LEGISLATIVE BILL 1139

Approved by the Governor April 19, 2002

Introduced by Landis, 46

AN ACT relating to insurance; to amend sections 44-1527, 44-1984, 44-2127, 44-2845, 44-32,161, 44-4834, 44-4842, 44-4859, 44-5120, 44-5260, 44-5261, 44-5601, 44-5603, 44-5814, 44-5815, and 44-6916, Reissue Revised Statutes of Nebraska, sections 44-787, 44-19,116, 44-5223, 44-5225, 44-5504, 44-6901, 44-6918, 44-7505, 44-7509, 44-7510, 44-7511, 44-7513, and 44-7515, Revised Statutes Supplement, 2000, and section 44-5503, Revised Statutes Supplement, 2001; to adopt the Multiple Employer Welfare Arrangement Act; to provide penalties; to change provisions relating to investigations, title insurers, mergers, medical review panels, priority of claims, bonding requirements, securities, the Small Employer Health Insurance Availability Act, filing requirements, reinsurance, group health plans, and rates and forms; to require certification of coverage; to harmonize provisions; to provide operative dates; and to repeal the original sections.

Be it enacted by the people of the State of Nebraska,

Section 1. Sections 1 to 17 of this act shall be known and may be cited as the Multiple Employer Welfare Arrangement Act.

Sec. 2. (1) The Legislature finds and declares that the United States Congress recognized multiple employer welfare arrangements as vehicles for offering traditional accident and health benefit programs through the Employee Retirement Income Security Act of 1974. Multiple employer welfare arrangements may be subject to state regulatory and fiscal standards not inconsistent with the federal act if the multiple employer welfare arrangement offers health benefit plans that are not fully insured. The provisions of the Multiple Employer Welfare Arrangement Act are consistent with and authorized by the federal act, which confers upon the states authority to regulate multiple employer welfare arrangements.

(2) It is the intent of the Legislature:

(a) To promote the legitimacy and the financial integrity of health benefit plans that are not fully insured by requiring multiple employer welfare arrangements offering such plans to obtain a certificate of registration from the director;

(b) That the Multiple Employer Welfare Arrangement Act not apply to fully insured health benefit plans offered by multiple employer welfare arrangements;

(c) That the act shall be construed to mean that multiple employer welfare arrangements are not insurers for purposes of the insurance laws of this state; and

(d) That the insurance laws of this state not apply to health benefit plans offered by multiple employer welfare arrangements except as specifically set forth in the act.

Sec. 3. For purposes of the Multiple Employer Welfare Arrangement Act:

(1) Certificate of registration means a document issued by the director authorizing a multiple employer welfare arrangement to offer a health benefit plan that is not fully insured;

(2) Covered employee means an employee who is covered by a health benefit plan provided through a multiple employer welfare arrangement in which the employer is participating. Covered employee includes a dependent of an employee as defined under the terms of the health benefit plan;

(3) Director means the Director of Insurance;

(4) Fully insured health benefit plan means a health benefit plan which provides for health benefits, all of which are guaranteed under a contract or policy of insurance issued by an insurance company licensed to transact the business of insurance in this state;

(5) Health benefit plan means an employee welfare benefit plan to the extent that it provides any hospital, surgical, or medical expense benefits to covered employees directly or through insurance, reimbursement, or otherwise. Health benefit plan does not include (a) accident-only, disability income, hospital confinement indemnity, dental, or credit insurance, (b) coverage issued as a supplement to liability insurance, (c) medicare or insurance provided as a supplement to medicare, (d) insurance arising from workers' compensation provisions, (e) automobile medical payment insurance,

(f) any other specific limited coverage, or (g) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy;

(6) Multiple employer welfare arrangement means a multiple employer welfare arrangement as defined by 29 U.S.C. 1002, as such section existed on January 1, 2002, if the multiple employer welfare arrangement is sponsored by an association of employers that offers a health benefit plan that is not fully insured; and

(7) Participating employer means an employer that participates in a multiple employer welfare arrangement.

Sec. 4. No multiple employer welfare arrangement may offer to an employer that is domiciled in this state or has its principal headquarters or principal administrative offices in this state a health benefit plan unless the health benefit plan is a fully insured health benefit plan or unless the multiple employer welfare arrangement obtains and maintains a certificate of registration pursuant to the Multiple Employer Welfare Arrangement Act.

Sec. 5. (1) A multiple employer welfare arrangement seeking to offer a health benefit plan that is not fully insured shall apply for a certificate of registration in a form prescribed by the director. The application shall be completed and submitted to the director together with a one-thousand-dollar fee and the following:

(a) Copies of all articles, bylaws, agreements, and other documents or instruments describing the organizational structure of the applicant;

(b) Copies of all materials and documents describing the rights and obligations of participating employers and covered employees with respect to the applicant;

(c) A copy of the trust agreement of the applicant;

(d) A copy of the unaudited financial statement required by section 13 of this act;

(e) A statement showing in full detail the plan for offering a health benefit plan by the applicant;

(f) Copies of all contracts and other instruments proposed to be made, offered, or sold by the applicant to its participating employers, together with a copy of its summary plan description and the proposed advertising matter to be used in the solicitation of participating employers;

(g) A copy of the contract with the third-party administrator retained, if any, to administer the health benefit plan;

(h) A copy of the stop-loss insurance policy required by section 9 of this act; and

(i) Any other reasonable information requested by the director.

(2) The director shall deny a certificate of registration if the applicant does not meet the requirements of the Multiple Employer Welfare Arrangement Act. Notice of denial shall be in writing and shall set forth the basis for the denial. If the applicant submits a written request for reconsideration within thirty days after the notice was sent by the director, the director shall conduct a hearing on the denial pursuant to the Administrative Procedure Act.

Sec. 6. A multiple employer welfare arrangement may only be established and maintained by an association of employers. The association shall not condition membership in the association, the amounts of dues or other payments for membership, or coverage under a health benefit plan on the basis of health-status-related factors with respect to the employees offered coverage under the health benefit plan. The association shall:

(1) Have been in existence and engaged in substantive activity for its members other than sponsorship of a health benefit plan for more than three years prior to application for a certificate of registration;

(2) Be composed of two or more members, all of which are in the same trade or industry; and

(3) Have, before application for a certificate of registration is made, applications for participation from two or more members who are employers with an aggregate of two hundred or more participating employees.

Sec. 7. (1) A multiple employer welfare arrangement offering a health benefit plan that is not fully insured shall establish a trust pursuant to a written trust agreement to hold all funds pertaining to the health benefit plan. The trust shall be operated by a board of trustees pursuant to the trust agreement.

(2)(a) All members of the board of trustees shall be owners, partners, officers, directors, or employees of one or more participating employers.

(b) No person may be a member of the board of trustees if such person:

(i) Is an owner, officer or employee, or a partner in, or a contract

administrator, or other service provider to the health benefit plan or of any third-party administrator of the multiple employer welfare arrangement; or

(ii) Has been convicted of any felony or a Class I, II, or III misdemeanor.

Sec. 8. The board of trustees of the multiple employer welfare arrangement as required by section 7 of this act shall:

(1) Serve as a fiduciary of the trust;

(2) Be responsible as plan administrator for all operations of the health benefit plan;

(3) Have in effect rules of operation and financial control based on an annual plan of operation, adequate to carry out the terms of the health benefit plan and to meet all requirements of the Multiple Employer Welfare Arrangement Act;

(4) Consider applications of association members for participation in the multiple employer welfare arrangement; and

(5) Hold and maintain a stop-loss insurance policy pursuant to the requirements of section 9 of this act.

Sec. 9. (1) A multiple employer welfare arrangement offering a health benefit plan that is not fully insured shall be a named insured under a stop-loss insurance policy that provides coverage in excess of the multiple employer welfare arrangement's retention of one hundred twenty-five percent of the multiple employer welfare arrangement's expected health claims costs as determined on an aggregate basis.

(2) A policy issued to satisfy the requirements of subsection (1) of this section shall:

(a) Be evidenced by a binder or policy by an insurer licensed to transact the business of insurance in this state; and

(b) Contain a provision that the coverage may not be terminated by the insurer unless the multiple employer welfare arrangement and the director receive a written notice of termination from the insurer at least thirty days before the effective date of the termination.

Sec. 10. If the assets of, and stop-loss insurance policy issued to, a multiple employer welfare arrangement are at any time insufficient to pay claims made against a health benefit plan, discharge liabilities and obligations relating to health benefit plan claims, and maintain adequate reserves and surpluses, the board of trustees shall be authorized to assess the participating employers in an amount necessary to remedy the deficiency.

Sec. 11. Any participating employer that voluntarily terminates its participation in the multiple employer welfare arrangement or that is involuntarily terminated by the multiple employer welfare arrangement shall remain liable subsequent to the date of termination for all contractual obligations it has entered into with the multiple employer welfare arrangement on or before the date of termination.

Sec. 12. (1) A multiple employer welfare arrangement shall notify in writing each participating employer and each employee applying for coverage by the multiple employer welfare arrangement that a health benefit plan provided by the multiple employer welfare arrangement is not:

(a) Insurance;

(b) Subject to state laws and requirements that apply to health insurance offered by a licensed insurer; and

(c) Covered by the Nebraska Life and Health Insurance Guaranty Association.

(2) The notice required by subsection (1) of this section shall, in ten-point or greater type, disclose that the multiple employer welfare arrangement is authorized under state law to assess participating employers for claims under the health benefit plan in addition to other remedies the multiple employer welfare arrangement may take if the multiple employer welfare arrangement is unable to pay claims.

