AM1832
LB855
KLM-02/11/2008

AMENDMENTS TO LB 855

Introduced by Banking, Commerce and Insurance.

1. Strike the original sections and insert the following new sections:

Section 1. Section 13-206, Revised Statutes Cumulative Supplement, 2006, is amended to read:

13-206 (1) The director shall adopt and promulgate rules and regulations for the approval or disapproval of the program proposals submitted pursuant to section 13-205 taking into account the economic need level and the geographic distribution of the population of the community development area. The director shall also adopt and promulgate rules and regulations concerning the amount of the tax credit for which a program shall be certified. The tax credits shall be available for contributions to a certified program which may qualify as a charitable contribution deduction on the federal income tax return filed by the business firm or individual making such contribution. The decision of the department to approve or disapprove all or any portion of a proposal shall be in writing. If the proposal is approved, the maximum tax credit allowance for the certified program shall be stated along with the approval. The maximum tax credit allowance approved by the department shall be final for the fiscal year in which the program is certified. A copy of all decisions shall be transmitted to the Tax Commissioner. A copy of all credits allowed to business firms under sections 44-150 and 77-908 shall be transmitted to the

Director of Insurance.

(2) For all business firms and individuals eligible for the credit allowed by section 13-207, except for insurance companies paying premium and related retaliatory taxes in this state pursuant to section 44-150 or 77-908, the Tax Commissioner shall provide for the manner in which the credit allowed by section 13-207 shall be taken and the forms on which such credit shall be allowed. The Tax Commissioner shall adopt and promulgate rules and regulations for the method of providing tax credits. The Director of Insurance shall provide for the manner in which the credit allowed by section 13-207 to insurance companies paying premium and related retaliatory taxes in this state pursuant to sections 44-150 and 77-908 shall be taken and the forms on which such credit shall be allowed. The Director of Insurance ~~shall~~ may adopt and promulgate rules and regulations for the method of providing the tax credit. The Tax Commissioner shall allow against any income tax due from the insurance companies paying premium and related retaliatory taxes in this state pursuant to section 44-150 or 77-908 a credit for the credit provided by section 13-207 and allowed by the Director of Insurance.

Sec. 2. Section 28-631, Revised Statutes Cumulative Supplement, 2006, is amended to read:

28-631 (1) A person or entity commits a fraudulent insurance act if he or she:

(a) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any agent

of an insurer, any statement as part of, in support of, or in denial of a claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim;

(b) Assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to or by an insurer or person in connection with or in support of any claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim;

(c) Makes any false or fraudulent representations as to the death or disability of a policy or certificate holder or a covered person in any statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;

(d) Knowingly and willfully transacts any contract, agreement, or instrument which violates this section;

(e) Receives money for the purpose of purchasing insurance and converts the money to the person's own benefit;

(f) Willfully embezzles, abstracts, purloins, misappropriates, or converts money, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance;

(g) Knowingly and with intent to defraud or deceive issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(h) Knowingly and with intent to defraud or deceive possesses fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(i) Knowingly and with intent to defraud or deceive makes any false entry of a material fact in or pertaining to any document or statement filed with or required by the Department of Insurance; ~~or~~

(j) Knowingly and with intent to defraud or deceive removes, conceals, alters, diverts, or destroys assets or records of an insurer or person engaged in the business of insurance or attempts to remove, conceal, alter, divert, or destroy assets or records of an insurer or person engaged in the business of insurance; ~~.~~

(k) Willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 38 of this act; or

(l) Willfully collects fees for purported membership in a discount medical plan organization but purposefully fails to provide the promised benefits.

(2)(a) A violation of subdivisions (1)(a) through (f) of this section is a Class III felony when the amount involved is one thousand five hundred dollars or more.

(b) A violation of subdivisions (1)(a) through (f) of this section is a Class IV felony when the amount involved is five hundred dollars or more but less than one thousand five hundred dollars.

(c) A violation of subdivisions (1)(a) through (f) of

this section is a Class I misdemeanor when the amount involved is two hundred dollars or more but less than five hundred dollars.

