered employees, the total premiums paid, and the total benefits paid on behalf of the employer's health plan~~Annual data for the previous three years on the premiums paid by the employer and the claims paid by the insurer or administrator.
 - b. A current census of employees and dependents covered under the employer's health plan.

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

Approved April 23, 2021

Filed April 23, 2021

CHAPTER 241

HOUSE BILL NO. 1154

(Representative Keiser)
(Senators Klein, Vedaa)

AN ACT to create and enact chapter 26.1-36.9 and sections 26.1-47-02.2 and 26.1-47-02.3 of the North Dakota Century Code, relating to prior authorization of dental services, dental networks, and payment of dental claims.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

26.1-36.9-01. Definitions.

As used in this chapter:

1. "Dental benefit plan" means a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered through a dental insurer.
2. "Dental insurer" means a dental insurance company, dental service corporation, or dental plan organization authorized to provide dental benefits.
3. "Dental provider" means a licensed provider of dental services in this state.
4. "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.
5. "Prior authorization" means confirmation by the covered individual's dental benefit plan that the services sought to be provided by the dental provider meet the criteria for coverage under the covered individual's dental benefit plan as defined by the covered individual's dental benefit plan.

26.1-36.9-02. Dental benefit plans - Prior authorization.

A dental benefit plan may not deny a claim subsequently submitted by a dental provider for procedures specifically included in a prior authorization, unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached due to utilization after issuance of the prior authorization.
2. The documentation for the claim provided by the dental provider submitting the claim clearly fails to support the claim as originally authorized.
3. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the

prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.
5. The denial of the payment was due to one of the following:
 - a. Another payor is responsible for payment.
 - b. The dental provider already has been paid for the procedures identified on the claim.
 - c. The claim was submitted fraudulently.
 - d. The individual receiving the procedure was not eligible to receive the procedure on the date of service.

SECTION 2. Section 26.1-47-02.2 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.2. Dental networks.

1. As used in this section:
 - a. "Affiliate" means a person that directly or indirectly through one or more intermediaries controls, or is under the control of, or is under common control with, the person specified.
 - b. "Contracting entity" means a person that enters a direct contract with a dental provider for the delivery of dental services.
 - c. "Network" means a group of preferred dental providers providing services under a network plan.
 - d. "Network plan" means a dental benefit plan that requires a covered individual to use, or creates incentives, including financial incentives, for a covered individual to use a dental provider managed by, owned by, under contract with, or employed by the dental insurer.
 - e. "Third party" means an entity that is not a party to a contracting entity's dental provider network.
2. A contracting entity may grant a third party access to a dental provider network contract, or a provider's dental services or contractual discounts provided pursuant to a dental provider network contract, if all of the following are met:
 - a. The contract specifically states the contracting entity may enter an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

- b. If the contracting entity is a dental insurer, the dental provider may opt out of the third-party access at the time the dental provider network contract was entered or renewed.
 - c. The contracting entity identifies, in writing or electronic form to the dental provider, all third parties in existence as of the date the contract is entered or renewed.
 - d. The contracting entity notifies dental network providers that a new third party is leasing or purchasing the network at least thirty days in advance of the relationship taking effect.
 - e. The contracting entity makes available a copy of the dental provider network contract relied on in the adjudication of a claim to a participating dental provider within thirty days of a request from the dental provider.
3. A dental provider's refusal to agree in writing to the third-party access to the dental provider network does not permit the contracting entity to end the contractual relationship with the dental provider.
 4. The provisions of this section do not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity.

SECTION 3. Section 26.1-47-02.3 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.3. Postpayment of dental claims - Payment recovery limitations.

1. As used in this section, "dental care provider" means a licensed provider of dental care services in this state.
2. Other than recovery for duplicate payments, a dental insurer, if engaging in overpayment recovery efforts, shall provide written notice to the dental care provider which identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.
3. A dental insurer shall provide a dental care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for a dental care provider to follow to challenge an overpayment recovery.
4. A dental insurer may not initiate overpayment recovery efforts more than twelve months after the original payment for the claim was made. This time limit does not apply to overpayment recovery efforts that are:
 - a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;
 - b. Required by, or initiated at the request of, a self-insured plan; or
 - c. Required by a state or federal government plan.