Sec. 13. (1) On an annual basis, each multiple employer welfare arrangement holding a certificate of registration shall file with the director a financial statement, attested to by the board of trustees and accompanied by a fee of two hundred dollars. The director shall review the financial statement and shall require additional filings as the director finds reasonably necessary to assure the legitimacy and the financial integrity of the multiple employer welfare arrangement.

(2) On an annual basis, a statement from a qualified actuary that the rates charged and reserves, both (a) incurred and (b) incurred but not reported, regarding sufficiency to pay claims and associated expenses for the health benefit plan shall be obtained and given to the director. The actuarial statement shall include a confirmation that the stop-loss insurance policy required by section 9 of this act is in force. The actuarial statement shall meet the requirements of any rules or regulations which shall be adopted

and promulgated by the director.

Sec. 14. (1) After notice and a hearing conducted pursuant to the Administrative Procedure Act, the director may suspend or revoke a certificate of registration or may impose an administrative fine not to exceed one thousand dollars per violation, or any combination of actions, if the director finds the multiple employer welfare arrangement:

(a) Fails to maintain the stop-loss insurance policy as required by section 9 of this act;

(b) Engages in financial practices that make further transaction of business in this state hazardous or injurious to its participating employers, covered employees, or the public;

(c) Within fifteen business days, fails to respond or request a reasonable amount of additional time to respond in which time a response is made, to an inquiry of the director;

(d) Fails for an unreasonable period to pay any final judgment rendered against it in this state on any contractual obligation;

(e) Conducts business fraudulently or has not met its contractual obligations in good faith;

(f) Made, published, disseminated, circulated, or placed before the public or caused, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the health benefit plan or with respect to any insurer in the conduct of his or her business which is untrue, deceptive, or misleading; or

(g) Violates any provision of the Multiple Employer Welfare Arrangement Act or section 44-106 or 44-114.

(2) Instead of or in addition to the penalties set forth in subsection (1) of this section, the director may issue a cease and desist order to a multiple employer welfare arrangement if such multiple employer welfare arrangement engages in any of the activities set forth in subsection (1) of this section.

Sec. 15. The director may adopt and promulgate rules and regulations to carry out the Multiple Employer Welfare Arrangement Act.

Sec. 16. (1) The offering of a health benefit plan by any multiple employer welfare arrangement shall not be deemed transacting business as an insurer, association, or exchange, except as specifically set forth in the Multiple Employer Welfare Arrangement Act. The insurance laws of this state do not apply to health benefit plans offered by multiple employer welfare arrangements except as specifically set forth in the act.

(2) Nothing in the act shall be construed to include an insolvent multiple employer welfare arrangement within the provisions of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Sec. 17. The Multiple Employer Welfare Arrangement Act shall apply to multiple employer welfare arrangements offering health benefit plans on or after the operative date of this section.

Sec. 18. Section 44-787, Revised Statutes Supplement, 2000, is amended to read:

44-787. (1) All individual health insurance policies and contracts issued by health carriers providing benefits consisting of medical care, which are provided directly, through insurance or reimbursement, under any hospital or medical service policy, hospital or medical service plan contract, or health maintenance organization contract shall be renewable at the option of the covered individual, except in any of the following cases:

(a) The covered individual has failed to pay premiums or contributions in accordance with the terms of the individual policy or contract or the health carrier has not received timely premium payments;

(b) The covered individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) A health carrier decides to discontinue offering a particular type of individual policy or contract in this state. A health carrier discontinuing such individual policy or contract shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all covered individuals, and to the commissioner of insurance in each state in which a covered individual is known to reside, at least ninety days prior to the nonrenewal of any individual policies or contracts by the health carrier. Notice to the director shall be provided at least three working days prior to

the notice to the covered individuals;

(iii) Offer to each covered individual provided the type of individual policy or contract the option to purchase all other individual policies or contracts currently being offered by the health carrier to individuals in this state; and

(iv) In exercising the option to discontinue the particular type of individual policy or contract and in offering the option of coverage under subdivision (1)(c)(iii) of this section, act uniformly without regard to any health-status-related factor relating to any covered individual who may become eligible for such coverage;

(d) A health carrier decides to discontinue offering and nonrenews all its individual policies and contracts delivered or issued for delivery to individuals in this state. A health carrier that discontinues such individual policies and contracts shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all covered individuals, and to the commissioner of insurance in each state in which a covered individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any individual policies or contracts by the health carrier. Notice to the director shall be provided at least three working days prior to the notice to the covered individuals; and

(iii) Discontinue all health insurance issued or delivered for issuance in the state's individual market and not renew coverage under any individual policy or contract issued to an individual; and

(e) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the covered individuals; or

(ii) Impair the health carrier's ability to meet its contractual obligations.

(2) A health carrier that elects not to renew all of its individual policies or contracts in the state under subdivision (1)(d) of this section shall be prohibited from writing new business in the individual market in this state for a period of five years after the date of notice to the director.

(3) A health carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (1) of this section in the case of an individual who no longer resides, lives, or works in the service area of the health carrier or in an area for which the health carrier is authorized to do business, but only if coverage is terminated under this section uniformly without regard to any health-status-related factor of covered individuals.

(4)(a) Health carriers shall provide written certification of creditable coverage to individuals covered under an individual health insurance policy or contract at the time:

(i) An individual ceases to be covered under the health insurance policy or contract; and

(ii) A request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage.

(b) The certificate of creditable coverage shall contain:

(i) Written certification of the period of creditable coverage of the individual under the health insurance policy or contract; and

(ii) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health insurance policy or contract.

(c) The entity providing the information pursuant to subdivision (4)(a) of this section may charge the requesting group health plan the reasonable cost of disclosing the information.

(5) For purposes of this section:

(a) Director means the Director of Insurance;

(b) Health carrier means any entity that issues a health insurance policy or contract, including an insurance company, a fraternal benefit society, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(c) Health-status-related factor means any of the following factors:

(i) Health status;

(ii) Medical condition, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(viii) Disability;

(d)(i) Individual policy or contract does not include one or more, or any combination, of the following:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for onsite medical clinics; and

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

(ii) Individual policy or contract does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the policy or contract:

(A) Limited-scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(C) Such other similar, limited benefits as are specified in federal regulations.

(iii) Individual policy or contract does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance:

(A) Coverage only for a specified disease or illness; and

(B) Hospital indemnity or other fixed indemnity insurance.

(iv) Individual policy or contract does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss, as such section existed on January 1, 2002;

(B) Coverage supplemental to the coverage provided under 10 U.S.C. ~~5501 et seq.~~ chapter 55, as such chapter existed on January 1, 2002;

(C) Similar supplemental coverage provided to coverage under a group health plan; and

(D) Short-term limited duration insurance that has an expiration date specified in the contract that is within twelve months of the effective date of the contract; and

(e) Network plan means health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

Sec. 19. Section 44-1527, Reissue Revised Statutes of Nebraska, is amended to read:

44-1527. The director may examine and investigate the affairs of every insurer doing business in this state in order to determine whether such insurer has been or is engaged in any unfair trade practice defined in section 44-1524. An insurer other than an agent, broker, or insurance consultant shall reimburse the department for the expense of examination in the same manner as provided for examination of insurance companies in the Insurers Examination Act. In the case of a depository institution, the director may examine and investigate the insurance activities of a depository institution in order to determine whether the depository institution has been or is engaged in any unfair trade practice defined in section 44-1524. The director shall notify the appropriate state or federal banking agency of the director's intent to examine and investigate a depository institution and advise the appropriate state or federal banking agency of the suspected violations of state law prior to commencing the examination and investigation.

Sec. 20. Section 44-1984, Reissue Revised Statutes of Nebraska, is amended to read:

44-1984. (1) No insurer that transacts any line of business other than title insurance shall be eligible for the issuance or renewal of a certificate of authority to transact the business of title insurance in this state nor shall title insurance be transacted, underwritten, or issued by any insurer transacting or authorized to transact any other line of business.

(2)(a) Notwithstanding subsection (1) of this section, ~~and to the extent such coverage is lawful within this state, a title insurer is expressly~~

~~authorized~~ ~~to~~ a title insurer shall issue closing or settlement protection ~~to~~ covering a proposed insured ~~upon request~~ if the title insurer issues a title insurance commitment or title insurance policy. Such closing or settlement protection shall conform to the terms of coverage and form of instrument as required by the director and ~~may~~ shall indemnify a proposed insured solely against loss of settlement funds only because of the following acts of a title insurer's named title insurance agent:

(i) Theft of settlement funds; and

(ii) Failure to comply with written closing instructions by the proposed insured when agreed to by the title insurance agent relating to title insurance coverage.

(b) The director may prescribe or approve a required charge for providing the coverage.

(c) A title insurer shall not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement, or closing services.

Sec. 21. Section 44-19,116, Revised Statutes Supplement, 2000, is amended to read:

44-19,116. (1)(a) A title insurance agent may operate as an escrow, security, settlement, or closing agent subject to the requirements of subdivisions (b) through (e) of this subsection.

(b) All funds deposited with the title insurance agent in connection with an escrow, settlement, closing, or security deposit shall be submitted for collection to or deposited in a separate fiduciary trust account or accounts in a qualified financial institution no later than the close of the next business day in accordance with the following requirements:

(i) The funds shall be the property of the person or persons entitled to them under the provisions of the escrow, settlement, security deposit, or closing agreement and shall be segregated for each depository by escrow, settlement, security deposit, or closing in the records of the title insurance agent in a manner that permits the funds to be identified on an individual basis; and

(ii) The funds shall be applied only in accordance with the terms of the individual instructions or agreements under which the funds were accepted.

(c) Funds held in an escrow account shall be disbursed only pursuant to a written instruction or agreement specifying how and to whom such funds may be disbursed.

(d) Funds held in a security deposit account shall be disbursed only pursuant to a written agreement specifying:

(i) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(ii) The duties of the title insurance agent with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(iii) Any other provisions the director may require.