(d) A violation of subdivisions (1)(a) through (f) of this section is a Class II misdemeanor when the amount involved is less than two hundred dollars.

(e) For any second or subsequent conviction under subdivision (2)(c) of this section, the violation is a Class IV felony.

(f) A violation of subdivisions (1)(g), (i), ~~and~~ (j)<u>, (k), and (l)</u> of this section is a Class IV felony.

(g) A violation of subdivision (1)(h) of this section is a Class I misdemeanor.

(3) Amounts taken pursuant to one scheme or course of conduct from one person, entity, or insurer may be aggregated in the indictment or information in determining the classification of the offense, except that amounts may not be aggregated into more than one offense.

(4) In any prosecution under this section, if the amounts are aggregated pursuant to subsection (3) of this section, the amount involved in the offense shall be an essential element of the offense that must be proved beyond a reasonable doubt.

(5) A prosecution under this section shall be in lieu of an action under section 44-6607.

(6) For purposes of this section:

(a) Insurer means any person or entity transacting insurance as defined in section 44-102 with or without a certificate of authority issued by the Director of Insurance.

Insurer also means health maintenance organizations, legal service insurance corporations, prepaid limited health service organizations, dental and other similar health service plans, discount medical plan organizations, and entities licensed pursuant to the Intergovernmental Risk Management Act and the Comprehensive Health Insurance Pool Act. Insurer also means an employer who is approved by the Nebraska Workers' Compensation Court as a self-insurer; and

(b) Statement includes, but is not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical records, X-rays, test result, or other evidence of loss, injury, or expense, whether oral, written, or computer-generated.

Sec. 3. Section 44-349, Reissue Revised Statutes of Nebraska, is amended to read:

44-349 No policy or contract of insurance or renewal thereof shall be made, issued, used, or delivered by any assessment insurer in this state unless it states on its face ~~whether it is issued by a stock, mutual, reciprocal, assessment, or fraternal company; PROVIDED, that any insurer organized under special charter provisions may so indicate upon its policy and may add a statement of the plan under which it operates in this state.~~ that it is issued by an assessment insurer.

Sec. 4. Section 44-356, Reissue Revised Statutes of Nebraska, is amended to read:

44-356 ~~Whoever violates~~ (1) A violator of any of the

provisions of ~~sections~~ section 44-353 ~~to 44-355~~ shall be fined ~~in any sum~~ not ~~less than twenty dollars nor~~ more than one hundred dollars.

(2) A violation of any of the provisions of section 44-354 or 44-355 shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Sec. 5. Section 44-789, Reissue Revised Statutes of Nebraska, is amended to read:

44-789 Notwithstanding section 44-3,131, no group policy of accident or health insurance, health services plan, or health maintenance organization subscription shall be offered for sale in this state on or after ~~July 15, 1998,~~ January 1, 2009, unless such policy, plan, subscription, or contract which specifically provides coverage for surgical and nonsurgical treatment involving a bone or joint of the skeletal structure includes the option to provide coverage, for an additional premium and subject to the insurer's standard of insurability, for the reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder. The purchaser of the group policy of accident or health insurance, health service plan, or health maintenance organization subscription shall accept or reject the coverage in writing on the application or an amendment thereto for the master group policy of accident or health insurance, health service plan, or health maintenance organization subscription. Benefits may be subject to the same preexisting conditions, limitations, deductibles, copayments, and coinsurance that generally apply to any other sickness. The maximum lifetime benefits for temporomandibular

joint disorder and craniomandibular disorder treatment shall be no less than two thousand five hundred dollars. Nothing in this section shall prevent an insurer from including such coverage for temporomandibular joint disorder and craniomandibular disorder as part of a policy's basic coverage instead of offering optional coverage. ~~for the same diagnostic or surgical procedure involving any other bone or joint of the face, neck, or head through the use of an endorsement or similar amendment. Such endorsement may limit benefits for services to an amount of not less than two thousand five hundred dollars.~~

Sec. 6. Section 44-1521, Reissue Revised Statutes of Nebraska, is amended to read:

44-1521 Sections 44-1521 to 44-1535 and section 7 of this act shall be known and may be cited as the Unfair Insurance Trade Practices Act.