Filed March 26, 2021

CHAPTER 242

HOUSE BILL NO. 1032

(Legislative Management)
(Health Care Committee)

AN ACT to create and enact a new chapter to title 26.1 of the North Dakota Century Code, relating to prescription drug cost transparency; to amend and reenact section 43-15.3-12 of the North Dakota Century Code, relating to wholesale drug license fees; to provide a continuing appropriation; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

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

Definitions.

As used in this chapter:

1. "Board" means the state board of pharmacy.
2. "Commissioner" means the insurance commissioner.
3. "Concession" includes a free good, delayed billing, and billing forgiveness.
4. "Drug" has the same meaning as provided under section 19-02.1-01.
5. "Drug manufacturer" means the entity that holds the national drug code for a drug which is engaged in the production, preparation, propagation, compounding, conversion, or processing of the drug or which is engaged in the packaging, repackaging, labeling, relabeling, or distribution of the drug. The term does not include a wholesale drug distributor or retail pharmacy licensed in this state.
6. "Health care plan" means an individual, blanket, or group plan, policy, or contract for health care services issued or delivered in this state by a health insurer.
7. "Health insurer" means an insurance company, nonprofit health service corporation, health maintenance organization, third-party payer, health program administered by a state agency other than the department of human services or state department of health, or other person engaged as principal in the business of insurance which issues or delivers a health care plan in this state.
8. "Manufacturer-packaged drug container" means a drug manufacturer-prepared supply of medication packaged in a container with a unique product-identifying national drug code number.

9. "Net spending" means the cost of drugs minus any discounts that lower the price of the drugs, including a rebate, fee, retained price protection, retail pharmacy network spread, and dispensing fee.
10. "Pharmacy benefits manager" has the same meaning as provided under section 19-03.6-01. The term does not include the department of human services or state department of health.
11. "Prescription drug" has the same meaning as under section 43-15-01.
12. "Rebate" includes any discount, financial incentive, or concession that affects the price of a drug to a pharmacy benefits manager or health insurer for a drug manufactured by the drug manufacturer.
13. "Specialty drug" has the same meaning as provided under section 19-02.1-16.2.
14. "Utilization management" means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.
15. "Wholesale acquisition cost" means, with respect to a prescription drug, the drug manufacturer's list price for the prescription drug to wholesalers or direct purchasers in the United States for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug pricing data, such as Medi-Span Price Rx, Gold Standard Drug Database, or First Databank drug data. The term does not include a rebate, prompt pay, or other discount or other reduction in price.

Disclosure of drug pricing information.

1. Each drug manufacturer shall submit a report to the commissioner no later than the fifteenth day of January, April, July, and October with the current wholesale acquisition cost information for the prescription drugs sold in or into the state by that drug manufacturer.
2. a. Not more than thirty days after an increase in wholesale acquisition cost of forty percent or greater over the preceding five calendar years or ten percent or greater in the preceding twelve months for a prescription drug with a wholesale acquisition cost of seventy dollars or more for a manufacturer-packaged drug container, a drug manufacturer shall submit a report to the commissioner. The report must contain the following information:
 - (1) Name of the drug;
 - (2) Whether the drug is a brand name or a generic;
 - (3) The effective date of the change in wholesale acquisition cost;
 - (4) Aggregate, company-level research and development costs for the previous calendar year;
 - (5) Aggregate rebate amounts paid to each pharmacy benefits manager for the previous calendar year;

2. Reports submitted by pharmacy benefits managers under this section may not disclose the identity of a specific health benefit plan or enrollee, the identity of a drug manufacturer, the prices charged for specific drugs or classes of drugs, or the amount of any rebates or fees provided for specific drugs or classes of drugs.

Disclosure of health insurer spending information.