(e)(i) Disbursements may be made out of an escrow, settlement, or closing account only if funds in an amount at least equal to the disbursement have first been received and if the funds received are in one of the following forms:

(A) Lawful money of the United States;

(B) Wired funds when unconditionally held by the title insurance agent;

(C) Cashier's checks, certified checks, bank money orders, or teller's checks issued by a federally insured financial institution and unconditionally held by the title insurance agent; and

(D) United States treasury checks, federal reserve bank checks, federal home loan bank checks, and State of Nebraska warrants.

(ii) For purposes of this subdivision, federally insured financial institution means an institution in which monetary deposits are insured by the Federal Deposit Insurance Corporation or National Credit Union Administration.

(2) On and after January 1, 2004, every ~~The~~ title insurance agent shall have an annual audit made of its escrow, settlement, closing, and security deposit accounts, conducted by a certified public accountant on a calendar year basis at its expense within ninety days after the close of the previous calendar year. The title insurance agent shall provide a copy of the audit report to each title insurer which it represents. The director may adopt and promulgate rules and regulations setting forth the minimum threshold level at which an audit would be required, the standards of audit, and the form of audit report required. ~~In lieu of such annual audit, a title insurance agent may provide a notarized certificate of reconciliation and availability of the title insurance agent's escrow accounts to each title~~

~~insurer which it represents within ninety days after the close of the previous calendar year on a form prescribed or approved by the director.~~ The director may also require a title insurance agent to provide a copy of its audit report ~~or certificate of reconciliation and availability~~ to the director. Title insurance agents who are attorneys and who issue title insurance policies as part of their legal representation of clients are exempt from the requirements of this subsection. However, the title insurer may, at its expense, conduct or cause to be conducted an annual audit of the escrow, settlement, closing, and security deposit accounts of the attorney. Attorneys who are exclusively in the business of title insurance are not exempt from the requirements of this subsection.

(3) If the title insurance agent is appointed by two or more title insurers and maintains fiduciary trust accounts in connection with providing escrow, closing, or settlement services, the title insurance agent shall allow each title insurer reasonable access to the accounts and any or all of the supporting account information in order to ascertain the safety and security of the funds held by the title insurance agent.

(4) Nothing in the Title Insurance Agent Act shall be deemed to prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction if all parties consent to the transaction in writing.

(5) Nothing in this section is intended to amend, alter, or supersede other sections of the act or the laws of this state or the United States regarding an escrow holder's duties and obligations.

(6) The director may prescribe a standard agreement for escrow, settlement, closing, or security deposit funds.

Sec. 22. Section 44-2127, Reissue Revised Statutes of Nebraska, is amended to read:

44-2127. (1) The director shall approve any merger or other acquisition of control referred to in subsection (1) of section 44-2126 unless, after a public hearing thereon, he or she finds that:

(a) After the change of control, the domestic insurer would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein;

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of policyholders of the insurer;

(d) The plans or proposals which the acquiring party has to liquidate the insurer, to sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure of management are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(e) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control;

(f) To the extent required under section 44-6115, an acquisition has not been approved by the director; or

(g) The acquisition is likely to be hazardous or prejudicial to the public.

(2) The public hearing referred to in subsection (1) of this section shall be held within thirty days after the statement required by subsection (1) of section 44-2126 is filed, and at least twenty days' notice thereof shall be given by the director to the person filing the statement. Not less than seven days' notice of such public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the director. The director shall make a determination within ~~thirty days after the conclusion of such hearing~~ the sixty-day period preceding the effective date of the proposed transaction. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the district court. All discovery proceedings shall be concluded not later than three days prior to the commencement of the public hearing.

(3) In connection with a change of control of a domestic insurer, any determination by the director that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to

the level required by the laws, rules, and regulations of this state shall be made not later than sixty days after the date of the director's determination. The director may retain at the acquiring person's expense any attorneys, actuaries, accountants, and other experts who are not employees of the Department of Insurance as may be reasonably necessary to assist the director in reviewing the proposed acquisition of control.

Sec. 23. Section 44-2845, Reissue Revised Statutes of Nebraska, is amended to read:

44-2845. Each member of the medical review panel shall be paid ~~at the rate of thirty~~ fifty dollars per day for all work performed as a member of the panel, exclusive of time and services involved if called as a witness to testify in court and reasonable expenses incurred. Fees of the panel, including expenses, shall be paid equally by each side. If a panel member is called as an expert witness at the trial, the panel member ~~he~~ shall be paid the customary expert witness fee.

Sec. 24. Section 44-32,161, Reissue Revised Statutes of Nebraska, is amended to read:

44-32,161. (1) Any supervision, rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the supervision, rehabilitation, liquidation, or conservation of an insurance company and shall be conducted pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. The director may apply for an order directing him or her to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in sections 44-4812 and 44-4817 or when in his or her opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by subdivision ~~(3)~~ (2) of section 44-4842 for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have the same priority of distribution of the general assets as established by subdivision ~~(4)~~ (5) of section 44-4842.

Sec. 25. Section 44-4834, Reissue Revised Statutes of Nebraska, is amended to read:

44-4834. (1) Within one hundred twenty days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) Such proposal shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors to the extent of the value of the security held and claims falling within the ~~priorities~~ priority established in ~~subdivisions (1) and (2)~~ subdivision (1) of section 44-4842;

(b) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

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

(d) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section 44-4842 in accordance with such priorities. No bond shall be required of any such association; and

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

(3) The liquidator's proposal shall provide for disbursements to the

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

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

(5) Notice of such application shall be given to the association in and to the director, commissioner, or equivalent official of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mail, first-class postage prepaid, at least thirty days prior to submission of such application to the court. Action on the application may be taken by the court if the required notice has been given and the liquidator's proposal complies with subdivisions (2)(a) and (b) of this section.

Sec. 26. Section 44-4842, Reissue Revised Statutes of Nebraska, is amended to read:

44-4842. The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) Class 1. The costs and expenses of administration during rehabilitation and liquidation, including, but not limited to, the following:

(a) The actual and necessary costs of preserving or recovering the assets of the insurer;

(b) Compensation for all properly authorized services rendered in the rehabilitation and liquidation;

(c) Any necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Authorized reasonable attorney's fees and fees for other professional services rendered in the rehabilitation and liquidation;

(f) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses; and

(g) The expenses of examinations conducted pursuant to the Insurers Examination Act;

(2) Class 2. ~~Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors of the insurer shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees;~~

~~(3) Class 3.~~ All claims under policies, including such claims of the federal or any state or local government, for losses incurred, including third-party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance or as gratuities. No payment by an employer to his or her employee shall be treated as a gratuity;

~~(4) Class 4.~~

(3) Class 3. Claims of the federal government other than those claims included in subdivision (2) of this section;

(4) Class 4. Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation

preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors of the insurer shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees;

(5) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors, including claims of ceding and assuming insurers in their capacity as such;

~~(5) Class 5~~ (6) Class 6. Claims of ~~the federal or~~ any state or local government except those under subdivision ~~(3)~~ (2) of this section. Claims, including those of ~~any~~ a governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subdivision ~~(8)~~ (9) of this section;

~~(6) Class 6~~ (7) Class 7. Claims filed late or any other claims other than claims under subdivisions ~~(7)~~ (8) and ~~(8)~~ (9) of this section;

~~(7) Class 7~~ (8) Class 8. Surplus or contribution notes or similar obligations and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law; and

~~(8) Class 8~~ (9) Class 9. The claims of shareholders or other owners in their capacity as shareholders.

Sec. 27. Section 44-4859, Reissue Revised Statutes of Nebraska, is amended to read:

44-4859. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his or her control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under subdivision ~~(7)~~ (8) of section 44-4842.

Sec. 28. Section 44-5120, Reissue Revised Statutes of Nebraska, is amended to read:

44-5120. (1) An insurer may lend its securities if:

(a) ~~Simultaneously~~ The securities are created or existing under the laws of the United States and, simultaneously with the delivery of the loaned securities, the insurer receives collateral from the borrower consisting of cash or securities backed by the full faith and credit of the United States or an agency or instrumentality of the United States, except that any securities provided as collateral shall not be of lesser quality than the quality of the loaned securities. Any investment made by an insurer with cash received as collateral for loaned securities shall be made in the same kinds, classes, and investment grades as those authorized under the Insurers Investment Act. The securities provided as collateral shall have a market value when the loan is made of at least one hundred two percent of the market value of the loaned securities;

(b) The securities are created or existing under the laws of Canada or are securities described in section 44-5137 and, simultaneously with the delivery of the loaned securities, the insurer receives collateral from the borrower consisting of cash or securities backed by the full faith and credit of the foreign country, except that any securities provided as collateral shall not be of lesser quality than the quality of the loaned securities. Any investment made by an insurer with cash received as collateral for loaned securities shall be made in the same kinds, classes, and investment grades as those authorized under the Insurers Investment Act. The securities provided as collateral shall have a market value when the loan is made of at least one hundred two percent of the market value of the loaned securities;

(c) Prior to the loan, the borrower or any indemnifying party furnishes the insurer with or the insurer otherwise obtains the most recent financial statement of the borrower or any indemnifying party;

~~(c)~~ (d) The insurer receives a reasonable fee related to the market value of the loaned securities and to the term of the loan;

~~(d)~~ (e) The loan is made pursuant to a written loan agreement; and

~~(e)~~ (f) The borrower is required to furnish by the close of each business day during the term of the loan a report of the market value of all collateral and the market value of all loaned securities as of the close of trading on the previous business day. If at the close of any business day the market value of the collateral for any loan outstanding to a borrower is less than one hundred percent of the market value of the loaned securities, the

borrower shall deliver by the close of the next business day an additional amount of cash or securities. The market value of the additional securities, together with the market value of all previously delivered collateral, shall equal at least one hundred two percent of the market value of the loaned securities for that loan.