Sec. 7. The Director of Insurance may adopt and promulgate rules and regulations to protect members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive, or unfair as required by the federal Military Personnel Financial Services Protection Act, Public Law 109-290, as such law existed on the operative date of this section.

Sec. 8. Section 44-1601, Reissue Revised Statutes of Nebraska, is amended to read:

44-1601 No policy of group life insurance shall be delivered in this state unless it is issued under one of the provisions of sections ~~21-1773,~~ 21-1740, 44-1602 to 44-1606.01, and

44-1615 and sections 14 and 15 of this act or under a policy or contract issued to any other substantially similar group which, in the discretion of the Director of Insurance, may be subject to the issuance of a group life insurance policy or contract.

Sec. 9. Section 44-1602, Revised Statutes Cumulative Supplement, 2006, is amended to read:

44-1602 A policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer shall be subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer or all of any class or classes thereof. ~~determined by conditions pertaining to their employment.~~ The policy may provide that the term employees shall include the employees of one or more subsidiary corporations and the employees, individual proprietors, partners, and members of one or more affiliated corporations, proprietors, partnerships, or limited liability companies if the business of the employer and of such affiliated corporations, proprietors, partnerships, or limited liability companies is under common control. ~~through stock ownership or contract.~~ The policy may provide that the term employees shall include the individual proprietor, partners, or members if the employer is an individual proprietor, partnership, or limited liability company. The policy may provide that the term employee ~~shall~~ may include retired employees, former employees, and directors of a corporate employer. ~~No director of a corporate~~

~~employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor, partner, or member shall be eligible for insurance under the policy unless he or she is actively engaged in and devotes a substantial part of his or her time to the conduct of the business of the proprietor, partnership, or limited liability company.~~

(2) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees or from both such funds. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(3) The policy must cover at least five employees at date of issue.~~

~~(4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustees.~~

Sec. 10. Section 44-1603, Reissue Revised Statutes of Nebraska, is amended to read:

44-1603 A policy issued to a creditor~~,~~ ~~who~~ or its parent holding company or to a trustee or agent designated by two or more creditors, which creditor, parent holding company, affiliate, trustee, or agent shall be deemed the policyholder, to

insure debtors of the creditor shall be subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor ~~whose indebtedness is repayable either (a) in installments or (b) in one sum at the end of a period not in excess of eighteen months from the initial date of the debt, or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness.~~ or creditors, or all of any class or classes of the creditors. The policy may provide that the term debtors shall include borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction, the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors, partnerships, or limited liability companies if the business of the policyholder and of such affiliated corporations, proprietors, partnerships, or limited liability companies is under common control; ~~through stock ownership, contract, or otherwise. No debtor shall be eligible unless the indebtedness constitutes an irrevocable obligation to repay which is binding upon him or her during his or her lifetime, at and from the date the insurance becomes effective upon his or her life;~~

(2) The premium for the policy shall be paid by the policyholder from the creditor's funds, from charges collected from the insured debtors, or from both. ~~A policy on which part or all of the premium is to be derived from the collection from the insured~~

~~debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent of the then eligible debtors elect to pay the required charges.~~ A policy on which no part of the premiums is to be derived from the ~~collection of such identifiable charges~~ funds contributed by insured debtors specifically for their insurance must insure all eligible debtors or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

~~(3) The policy may be issued (a) only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly or may reasonably be expected to receive at least one hundred new entrants during the first policy year and (b) only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent of the new entrants become insured. The policy may exclude from the classes eligible for insurance classes of debtors determined by age;~~

~~(4)~~ (3) The amount of insurance on the life of any debtor shall at no time exceed the ~~amount owed by such debtor which is repayable in installments to the creditor. Where the indebtedness is repayable in one sum to the creditor, the insurance on the life of any debtor shall in no instance be in effect for a period in excess of eighteen months, except that such insurance may be continued for an additional period not exceeding six months in the~~