1. On or before April first of each year, each health insurer shall submit a report to the commissioner. The report must contain the following information for the previous two calendar years:
 - a. Names of the twenty-five most frequently prescribed drugs across all plans;
 - b. Names of the twenty-five prescription drugs dispensed with the highest dollar spend in terms of gross revenue;
 - c. Percent increase in annual net spending for prescription drugs across all plans;
 - d. Percent increase in premiums which is attributable to prescription drugs across all plans;
 - e. Percentage of specialty drugs with utilization management requirements across all plans; and
 - f. Premium reductions attributable to specialty drug utilization management.
2. A report submitted by a health insurer may not disclose the identity of a specific health benefit plan or the prices charged for specific prescription drugs or classes of prescription drugs.

Website.

1. The commissioner shall develop a website to publish information the commissioner receives under this chapter. The commissioner shall make the website available on the commissioner's website with a dedicated link prominently displayed on the home page, or by a separate, easily identifiable internet address.
2. Within sixty days of receipt of reported information under this chapter, the commissioner shall publish the reported information on the website developed under this section. The information the commissioner publishes may not disclose or tend to disclose trade secret, proprietary, commercial, financial, or confidential information of any pharmacy, pharmacy benefits manager, drug wholesaler, or hospital.

Rulemaking - Forms - Services - Records.

1. The commissioner may adopt rules to implement this chapter.
2. In consultation with the board, the commissioner shall develop forms that must be used for reporting required under this chapter.
3. The commissioner may contract for services to implement this chapter.

4. A report received by the commissioner is an exempt record as defined by section 44-04-17.1; however, as provided under section 44-04-18.4 any portion of a report which discloses trade secret, proprietary, commercial, or financial information is confidential if it is of a privileged nature and has not been previously publicly disclosed.

Drug pricing fund - Transfer - Continuing appropriation.

There is created in the state treasury the drug pricing fund, which consists of any money deposited in the fund by the board and any interest earned on moneys in the fund. The board may deposit up to six hundred dollars of every wholesaler license fee and every virtual wholesaler license fee collected by the board under section 43-15.3-12 to the drug pricing fund. All moneys in the fund, not otherwise appropriated, are appropriated to the insurance department to implement this chapter.

Civil penalty.

A health insurer, drug manufacturer, or pharmacy benefits manager that violates this chapter is subject to the imposition by the attorney general of a civil penalty not to exceed ten thousand dollars for each violation. The attorney general may waive or reduce a fine under this section upon a finding of good cause, such as excusable neglect or other extenuating circumstances. The fine may be collected and recovered in an action brought in the name of the state.

SECTION 2. AMENDMENT. Section 43-15.3-12 of the North Dakota Century Code is amended and reenacted as follows:

43-15.3-12. Fees.

The board shall charge and collect the following fees under this chapter:

Chain drug warehouse	\$200
Chain pharmacy warehouse	\$200
Durable medical equipment distributor, medical gas distributor, or both	\$200
Durable medical equipment retailer, medical gas retailer and distributor, or both	\$300
Hospital offsite warehouse	\$200
Jobber or broker	\$400 <u>Not to exceed \$1,000</u>
Manufacturer	\$400 <u>Not to exceed \$1,000</u>
Medical gas retailer, durable medical equipment retailer, or both	\$200
Medical gas durable medical equipment distributor and retailer	\$300
Outsourcing facility	\$200
Own label distributor	\$400 <u>Not to exceed \$1,000</u>
Pharmacy distributor	\$200
Private label distributor	\$400 <u>Not to exceed \$1,000</u>
Repackager	\$400 <u>Not to exceed \$1,000</u>
Reverse distributor	\$200
Third-party logistic provider	\$400 <u>Not to exceed \$1,000</u>
Veterinary-only distributor	\$200
Virtual manufacturer	\$400
Virtual wholesaler or distributor	\$400 <u>Not to exceed \$1,000</u>
Wholesaler or distributor	\$400 <u>Not to exceed \$1,000</u>

Approved April 27, 2021

Filed April 28, 2021

CHAPTER 243

HOUSE BILL NO. 1493

(Representatives Weisz, Beltz, Fegley, Skroch)
(Senator Lee)