(2) If at the close of any business day the market value of the collateral for all loans outstanding to a borrower is less than one hundred two percent of the market value of the loaned securities, the borrower shall deliver by the close of the next business day an additional amount of cash or securities. The market value of the additional securities, together with the market value of all previously delivered collateral, shall equal at least one hundred two percent of the market value of the loaned securities for all loans to that borrower.

(3) For purposes of this section, market value shall include accrued interest.

(4) An insurer shall effect securities lending only through the services of a custodian bank or similar entity as approved by the director.

(5) An insurer's investments authorized under this section shall not exceed ten percent of its admitted assets.

Sec. 29. Section 44-5223, Revised Statutes Supplement, 2000, is amended to read:

44-5223. Sections 44-5223 to 44-5267 and sections 31, 32, and 34 of this act shall be known and may be cited as the Small Employer Health Insurance Availability Act.

Sec. 30. Section 44-5225, Revised Statutes Supplement, 2000, is amended to read:

44-5225. For purposes of the Small Employer Health Insurance Availability Act, the definitions found in sections 44-5226 to 44-5255.01 and sections 31 and 32 of this act shall be used.

Sec. 31. Affiliation period means a period of time that must expire before health insurance coverage provided by a carrier becomes effective and during which the carrier is not required to provide benefits.

Sec. 32. Health maintenance organization means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

Sec. 33. Section 44-5260, Reissue Revised Statutes of Nebraska, is amended to read:

44-5260. (1) For purposes of this section, small employer shall mean, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code shall be treated as one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Small Employer Health Insurance Availability Act that apply to a small employer shall continue to apply at least until the health benefit plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in the act to an employer shall include a reference to any predecessor of such employer.

(2)(a) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state, including at least two health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan, and one plan shall be a standard health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan by such small employer carrier.

(b)(i) Subject to subdivision (2)(a) of this section, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit

plan not inconsistent with the Small Employer Health Insurance Availability Act. However, no small employer carrier shall be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

(ii) In the case of a small employer carrier that establishes more than one class of business, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if:

(A) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic health benefit plan or a standard health benefit plan;

(B) The criteria are not related to the health status or claim experience of employees or dependents of the small employer;

(C) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(D) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of subdivision (2)(b)(ii) of this section shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(3)(a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subsection may be used by a small employer carrier beginning thirty days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic health benefit plan or standard health benefit plan on the grounds that the plan does not meet the requirements of the act.

(4) Health benefit plans covering small employers shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months, or eighteen months in the case of a late enrollee, following the enrollment date of the individual's coverage due to a preexisting condition or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section 44-5246.02. A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(b) A health benefit plan shall not impose any preexisting condition exclusion:

(i) To an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage, and the individual had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage; or

(ii) To a child less than eighteen years of age who is adopted or placed for adoption and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage, and the child had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage;

(c)(i) A small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the aggregate period of time an individual was previously covered by creditable coverage that provided benefits with respect to such services if the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage. The period of continuous coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier. This subdivision shall not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(ii) A small employer carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period:

(A) That does not exceed sixty days for new entrants and does not exceed ninety days for late enrollees;

(B) During which the carrier charges no premiums and the coverage issued is not effective; and

(C) That is applied uniformly, without regard to any health-status-related factor.

(iii) This subdivision does not preclude application of any waiting period applicable to all enrollees under the health benefit plan if any carrier waiting period is no longer than sixty days.

(iv)(A) In lieu of the requirements of subdivision (4)(c)(i) of this section, a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations.

(B) A small employer electing to reduce the period of any preexisting condition exclusion using the alternative method described in subdivision (4)(c)(iv)(A) of this section shall make the election on a uniform basis for all enrollees and count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(C) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described in subdivision (4)(c)(iv)(A) of this section shall prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage and include in the disclosure statements the effect of the election;

(d)(i) A small employer carrier shall permit an eligible employee or dependent, who requests enrollment following the open enrollment opportunity, to enroll, and the eligible employee or dependent shall not be considered a late enrollee if the eligible employee or dependent:

(A) Was covered under another health benefit plan at the time the eligible employee or dependent was eligible to enroll;

(B) Stated in writing at the time of the open enrollment period that coverage under another health benefit plan was the reason for declining enrollment but only if the health benefit plan or health carrier required such a written statement and provided a notice of the consequences of such written statement;

(C) Has lost coverage under another health benefit plan as a result of the termination of employment, the termination of the other health benefit plan's coverage, death of a spouse, legal separation, or divorce or was under a continuation-of-coverage policy or contract available under federal law and the coverage was exhausted; and

(D) Requests enrollment within thirty days after the termination of coverage under the other health benefit plan.

(ii)(A) If a small employer carrier issues a health benefit plan and makes coverage available to a dependent of an eligible employee and such dependent becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption, then such health benefit plan shall provide for a dependent special enrollment period during which the dependent may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of an eligible employee may be enrolled if otherwise eligible for coverage.

(B) A dependent special enrollment period shall be a period of not less than thirty days and shall begin on the later of (I) the date such dependent coverage is available or (II) the date of the marriage, birth, adoption, or placement for adoption.

(C) If an eligible employee seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(I) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(II) In the case of the birth of a dependent, as of the date of birth; and

(III) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;

(e)(i) Except as provided in subdivision (4)(e)(iv) of this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum

participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii)(A) Except as provided in subdivision (4)(e)(iii)(B) of this section, in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage; and

(f)(i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents <u>who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan</u>. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group except in the case of late enrollees as provided in subdivision (4)(a) of this section.

(ii) Except as permitted under subdivisions (a) and (d) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

<u>(iii) A small employer carrier shall not place any restriction in regard to any health-status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.</u>

(5) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (2) of this section in the case of the following:

(a) To an employee if previous basic health benefit plans or standard health benefit plans have, in the aggregate, paid one million dollars in benefits on behalf of the employee. Benefits paid on behalf of the employee in the immediately preceding two calendar years by prior small employer carriers under basic and standard plans shall be included when calculating the lifetime maximum benefits payable under the succeeding basic or standard plans. In any situation in which a determination of the total amount of benefits paid by prior small employer carriers is required by the succeeding carrier, prior carriers shall furnish a statement of the total benefits paid under basic and standard plans at the succeeding carrier's request; or

(b) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(6)(a) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (2) of this section to or from a small employer as defined in subsection (1) of this section:

(i) If the small employer does not have eligible employees who live, work, or reside in the service area for such network plan; or

(ii) If the small employer does have eligible employees who live, work, or reside in the service area for such network plan, the carrier has demonstrated, if required, to the director that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying subdivision (6)(a)(ii) of this section uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health-status-related factor relating to such employees and dependents.

(b) A small employer carrier, upon denying health insurance coverage in any service area in accordance with subdivision (6)(a)(ii) of this section, shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the date such coverage is denied.

(7) A small employer carrier shall not be required to provide

coverage to small employers pursuant to subsection (2) of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of such subsection would place the small employer carrier in a financially impaired condition.

Sec. 34. (1) Small employer carriers shall provide written certification of creditable coverage to individuals in accordance with subsection (2) of this section.

(2) The certification of creditable coverage shall be provided:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(b) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(c) At the time a request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage described in subdivision (2)(a) or (b) of this section, whichever is later.

(3) Small employer carriers may provide the certification of creditable coverage required under subdivision (2)(a) of this section at a time consistent with notices required under any applicable COBRA continuation provision.

(4) The certificate of creditable coverage required to be provided pursuant to subsection (1) of this section shall contain:

(a) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(b) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(5) To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under subsection (1) of this section if the small employer carrier offering the coverage provides for certification in accordance with subsection (2) of this section.

(6)(a) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to subdivision (4)(c)(iv) of section 44-5260 and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (3) of this section, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.

(b) The entity providing the information pursuant to subdivision (6)(a) of this section may charge the requesting group health plan the reasonable cost of disclosing the information.

Sec. 35. Section 44-5261, Reissue Revised Statutes of Nebraska, is amended to read:

44-5261. (1) There is hereby created a nonprofit entity to be known as the Nebraska Small Employer Health Reinsurance Program.

(2)(a) The program shall operate subject to the supervision and control of the board. Subject to this subsection, the board shall consist of eight members appointed by the director and the director or his or her designated representative who shall serve as an ex officio member of the board.

(b) In selecting the members of the board, the director shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the director. At least five members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the director.

(c) The initial board members shall be appointed as follows: Two of the members to serve terms of two years; three of the members to serve terms of four years; and three of the members to serve terms of six years. Subsequent board members shall serve for terms of three years. A board member's term shall continue until his or her successor is appointed.

(d) A vacancy in the board shall be filled by the director. A board member may be removed by the director for cause.

(3) Within sixty days after January 1, 1995, each small employer carrier shall make a filing with the director containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

(4) Within one hundred eighty days after the appointment of the initial board, the board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable, and equitable administration of the program and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the director.

(5) If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the director shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The director shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the director.

(6) The plan of operation shall:

(a) Establish procedures for handling and accounting of program assets and money and for an annual fiscal reporting to the director;

(b) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

(e) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers ~~though~~ through capitation or salary; and

(f) Provide for any additional matters necessary for the implementation and administration of the program.