~~case of default, extension, or recasting of the loan. The amount of the insurance on the life of any debtor shall at no time exceed the amount of the unpaid indebtedness; and~~ greater of the scheduled or actual amount of unpaid indebtedness to the creditor, except that insurance written in connection with open-end credit having a credit limit exceeding ten thousand dollars may be in an amount not exceeding the credit limit;

~~(5)~~ (4) The insurance shall be payable to the ~~policyholder and such~~ creditor or any successor to the right, title, and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment and any excess of the insurance shall be payable to the estate of the insured; and ~~.~~

(5) Notwithstanding subdivisions (1) through (4) of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

Sec. 11. Section 44-1604, Reissue Revised Statutes of Nebraska, is amended to read:

44-1604 A policy issued to a labor union or similar employee organization, which shall be deemed the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents shall be subject to the

following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof; and ~~determined by conditions pertaining to their employment, or to membership in the union, or both.~~

(2) The premium for the policy shall be paid ~~by the policyholder,~~ either ~~wholly~~ from the union's funds~~,~~ or ~~partly from such funds and partly~~ from funds contributed by the insured members specifically for their insurance or from both. ~~No policy may be issued on which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance. A policy on which part of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force only if at least seventy-five percent of the then eligible members, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions.~~ A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(3) The policy must cover at least twenty-five members at date of issue.~~

~~(4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the~~

~~members or by the union.~~

Sec. 12. Section 44-1605, Reissue Revised Statutes of Nebraska, is amended to read:

44-1605 A policy issued to a trust or to the trustees of a fund established or adopted by two or more employers or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations shall be subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. ~~determined by conditions pertaining to their employment, or to membership in the unions, or to both. The policy may provide that the term employees shall include retired employees and the individual proprietor, partners, or members if an employer is an individual proprietor, partnership, or limited liability company. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor, partner, or member shall be eligible for insurance under the policy unless he or she is actively engaged in and devotes a substantial part of his or her time to the conduct of the business~~

~~of the proprietorship, partnership, or limited liability company.~~ The policy may provide that the term employees shall include the employees of one or more subsidiary corporations and the employees, individual proprietors, members, and partners of one or more affiliated corporations, proprietorships, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, or partnerships is under common control. The policy may provide that the term employees shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term employees may include retired employees, former employees, and directors of a corporate employer. The policy may provide that the term employees shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship; and

(2) The premium for the policy shall be paid ~~by the trustees wholly~~ from funds contributed by the employer or employers of the insured persons, ~~or~~ by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. ~~No policy may be issued on which any part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance. The~~ A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance shall insure all eligible persons, except those who reject the coverage in writing, or all except any

as to whom evidence of individual insurability is not satisfactory to the insurer. ~~;~~

~~(3) The policy shall cover at date of issue at least fifty persons and not less than an average of three persons per employer unit. If the fund is established by the members of an association of employers, the policy may be issued only if (a) either the participating employers constitute at the date of issue at least sixty percent of those employer members whose employees are not already covered for group life insurance or the total number of persons covered at date of issue exceeds six hundred and (b) the policy shall not require that, if a participating employer discontinues membership in the association, the insurance of his or her employees shall cease solely by reason of such discontinuance; and~~

~~(4) The amount of insurance under the policy shall be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions.~~

Sec. 13. Section 44-1606.01, Reissue Revised Statutes of Nebraska, is amended to read:

44-1606.01 (1) A policy may be issued to an association ~~whose eligible members have the same profession, trade, or occupation and which has been organized and is maintained for purposes other than that of obtaining insurance, which shall be deemed the policyholder, to insure members, or employees of members, of such association for the benefit of persons other than the association, or any of its officials, representatives, or agents,~~ or to a trust or to the trustees of a fund established,

created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of one hundred persons, shall have been organized and maintained in good faith for purposes other than that of obtaining insurance, shall have been in active existence for at least two years, and shall have a constitution and bylaws which provides that (a) the association or associations shall hold regular meetings not less than annually to further the purposes of the members, (b) except for credit unions, the association or associations shall collect dues or solicit contributions from members, and (c) the members shall have voting privileges and representation on the governing board and committees.