AN ACT to amend and reenact section 26.1-47-10 of the North Dakota Century Code and section 10 of chapter 194 of the 2017 Session Laws, relating to air ambulance services; and to provide for ambulance service operation funding.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

¹⁵⁴ **SECTION 1. AMENDMENT.** Section 26.1-47-10 of the North Dakota Century Code is amended and reenacted as follows:

26.1-47-10. Preferred provider arrangements - Requirements for accessing air ambulance providers. (~~Contingent effective date~~ - [See note](#))

1. In addition to the other preferred provider arrangement requirements under this chapter, a preferred provider arrangement must require the health care insurer and health care provider comply with this section.
2. Except as otherwise provided under this section, before a health care provider arranges for air ambulance services for an individual the health care provider knows to be a covered person, the health care provider shall request a prior authorization from the covered person's health care insurer for the air ambulance services to be provided to the covered person. If the health care provider is unable to request or obtain prior authorization from the covered person's health care insurer:
 - a. The health care provider shall provide the covered person or the covered person's authorized representative an out-of-network services written disclosure stating the following:
 - (1) Certain air ambulance providers may be called upon to render care to the covered person during the course of treatment;
 - (2) These air ambulance providers might not have contracts with the covered person's health care insurer and are, therefore, considered to be out of network;
 - (3) If these air ambulance providers do not have contracts with the covered person's health care insurer, the air ambulance services will be provided on an out-of-network basis;
 - (4) A description of the range of the charges for the out-of-network air ambulance services for which the covered person may be responsible;

¹⁵⁴ Section 26.1-47-10 was also amended by section 326 of House Bill No. 1247, chapter 352.

- (5) A notification the covered person or the covered person's authorized representative may agree to accept and pay the charges for the out-of-network air ambulance services, contact the covered person's health care insurer for additional assistance, or rely on other rights and remedies that may be available under state or federal law; and
 - (6) A statement indicating the covered person or the covered person's authorized representative may obtain a list of air ambulance providers from the covered person's health care insurer which are preferred providers and the covered person or the covered person's representative may request those participating air ambulance providers be accessed by the health care provider.
 - b. Before air ambulance services are accessed for the covered person, the health care provider shall provide the covered person or the covered person's authorized representative the written disclosure, as outlined by subdivision a and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging the covered person or the covered person's authorized representative received the disclosure document before the air ambulance services were accessed. If the health care provider is unable to provide the written disclosure or obtain the signature required under this subdivision, the health care provider shall document the reason, which may include the health and safety of the patient. The health care provider documentation satisfies the requirement under this subdivision.
3. This section does not:
 - a. ~~Preclude a covered person from agreeing to accept and pay the charges for the out-of-network services and not access the covered person's health care insurer's out-of-network air ambulance billing process described under this section.~~
 - b. ~~Preclude a covered person from agreeing to accept and pay the bill received from the out-of-network air ambulance provider or from not accessing the air ambulance provider mediation process described under this section.~~
 - c. ~~Regulate an out-of-network air ambulance provider's ability to charge certain fees for services or to charge any amount of fee for services provided to a covered person by the out-of-network air ambulance provider.~~
4. ~~A health care insurer shall develop a program for payment of out-of-network air ambulance bills submitted under this section. A health benefit plan may not be issued in this state without the terms of the health benefit plan including the provisions of the health care insurer's program for payment of out-of-network air ambulance bills.~~
 - a. ~~A health care insurer may elect to pay out-of-network air ambulance provider bills as submitted, or the health care insurer may elect to use the out-of-network air ambulance provider mediation process described in subsection 5.~~