(7) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Small Employer Health Insurance Availability Act, including the authority, with the approval of the director, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) Take any legal action necessary to avoid the payment of improper claims against the program;

(d) Define the health benefit plans for which reinsurance will be provided and issue reinsurance policies, in accordance with the requirements of the act;

(e) Establish rules, conditions, and procedures for reinsuring risks under the program;

(f) Establish actuarial functions as appropriate for the operation of the program;

(g) Assess reinsuring carriers in accordance with the provisions of subsection (11) of this section, and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(h) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and

(i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(8) A reinsuring carrier may reinsure with the program as provided for in this subsection:

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic health benefit plan or standard health benefit

plan.

(b) A small employer carrier may reinsure an entire employer group within sixty days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty days of the commencement of his or her coverage.

(d)(i) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent of the next fifty thousand dollars of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subdivision shall not exceed a maximum limit of ten thousand dollars in any one calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the reinsuring carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers of the United States Department of Labor, Bureau of Labor Statistics, unless the board proposes and the director approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. ~~300e(c)(2)(A)~~ 300e(c)(2)(A), as such section existed on January 1, 2002, and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in subdivision (d) of this subsection, shall be reduced to reflect that portion of the risk above the amount set forth in subdivision (d) of this subsection that may not be ceded to the program, if any.

(g) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, restricted network provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(9)(a) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in this subsection to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan adjusted to reflect retention levels required under the act.

(b) Premiums for the program shall be as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection; and

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection.

(c) The board periodically shall review the methodology established under subdivision (a) of this subsection, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(10) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the

requirements relating to premium rates set forth in section 44-5258.

(11)(a) Prior to ~~March~~ April 1 of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(i) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(A) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(B) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(ii) The formula established pursuant to this subsection shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of (A) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (B) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(iii) The board may, with approval of the director, change the assessment formula established pursuant to this subsection from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.

(iv) Subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. ~~300~~ 300e et seq., as such section existed on January 1, 2002, to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(c)(i) Prior to ~~March~~ April 1 of each year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(ii) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subdivision (c)(iii) of this subsection, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the director within ninety days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement such amendments to the plan of operation as the director deems necessary to reduce future losses and assessments.

(iii) For any calendar year, the amount specified in this subdivision is one percent of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) If the assessment in any calendar year exceeds the amount specified in subdivision (c)(iii) of this subsection, the board shall notify the director who shall, within ten days of receipt of such notice, suspend the guarantee-issue requirement of subdivision (2)(b)(i) of section 44-5260 until such time as the board has implemented changes to the reinsurance program which the board, with the director's approval, determines will be sufficient to fully fund future program liabilities and administrative expenses.

(e) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. Future losses shall include reserves for incurred but not reported claims.

(f) Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports

deemed necessary by the board and filed by the reinsuring carriers with the board.

(g) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(h) A reinsuring carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a reinsuring carrier if the director determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessment.

(12) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by the act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

(13) The board, as part of the plan of operation, shall develop standards setting forth the manner and level of compensation to be paid to agents and brokers for the sale of basic health benefit plans and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(14) The program shall be exempt from any and all taxes.

Sec. 36. Section 44-5503, Revised Statutes Supplement, 2001, is amended to read:

44-5503. The department, in consideration of the payment of the license fee, ~~and the furnishing of a bond as provided in section 44-5504,~~ may issue a surplus lines license, revocable at any time, to any individual who currently holds an insurance producer license or to a foreign or domestic corporation. The corporate surplus lines license shall list all officers or employees of the corporation who currently hold an insurance producer license or meet the requirements for an individual surplus lines license and who have authority to transact surplus lines business on behalf of the corporation. Only individuals listed on the corporate surplus lines license shall transact surplus lines business on behalf of the corporate licensee. If the applicant is an individual, the application for the license shall include the applicant's social security number.

Sec. 37. Section 44-5504, Revised Statutes Supplement, 2000, is amended to read:

44-5504. (1) No person shall place, procure, or effect insurance upon any risk located in this state in any nonadmitted insurer until such person has first been issued a surplus lines license from the department as provided in section 44-5503.

(2) Application for a surplus lines license shall be made to the department on forms designated and furnished by the department and shall be accompanied by a license fee as established by the director not to exceed two hundred fifty dollars for each individual and corporate surplus lines license.

(3)(a) ~~Before the issuance of a surplus lines license, the applicant shall file with the director and maintain in force while so licensed a bond in favor of the State of Nebraska in the penal sum of not less than ten thousand dollars with authorized surety insurers approved by the director. The director may require a bond in an amount greater than ten thousand dollars if he or she determines that the volume of business written or to be written by a licensee warrants the maintenance of such a bond. In no event shall the director require a bond greater than one hundred thousand dollars. The bond shall be conditioned that the surplus lines licensee shall: (a) Transact business under such license in accordance with the Surplus Lines Insurance Act; (b) duly account for and pay to persons entitled thereto funds received by the licensee in transactions under the license; and (c) pay the taxes required by section 44-5506. The bond shall remain in force until released by the director or until canceled by the surety. Without prejudice to any liability previously incurred under the bond, the surety may cancel the bond upon thirty days' written notice to the licensee and the director. The form of bond shall have the prior written approval of the director.~~

~~(4)(a)~~ All corporate surplus lines licenses shall expire on April 30

of each year, and all individual surplus lines licenses shall expire on the licensee's birthday in the first year after issuance in which his or her age is divisible by two, and all individual surplus lines licenses may be renewed within the ninety-day period before their expiration dates and all individual surplus lines licenses also may be renewed within the thirty-day period after their expiration dates upon payment of a late renewal fee as established by the director not to exceed two hundred dollars in addition to the applicable fee otherwise required for renewal of individual surplus lines licenses as established by the director pursuant to subsection (2) of this section. All individual surplus lines licenses renewed within the thirty-day period after their expiration dates pursuant to this subdivision shall be deemed to have been renewed before their expiration dates. The department shall establish procedures for the renewal of surplus lines licenses.

(b) Every licensee shall notify the department within thirty days of any changes in the licensee's residential or business address.

Sec. 38. Section 44-5601, Reissue Revised Statutes of Nebraska, is amended to read:

44-5601. Sections 44-5601 to 44-5613 and sections 40 and 41 of this act shall be known and may be cited as the Reinsurance Intermediary Act.

Sec. 39. Section 44-5603, Reissue Revised Statutes of Nebraska, is amended to read:

44-5603. (1) No person, firm, association, or corporation shall act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker maintains an office directly, as a member or employee of a firm or association, or as an officer, director, or employee of a corporation:

(a) In this state unless such reinsurance intermediary-broker is a licensed producer or reinsurance intermediary in this state; or

(b) In another state unless such reinsurance intermediary-broker is a licensed producer or reinsurance intermediary in this state or another state having a law substantially similar to the Reinsurance Intermediary Act or such reinsurance intermediary-broker is licensed in this state as a nonresident reinsurance intermediary.

(2) No person, firm, association, or corporation shall act as a reinsurance intermediary-manager:

(a) For a reinsurer domiciled in this state unless such reinsurance intermediary-manager is a licensed producer or reinsurance intermediary in this state; or

(b) In this state if the reinsurance intermediary-manager maintains an office directly, as a member or employee of a firm or association, or as an officer, director, or employee of a corporation in this state unless such reinsurance intermediary-manager is a licensed producer or reinsurance intermediary in this state. ~~, or~~

~~(c) In another state for an insurer not domiciled in this state unless such reinsurance intermediary-manager is a licensed producer in this state or another state having a law substantially similar to the Reinsurance Intermediary Act or such reinsurance intermediary-manager is licensed in this state as a nonresident reinsurance intermediary.~~

(3) The director may require a resident reinsurance intermediary-manager subject to subsection (2) of this section to:

(a) File a bond in an amount from an insurer acceptable to the director for the protection of the reinsurer; and

(b) Maintain an errors and omissions policy in an amount acceptable to the director.

(4)~~(a)~~ The director may issue a reinsurance intermediary license to any person, firm, association, or corporation which has complied with the requirements of the Reinsurance Intermediary Act. Any such license issued to a firm or association shall authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers and any designated employees and directors to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

~~(b) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall (i) designate the director as agent for service of process in the manner and with the same legal effect provided for by Chapter 44 for designation of agents for service of process upon unauthorized insurers and (ii) furnish the director with the name and address of a resident of this state upon whom notices or orders of the director or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall promptly notify the director in writing of every change in its designated~~

~~agent for service of process, and such change shall not become effective until acknowledged by the director.~~

(5) The director may refuse to issue a reinsurance intermediary license if in his or her judgment he or she determines that the applicant, any person named on the application, or any member, principal, officer, or director of the applicant is not trustworthy, that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing have given cause for revocation or suspension of such license or have failed to comply with any prerequisite for the issuance of such license. Upon written request by the applicant, the director shall furnish to the applicant a summary of the basis for refusal to issue a license, which summary shall be privileged and not subject to public disclosure.

(6)(a) Applications for resident reinsurance intermediary licenses shall be made to the director on forms designated and furnished by the director and shall be accompanied by a license fee established by the director not to exceed two hundred fifty dollars. If the applicant is an individual, the application for the license shall also include the applicant's social security number.

(b) The director shall issue a nonresident reinsurance intermediary license if:

(i) The person is currently licensed as a resident reinsurance intermediary or insurance producer and is in good standing in his or her home state;

(ii) The person has submitted or transmitted to the director the application for licensure that the person submitted to his or her home state, or in lieu of that application, a completed application deemed appropriate by the director, accompanied by a license fee established by the director not to exceed two hundred fifty dollars; and

(iii) The person's home state awards nonresident licenses to residents of this state on the same basis.

(c) All reinsurance intermediary licenses shall expire on April 30 of each year. Reinsurance intermediary licenses may be renewed within the ninety-day period before their expiration dates. The director shall establish procedures for the renewal of reinsurance intermediary licenses. Every licensee shall notify the director within thirty days of any change in the licensee's business or residential address.

(7) Attorneys of this state acting in their professional capacity shall be exempt from this section.

Sec. 40. (1) The director shall waive any requirements for a nonresident reinsurance intermediary license applicant with a valid license from the applicant's home state, except the requirements imposed by section 44-5603, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(2) A nonresident reinsurance intermediary's satisfaction of any applicable home-state continuing education requirements, if any, for licensed insurance producers or reinsurance intermediaries shall constitute satisfaction of the continuing education requirements of this state if the home state of the reinsurance intermediary recognizes the satisfaction of its continuing education requirements imposed upon insurance producers or reinsurance intermediaries from this state on the same basis.

Sec. 41. A reinsurance intermediary, by accepting licensure in this state, is deemed to have consented to the jurisdiction of the director and of the courts of this state with respect to all activities conducted under the license and to have designated the director as its agent for service of process. Each licensed reinsurance intermediary shall furnish the director with the name and address of a designated contact resident of this state to whom notices or orders of the director or process affecting the reinsurance intermediary may be forwarded. The licensee shall promptly notify the director in writing of every change in its designated contact for service of process, and such changes shall not become effective until acknowledged by the director.

Sec. 42. Section 44-5814, Reissue Revised Statutes of Nebraska, is amended to read:

44-5814. (1) Each third-party administrator shall file an annual report for the preceding calendar year with the director on or before March 1 of each year or within such extension of time therefor as the director for good cause may grant. The annual report shall be in the form and contain such matters as the director prescribes and shall be verified by at least two officers of the third-party administrator.

(2) The annual report shall include the complete names and addresses of all insurers with which the third-party administrator had a written

agreement during the preceding fiscal year.

(3) At the time of filing its annual report, the third-party administrator shall pay to the director a filing fee of two hundred dollars.

(4)(a) Within seven business days after the failure of a third-party administrator to comply with the requirements of this section, the director shall notify the third-party administrator of such failure.

(b) Subject to subdivision (4)(c) of this section, if a third-party administrator fails to comply with the requirements of this section and any rules and regulations adopted and promulgated under this section and any orders issued under this section:

(i) Such third-party administrator shall forfeit fifty dollars for each day thereafter such failure continues and the third-party administrator continues to transact any business of insurance; and

(ii) In addition to the forfeiture required under subdivision (4)(b)(i) of this section, the director may suspend or refuse to renew the certificate of authority of the third-party administrator until it has complied with the requirements of this section, any rules and regulations adopted and promulgated under this section, and any orders issued under this section. All such forfeitures collected by the director shall be remitted to the State Treasurer for credit to the permanent school fund.

(c) For good and sufficient cause shown, the director may grant a reasonable extension of time not to exceed thirty days within which the annual report may be filed as required under this section without the forfeiture required under subdivision (4)(b)(i) of this section and without any suspension or refusal to renew authorized under subdivision (4)(b)(ii) of this section.

Sec. 43. Section 44-5815, Reissue Revised Statutes of Nebraska, is amended to read:

44-5815. (1) The director shall suspend or revoke the certificate of authority as a third-party administrator if the director finds that the third-party administrator:

(a) Is in an unsound financial condition;

(b) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to certificate holders, subscribers, or the public; or

(c) Has failed to pay any judgment rendered against it in this state within sixty days after the judgment has become final.

(2) The director may, in his or her discretion, suspend or revoke the certificate of authority as a third-party administrator if the director finds that the third-party administrator:

(a) Has violated any lawful rule or regulation or order of the director or any provision of the insurance laws of this state;

(b) Has refused to be examined or to produce its accounts, records, and files for examination or if any of its officers has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to such examination, when required by the director;

(c) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused certificate holders, subscribers, or claimants to accept less than the amount due them or caused certificate holders, subscribers, or claimants to retain attorneys or bring actions against the third-party administrator to secure full payment or settlement of such claims;

(d) Is affiliated with or under the same general management or interlocking directorate or ownership as another third-party administrator or insurer which unlawfully transacts business in this state without having a certificate of authority as a third-party administrator;

(e) At any time fails to meet any qualification for which issuance of the certificate of authority as a third-party administrator could have been refused had such failure then existed and been known to the director;

(f) Has been convicted of or has entered a plea of guilty or nolo contendere to a felony without regard to whether adjudication was withheld; or

(g) Is under suspension or revocation in another state.

(3) The director may, in his or her discretion and without advance notice or hearing thereon, immediately suspend the certificate of authority as a third-party administrator if the director finds that one or more of the following circumstances exist:

(a) The third-party administrator is insolvent or impaired;

(b) A proceeding for supervision, rehabilitation, conservation, receivership, or other delinquency proceeding regarding the third-party administrator has been commenced in any state; or

(c) The financial condition or business practices of the third-party administrator otherwise pose an imminent threat to the public health, safety,

or welfare of the residents of this state.

(4) ~~If~~ Except as provided in subsection (4) of section 44-5814, if the director finds that one or more grounds exist for the suspension or revocation of a certificate of authority as a third-party administrator, the director may, in lieu of such suspension or revocation and after notice and hearing, impose an administrative penalty upon the third-party administrator in an amount not less than one thousand dollars nor more than ten thousand dollars.

Sec. 44. Section 44-6901, Revised Statutes Supplement, 2000, is amended to read:

44-6901. For purposes of sections 44-6901 to 44-6918 and sections 45 and 47 of this act, the definitions found in sections 44-6902 to 44-6915.01 and section 45 of this act shall be used.

Sec. 45. Health maintenance organization means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

Sec. 46. Section 44-6916, Reissue Revised Statutes of Nebraska, is amended to read:

44-6916. (1) A health carrier shall not:

(a) Offer coverage to only certain individuals in an employer group or to only a part of the group except in the case of late enrollees;

(b) Require any individual to pay a premium which is greater than such premium for a similarly situated individual enrolled in the health benefit plan on the basis of any health-status-related factor in relation to the individual or a dependent; or

(c) Establish rules for eligibility and continued eligibility of any individual to enroll under the terms of the health benefit plan based on a health-status-related factor of the individual or a dependent.

(2) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months, or eighteen months in the case of a late enrollee, following the enrollment date of the individual's coverage due to a preexisting condition or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. Genetic information shall not be treated as a preexisting condition unless there is a diagnosis of the condition related to such information. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section 44-6915. A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(3) A health benefit plan shall not impose any preexisting condition exclusion:

(a) To an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage, and the individual had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage; or

(b) To a child less than eighteen years of age who is adopted or placed for adoption and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage, and the child had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage.

(4) A health carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the aggregate period of time an individual was previously covered by creditable coverage that provided benefits with respect to such services if the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage. The period of continuous coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the plan sponsor or the health carrier. This subsection shall not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(5)(a) A health carrier shall permit an eligible employee or dependent, who requests enrollment following the open enrollment opportunity, to enroll, and the eligible employee or dependent shall not be considered a late enrollee if the eligible employee or dependent:

(i) Was covered under another health benefit plan at the time the eligible employee or dependent was eligible to enroll;

(ii) Stated in writing at the time of the open enrollment period that coverage under another health benefit plan was the reason for declining enrollment but only if the health benefit plan or health carrier required such

a written statement and provided a notice of the consequences of such written statement;

(iii) Has lost coverage under another health benefit plan as a result of the termination of employment, the termination of the other health benefit plan's coverage, death of a spouse, legal separation, or divorce or was under a continuation-of-coverage policy or contract available under federal law and the coverage was exhausted; and

(iv) Requests enrollment within thirty days after the termination of coverage under the other health benefit plan.

(b)(i) If a health carrier issues a health benefit plan and makes coverage available to a dependent of an eligible employee and such dependent becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption, then such health benefit plan shall provide for a dependent special enrollment period during which the dependent may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of an eligible employee may be enrolled if otherwise eligible for coverage.

(ii) A dependent special enrollment period shall be a period of not less than thirty days and shall begin on the later of (A) the date such dependent coverage is available or (B) the date of the marriage, birth, adoption, or placement for adoption.

(iii) If an eligible employee seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(A) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(B) In the case of the birth of a dependent, as of the date of birth; and

(C) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(6)(a) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion with respect to any particular coverage option may impose an affiliation period for such coverage option but only if:

(i) Such period is applied uniformly without regard to any health-status-related factors; and

(ii) Such period does not exceed two months or, in the case of a late enrollee, three months.

(b) An affiliation period under a group health plan shall run concurrently with any waiting period under the group health plan.

(c) A health maintenance organization may use alternative methods, from those described in subdivision (6)(a) of this section, to address adverse selection, as approved by the director.

Sec. 47. (1) Health carriers shall provide written certification of creditable coverage to individuals in accordance with subsection (2) of this section.

(2) The certification of creditable coverage shall be provided:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(b) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(c) At the time a request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage described in subdivision (2)(a) or (b) of this section, whichever is later.

(3) Health carriers may provide the certification of creditable coverage required under subdivision (2)(a) of this section at a time consistent with notices required under any applicable COBRA continuation provision.

(4) The certificate of creditable coverage required to be provided pursuant to subsection (1) of this section shall contain:

(a) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(b) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(5) To the extent medical care under a group health plan consists of

group health insurance coverage, the plan is deemed to have satisfied the certification requirement under subsection (1) of this section if the health carrier offering the coverage provides for certification in accordance with subsection (2) of this section.

(6)(a) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to subdivision (6)(c) of section 44-6916 and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (3) of this section, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.

(b) The entity providing the information pursuant to subdivision (6)(a) of this section may charge the requesting group health plan the reasonable cost of disclosing the information.

Sec. 48. Section 44-6918, Revised Statutes Supplement, 2000, is amended to read:

44-6918. The director may adopt and promulgate rules and regulations to carry out sections 44-6901 to 44-6918 and sections 45 and 47 of this act.