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- b. ~~This section does not preclude a health care insurer and an out-of-network facility air ambulance provider from agreeing to a separate payment arrangement.~~
5. ~~A health care insurer shall establish an air ambulance provider mediation process for payment of out-of-network air ambulance provider bills. A health benefit plan may not be issued in this state if the terms of the health benefit plan do not include the provisions of the health care insurer's air ambulance provider mediation process for payment of out-of-network air ambulance provider bills.~~
- a. ~~A health care insurer's air ambulance provider mediation process must be established in accordance with mediation standards recognized by the department by rule.~~
 - b. ~~If the health care insurer and the out-of-network air ambulance provider agree to a separate payment arrangement or if the covered person agrees to accept and pay the out-of-network air ambulance provider's charges for the out-of-network services, compliance with the air ambulance provider mediation process is not required.~~
 - c. ~~A health care insurer shall maintain records on all requests for mediation and completed mediation under this subsection for one year and, upon request of the commissioner, submit a report to the commissioner in the format specified by the commissioner.~~
6. The rights and remedies provided under this section to covered persons are in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.
- ~~7.4.~~ The department shall enforce this section and shall report a violation of this section by a facility to the state department of health.
- ~~8.5.~~ This section does not apply to a policy or certificate of insurance, whether written on a group or individual basis, which provides coverage limited to:
- a. A specified disease, a specified accident, or accident-only coverage;
 - b. Credit;
 - c. Dental;
 - d. Disability;
 - e. Hospital;
 - f. Long-term care insurance as defined by chapter 26.1-45;
 - g. Vision care or any other limited supplemental benefit;
 - h. A Medicare supplement policy of insurance, as defined by the commissioner by rule or coverage under a plan through Medicare;
 - i. Medicaid;

- j. The federal employees health benefits program and any coverage issued as a supplement to that coverage;
- k. Coverage issued as supplemental to liability insurance, workers' compensation, or similar insurance; or
- l. Automobile medical payment insurance.

9-6. A health care provider is exempt from complying with this section if the health care provider determines and documents that due to emergency circumstances, compliance might jeopardize the health or safety of the patient.

7. The commissioner may adopt rules to implement this section.

155 **SECTION 2. AMENDMENT.** Section 10 of chapter 194 of the 2017 Session Laws is amended and reenacted as follows:

SECTION 10. EFFECTIVE DATE – ~~CONTINGENT EFFECTIVE DATE.~~
 Sections 2, 4, 5, and 6 of this Act become effective January 1, 2018. ~~If section 6 of this Act is declared invalid, sections~~ Sections 3, 7, and 8 of this Act become effective on the date the insurance commissioner certifies the invalidity of section 6 to the secretary of state and the legislative council ~~August 1, 2021.~~

SECTION 3. AMBULANCE SERVICE OPERATION FUNDING DISTRIBUTION.
 Notwithstanding section 23-46-04, during the biennium beginning July 1, 2021, and ending June 30, 2023, the state department of health, in consultation with the emergency medical services advisory council, shall provide state financial assistance annually to each eligible ambulance service operation pursuant to the following calculation:

1. The minimum reasonable budget for each operation must be determined by adding the product of the operation's average number of runs for the two most recent calendar years multiplied by the median cost of a run. The cost of a run is determined using statewide data. The minimum budget for each ambulance service operation may not be less than \$60,000, or other base amount determined by the department.
2. The operation's grant amount must be determined by deducting the following amounts from the operation's budget calculated under subsection 1:
 - a. The product of the operation's average number of runs for the two most recent calendar years multiplied by the median amount of reimbursement for a run. The reimbursement amount for a run is determined using statewide data; and
 - b. The product of the property tax valuation, as provided to the state department of health by the county auditor no later than July thirty-first of each year, of the operation's response area for the prior taxable year multiplied by five mills. If the response area covers multiple counties, the county auditor with the most response area is responsible for coordinating with the other county auditors.

155 Section 26.1-47-01 was also amended by section 325 of House Bill No. 1247, chapter 352.

3. The department shall distribute a prorated share of the operation's calculated grant amount if legislative appropriations for state financial assistance for emergency medical services is not sufficient to provide full grant funding calculated under this section.
4. An operation is not eligible to receive funding under this section if the operation's average number of runs for the two most recent fiscal years is more than seven hundred.

Approved April 23, 2021

Filed April 23, 2021