Sec. 49. Section 44-7505, Revised Statutes Supplement, 2000, is amended to read:

44-7505. (1) The Property and Casualty Insurance Rate and Form Act applies to any insurer holding a certificate of authority issued by the director to transact insurance business in this state for the lines of insurance specified in subdivisions (5) through (14) and (16) through (20) of section 44-201 and to any combination of any of the foregoing on risks or operations in this state.

(2) The act does not apply to:

(a) Reinsurance, except as provided in section 44-7525 for joint reinsurance pools;

(b) Ocean marine insurance;

(c) Rating systems for insurance against loss or damage to aircraft or against liability, other than workers' compensation and employers liability, arising out of the ownership, maintenance, or use of aircraft;

(d) Rating systems or policy forms used ~~for~~ by insurers to provide warranties or service contracts, or rating systems or policy forms used by insurers to provide coverage for the risk assumed by businesses that provide warranties or service contracts for their customers;

(e) Rating systems or policy forms for financial guaranty insurance as defined in subdivision (19) of section 44-201, except that the act applies to financial guaranty coverage for loss of value for motor vehicles leased or sold on credit to private parties;

(f) Rating systems for the lines of insurance specified in subdivisions (5), (7), and (18) of section 44-201 for insurance written by domestic assessment associations doing business under Chapter 44, article 8; and

(g) Policy forms or rates for contracts of suretyship, except that policy forms and prospective loss costs developed or filed by advisory organizations are subject to the act.

Sec. 50. Section 44-7509, Revised Statutes Supplement, 2000, is amended to read:

44-7509. (1) For medical professional liability insurance and for insurance subject to section 44-7508, insurers may increase or decrease premiums on an individual risk basis up to forty percent based on any factor except:

(a) The rate adjustment cannot be based upon the race, creed, national origin, or religion of the insured; and

(b) The rate adjustment cannot violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

(2) If the director finds after a hearing that (a) the utilization of this section by the insurance industry has produced a significant number of rate modifications at or near the upper limit and at the lower limit of the allowable range of modification and (b) the modifiers at and near the upper and lower limits of the allowable range of modification appear to be predominantly correlated with individual risk factors that relate to expected losses and expenses, the director may, by rules and regulations, broaden the range of plus or minus forty percent for any line or type of insurance subject to section 44-7508.

(3) If the director finds after a hearing that modifiers at or near the upper or lower limits of the allowable range of modification are not predominantly correlated with individual risk factors that relate to expected

losses and expenses, the director may, by rules and regulations, reduce the range of plus or minus forty percent for any line or type of insurance subject to section 44-7508, but such reduction shall not be to less than plus or minus twenty-five percent.

Sec. 51. Section 44-7510, Revised Statutes Supplement, 2000, is amended to read:

44-7510. (1) Rating systems shall not produce premiums that are excessive. A premium level is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered. In the evaluation of a premium level, due consideration shall be given to loss experience within and outside this state; reasonably anticipated trends; investment income; special assessments, conflagration, and catastrophe hazards; a reasonable margin for profit; dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to policyholders, members, or subscribers; expense experience both countrywide and specially applicable to this state; and other relevant factors.

(2) Rating systems shall not produce premiums that are inadequate. A premium level is inadequate only if (a) it would endanger the solvency of the insurer or (b) it would not be expected to generate a profit on a direct basis and would be likely to have the effect of diminishing competition.

(3)(a) Rating systems shall not produce premiums that are unfairly discriminatory. Premiums are unfairly discriminatory if, after allowing for practical limitations, price differentials fail to equitably reflect differences in expense requirements or expected losses.

(b) Risks may be grouped by classification groupings that identify objective risk differences for the establishment of rates and prospective loss costs and for the use of rating systems.

(c) Rates and premiums may be modified for individual risks or groups of risks in accordance with objective standards for measuring differences among risks or groups of risks that can be demonstrated to have a probable effect upon losses or expenses. The fact that experience rating plans use loss reserves shall not be interpreted as making experience rating plans subjective.

(d) Notwithstanding subdivisions (3)(b) and (c) of this section, fire insurance rating plans applying to commercial risks for the sole use by advisory organizations that contain reasonable subjective rating factors, but that otherwise meet the standards contained in the Property and Casualty Insurance Rate and Form Act, shall be approved.

(e) A rate is not unfairly discriminatory if it is averaged broadly among persons insured under a group, franchise, or blanket policy or a mass marketed plan. Mass marketed plan means a method of selling property liability insurance wherein:

(i) The insurance is offered to employees of particular employers, members of particular associations or organizations, or stockholders of publicly held corporations or to persons grouped in other ways, except groupings formed principally for the purpose of obtaining such insurance; and

(ii) The employer or other organization has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees or other groupings of persons affiliated with it.

~~(e)~~ (f) An insurer may have different rate levels for otherwise similar insureds based on expense differences between coverage sold:

(i) Through direct sales using employees of the insurer;

(ii) Through direct sales by the insurer using the Internet; and

(iii) Through agents that are not employees of the insurer.

~~(f)~~ (g) No risk classification or grouping may be based upon the race, creed, national origin, or religion of the insured.

~~(g)~~ (h) No rating system may violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

(4) Prospective loss costs shall be as near as is practical to the expected cost of future losses, including loss adjustment expenses. Anticipated special assessments may be included with prospective loss costs.

Sec. 52. Section 44-7511, Revised Statutes Supplement, 2000, is amended to read:

44-7511. (1) Each insurer to which this section applies as provided in section 44-7506 shall file with the director every rating system and every modification of such rating system that it proposes to use. No insurer shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act, except:

(a) As provided in subsections (6) and (7) of this section;

(b) As provided by rules and regulations adopted and promulgated

pursuant to section 44-7515; or

(c) For types of inland marine risks that have, by custom of the industry, not been written according to manual rates or rating plans. For types of inland marine risks for which the custom of the industry has not been established, the director shall consider the similarity of the new insurance to existing types of insurance and classes of risk and whether it would be reasonably practical to create and file rating systems prior to use.

(2) Every filing shall state its proposed effective date, which shall not be prior to the date that the director receives the filing. Instead of a specific date, a filing may indicate that it will be effective a reasonable specified period of time after approval or that the insurer will notify the director of the effective date within ninety days after approval.

(3) Every filing shall provide an objective description of the risks and the coverages to which the rating system will apply. If the insurer has another rating system on file or pending that applies to some or all of these same risks, the filing shall disclose this and shall objectively identify those risks to which each rating system will apply. Filings shall include a list of manual pages and other rating system elements that will be replaced when the approval of a filing will result in the replacement or alteration of previously approved rating systems. In addition, insurers shall maintain listings of manual pages and other rating system elements that have been approved by the director so that such listings can be provided upon request.

(4) Each insurer shall file or incorporate by reference to material filed with the director all supporting information relating to a rating system. If a filing is not accompanied by such information or if additional information is required to complete review of the filing, the director may require the filer to furnish the information, and in that event the review period in subsection (10) of this section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(5) An insurer may authorize the director to accept rating system filings and prospective loss cost filings made on its behalf by an advisory organization. The insurer shall file additional information as is necessary to complete its rating systems on file with the director.

(6)(a) Except as otherwise provided in subdivision (6)(b) of this section for workers' compensation insurance and subdivision (6)(c) of this section for medical professional liability insurance, a rate or premium in excess of that provided by a filing otherwise applicable may be used on any specific risk upon the prior written application of the insured that describes the insured's unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that class of risk, filed with and approved by the director.

(b) For workers' compensation insurance, a rate or premium in excess of that provided by a filing otherwise applicable may be used for any specific employer upon the prior written consent of the employer that describes its unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that employer's rate classification. For employers that are offered coverage at a rate higher than would be available in the assigned risk plan, the consent must include an acknowledgment of the availability of coverage at a lower price from the assigned risk plan. Such signed consent shall be filed with the director no later than thirty days after the effective date of the insurance to which it applies. The director shall monitor such rate applications to assure compliance with this ~~subsection~~ subdivision. The director may, after a hearing, require by order that such applications for an insurer that has demonstrated a pattern of using this rating device for employers that do not possess unusual or extrahazardous exposures, or that otherwise fails to comply with this ~~subsection~~ subdivision, shall be subject to prior approval pursuant to subdivision (6)(a) of this section. Upon application by an insurer affected by such order, demonstrating that its filings made subsequent to the order have been in compliance with this subdivision, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.

(c) For medical professional liability insurance, a rate or premium in excess of that provided by a filing otherwise applicable may be used for any specific medical professional upon the prior written consent of the medical professional that describes its unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that medical professional's rate classification. Such signed consent shall be filed with

the director no later than thirty days after the effective date of the insurance to which it applies. The director shall monitor such rate applications to assure compliance with this subdivision. The director may, after a hearing, require by order that such applications for an insurer that has demonstrated a pattern of using this rating device for medical professionals that do not possess unusual or extrahazardous exposures, or that otherwise fails to comply with this subdivision, shall be subject to prior approval pursuant to subdivision (6)(a) of this section. Upon application by an insurer affected by such order, demonstrating that its filings made subsequent to the order have been in compliance with this subdivision, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.

(7) The director may by rules and regulations or by order suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which rating systems cannot practicably be filed before they are used. In making this finding, the director shall ascertain whether a system of rating classifications and exposure bases that would equitably reflect the differences in expense requirements and expected losses between individual risks has been developed or appears reasonably capable of being developed. The director may examine insurers as is necessary to ascertain whether any rating systems affected by such rules and regulations meet the standards contained in this section.

(8) No filing or any supporting information provided by an insurer pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the approval or disapproval of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

(9) The director shall review filings as soon as reasonably possible after they have been made. The director shall disapprove a filing if:

(a) The filing fails to meet the standards contained in section 44-7510;

(b) The insurer has more than one rating system applicable to the line or type of insurance and the insurer fails to specify objective differences between risks to determine the risks and the coverages to which the rating system will apply;

(c) The filing proposes to discriminate between risks based on optional commission differences for agents; or

(d) The filing discriminates between risks based on subjective factors, except that (i) an experience rating plan may use loss reserves without being considered as subjective and (ii) a fire insurance rating plan applying to commercial risks filed for the sole use by an advisory organization may be approved even though it contains subjective rating factors.

(10) Within thirty days after receipt, the director shall approve a filing that meets the requirements of the act, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer or advisory organization. A filing shall be deemed to meet the requirements of the act unless disapproved by the director within the review period or any extension thereof.

(11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of the act, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and state that such filing shall not become effective.

(12) Filings shall become effective on their proposed effective date if approved or deemed approved on or before that date. Filings approved or deemed approved after their proposed effective dates shall become effective after notification by the insurer of a revised effective date, which shall not be prior to the date that the insurer mails the notification to the director. If an insurer fails to furnish a revised effective date within a reasonable period of time not less than ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(13) An insurer or advisory organization whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.

(14) If, at any time after approval, the director finds that a rating system or modification thereof does not meet or no longer meets the requirements of the act, the director shall hold a hearing in accordance with section 44-7532.

(15) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

(16) If, after a hearing initiated pursuant to subsection (14) or (15) of this section, the director finds that a filing does not meet the requirements of the act, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such rating system or aspect of a rating system shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Sec. 53. Section 44-7513, Revised Statutes Supplement, 2000, is amended to read:

44-7513. (1) Each insurer shall file with the director every policy form and related attachment rule and every modification thereof which it proposes to use. No insurer shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act except as provided in subsection (6) or (7) of this section or as provided by rules and regulations adopted and promulgated pursuant to section 44-7514 or 44-7515.

(2) Every filing shall state its proposed effective date, which shall not be prior to the date that the director receives the filing. Instead of a specific date, a filing may indicate that it will be effective a reasonable specified period of time after approval or that the insurer will notify the director of the effective date within ninety days after approval.

(3) Every policy form filing shall explain the intended use of such policy forms. Filings shall include a list of policy forms that will be replaced when the approval of a filing will result in the replacement of previously approved policy forms. In addition, insurers shall maintain listings of policy forms that have been filed and approved by the director so that such listings can be provided upon request.

(4) If additional information is needed to complete review of a policy form filing, the director may require the filer to furnish the information and in that event the review period in subsection (10) of this section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(5) An insurer may authorize the director to accept policy form filings made on its behalf by an advisory organization.

(6)(a) Subject to the following requirements, policy forms unique in character and designed for and used with regard to an individual risk under common ownership subject to the rate filing provisions of section 44-7508 shall be exempt from the approval requirements contained in subsection (1) of this section.

(b) At the earliest practical opportunity, but no later than thirty days after the effective date of the policy using unfiled provisions, the insurer shall provide the prospective insured with a written listing of the policy forms that have not been approved by the director and receive written acknowledgment from prospective insureds for which it ultimately provides coverage. This requirement does not apply to renewals using the same unfiled policy forms.

(c) A policy form that has been used in this state or elsewhere by the insurer for another risk shall not be subject to the exemption provided by this subsection, except that an insurer may use a policy form previously developed for a single risk for a second risk if the policy form is filed for approval within sixty days after its second usage.

(d) The exemption provided by this subsection shall not apply to excess workers' compensation or to policy forms that, prior to their use by the insurer, had been filed by an advisory organization in this state or had been filed by the insurer in any jurisdiction, regardless of whether approval was received.

(e) The director may by rules and regulations or by order make

specific restrictions relating to the exemption provided by this subsection and may require the informational filing of policy forms subject to such exemption within a reasonable time after their use.

(7) The director may by rules and regulations suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which policy forms cannot practicably be filed before they are used. The director may examine insurers as is necessary to ascertain whether any policy forms affected by such rules and regulations meet the standards contained in the act.

(8) No filing or any supporting information provided by an insurer pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the approval or disapproval of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

(9) The director shall review filings as soon as reasonably possible after they have been made. The director shall disapprove a filing that contains provisions, exceptions, or conditions that: (a) Are unjust, unfair, ambiguous, inconsistent, inequitable, misleading, deceptive, or contrary to public policy; (b) are written so as to encourage the misrepresentation of coverage; (c) fail to reasonably provide the general coverage for policies of that type; (d) fail to comply with the provisions or the intent of the laws of this state; or (e) would provide coverage contrary to the public interest.

(10) Within thirty days after receipt, the director shall approve filings that meet the requirements of the act, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer or advisory organization. A filing shall be deemed to meet the requirements of the act unless disapproved by the director within the review period or any extension thereof.

(11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of the act, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and state that such filing shall not become effective.

(12) Filings shall become effective on their proposed effective date if approved or deemed approved on or before that date. Filings approved or deemed approved after their proposed effective dates shall become effective after notification by the insurer of a revised effective date, which shall not be prior to the date that the insurer mails the notification to the director. If an insurer fails to furnish a revised effective date within a reasonable period of time not less than ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(13) An insurer or advisory organization whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.

(14) If, at any time after approval, the director finds that a policy form, attachment rule, or modification thereof does not meet or no longer meets the requirements of the act, the director shall hold a hearing in accordance with section 44-7532.

(15) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

(16) If, after a hearing initiated pursuant to subsection (14) or (15) of this section, the director finds that a filing does not meet the requirements of the act, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such policy form or attachment rule shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Sec. 54. Section 44-7515, Revised Statutes Supplement, 2000, is amended to read:

44-7515. (1) The director shall adopt and promulgate rules and

regulations to modify or eliminate requirements for insurers to use filed rates and policy forms for commercial policyholders under common ownership identified through the application of subsection (4) of this section.

(2) The rules and regulations adopted and promulgated pursuant to this section may establish requirements and thresholds that differ by line or type of insurance or that differ for rates and policy forms.

(3) The rules and regulations adopted and promulgated pursuant to this section shall require insurers to inform exempt commercial policyholders ~~prior to~~ at the earliest practical date, but no later than thirty days after the inception of coverage, of those policy forms applying to them that have not been approved by the director.

(4) The director shall consider the following factors in determining those commercial policyholders to which the rules and regulations adopted and promulgated pursuant to this section shall apply:

(a) For modification or elimination of the applicability of filed rates, characteristics of insureds that are likely to avail themselves of regular price comparisons between competing insurers and are likely to study and understand the differences and details of pricing proposals that they receive;

(b) For modification or elimination of the applicability of filed rates, characteristics of insureds for which filed rates and rating plans are less likely to provide the lowest premiums otherwise consistent with the provisions of the Property and Casualty Insurance Rate and Form Act;

(c) Modification or elimination of the applicability of filed rates for commercial insureds that are primarily located in another jurisdiction where they are subject to similar exemptions or waivers in that jurisdiction;

(d) For modification or elimination of the applicability of filed policy forms, characteristics of insureds that are likely to study and understand the details of their business risks and insurance coverages and exclusions;

(e) For modification or elimination of the applicability of filed policy forms, characteristics of insureds that are likely to require individually written policies, as contrasted to insureds that can customarily have their coverage needs met using policy forms that could also be used for other insureds;

(f) For both rates and policy forms, favorable or adverse experiences with the modification or elimination of regulatory requirements, especially the experience in this state; and

(g) Any other relevant factor.

(5) For exempt commercial policyholders to which rating system regulation is made otherwise inapplicable, insurers shall allocate premiums between policies, exposures, and states in proportion to the expected losses and expenses for those policies, exposures, and states.

(6) The following restrictions apply to rules and regulations adopted and promulgated pursuant to this section:

(a) The rules and regulations may not allow any reduction of the benefits payable under workers' compensation or excess workers' compensation policies or any alteration of provisions for the handling and settlement of claims under such policies, but the rules and regulations may allow exempt commercial policyholders to negotiate workers' compensation or excess workers' compensation premiums and premium payment provisions;

(b) The rules and regulations may not allow any reduction of automobile insurance coverage limits to less than those required by Nebraska law, but the rules and regulations may allow exempt commercial policyholders to negotiate automobile insurance premiums and premium payment provisions;

(c) The rules and regulations may not allow any limitation of the coverage provisions necessary for health care providers to qualify under the Nebraska Hospital-Medical Liability Act, but the rules and regulations may allow exempt commercial policyholders to negotiate medical professional liability insurance premiums and premium payment provisions;

(d) The rules and regulations may not reduce the rate regulatory requirements applying to any policyholder with total premiums of less than twenty-five thousand dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act; and

(e) The rules and regulations may not reduce the form regulatory requirements applying to any policyholder with total premiums of less than fifty thousand dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act.

Sec. 55. Sections 20 and 56 of this act become operative on January 1, 2003. The other sections of this act become operative on their effective date.

Sec. 56. Original section 44-1984, Reissue Revised Statutes of

Nebraska, is repealed.

Sec. 57. Original sections 44-1527, 44-2127, 44-2845, 44-32,161, 44-4834, 44-4842, 44-4859, 44-5120, 44-5260, 44-5261, 44-5601, 44-5603, 44-5814, 44-5815, and 44-6916, Reissue Revised Statutes of Nebraska, sections 44-787, 44-19,116, 44-5223, 44-5225, 44-5504, 44-6901, 44-6918, 44-7505, 44-7509, 44-7510, 44-7511, 44-7513, and 44-7515, Revised Statutes Supplement, 2000, and section 44-5503, Revised Statutes Supplement, 2001, are repealed.