(2) The policy shall be subject to the following requirements:

~~(1) The members or employees eligible for insurance under the policy shall be all the members, and all the employees of the members, of the association, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the association, or both. The policy may provide that the term employees shall include the employees of the association if their duties are principally connected with such association;~~

(a) The policy may insure members of the association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer;

~~(2)~~ (b) The premium for the policy shall be paid ~~by the policyholder, either from the association's own funds, or~~

~~from charges collected from the insured members or employees specifically for their insurance, or from both. A policy on which any part or all of the premium is to be derived from funds contributed by the insured members or employees specifically for their insurance may be placed in force only if at least fifty percent of the then eligible members or a minimum of two hundred members and employees, whichever is less, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions.~~ from funds contributed by the association or associations, by the employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the associations or employer members; and

(c) A policy on which no part of the premium is to be derived from funds contributed by the ~~insured members or employees~~ covered persons specifically for their insurance must insure all eligible ~~members or employees,~~ persons, except those who reject the coverage in writing, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer. ~~;~~

~~(3) The policy must cover at least twenty-five persons, members or employees at date of issuance; and~~

~~(4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or employees or by the association.~~

Sec. 14. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be

deemed the policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, shall be subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes of the members; and

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and shall insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. 15. (1) Group life insurance offered to a resident of this state under a group life insurance policy issued to a group other than one described in sections 21-1740, 44-1602 to 44-1606.01, and 44-1615 and section 14 of this act shall be subject to the following requirements:

(a) A group life insurance policy shall not be delivered in this state unless the Director of Insurance finds that:

(i) The issuance of the group policy is not contrary to the best interests of the public;

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

(iii) The benefits are reasonable in relation to the premiums charged;

(b) A group life insurance policy shall not be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements

substantially similar to those contained in subdivision (1)(a) of this section has made a determination that the requirements have been met;

(c) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both; and

(d) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2)(a) In the case of a program of insurance which, if issued on a group basis, would not qualify under sections 21-1740, 44-1602 to 44-1606.01, and 44-1615 and section 14 of this act, the insurer shall cause to be distributed to prospective insureds a written notice that compensation shall or may be paid, if compensation of any kind shall or may be paid, to:

(i) A policyholder or sponsoring or endorsing entity in the case of a group policy; or

(ii) A sponsoring or endorsing entity in the case of an individual, blanket, or franchise policy marketed by means of direct response solicitation;

(b) The notice shall be distributed:

(i) Whether compensation is direct or indirect; and

(ii) Whether the compensation is paid to or retained by the policyholder or sponsoring or endorsing entity, or paid to or retained by a third party at the direction of the policyholder or sponsoring or endorsing entity, or an entity affiliated therewith by way of ownership, contract, or employment;

(c) The notice required by this section shall be placed on or accompany an application or enrollment form provided to prospective insureds; and

(d) For purposes of this section:

(i) Direct response solicitation means a solicitation by a sponsoring or endorsing entity through the mail, telephone, or other mass communications media; and

(ii) Sponsoring or endorsing entity means an organization that has arranged for the offering of a program of insurance in a manner that communicates that eligibility for participation in the program is dependent upon affiliation with the organization or that it encourages participation in the program.

Sec. 16. Section 44-1607, Reissue Revised Statutes of Nebraska, is amended to read:

44-1607 No policy of group life insurance shall be delivered in this state unless it contains in substance the following provisions or provisions which in the opinion of the Director of Insurance are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder, except that provisions of subdivisions (6) through (10) of this section shall not apply to policies ~~issued to a creditor to insure debtors of such creditor,~~ insuring the lives of debtors, that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies, and that if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the

Director of Insurance is or are equitable to the insured persons and to the policyholder, but nothing in this section shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies:

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him or her. This provision shall not preclude the assertion at any time of defenses based upon provisions in the policy that relate to eligibility for coverage;

(3) A provision that a copy of the application, if any,

of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person ~~or to his or her beneficiary;~~ or, in the event of death or incapacity of the insured person, to his or her beneficiary or personal representative;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage;

(5) A provision specifying that an equitable adjustment of premiums, of benefits, or of both is to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(6) A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except that, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding two thousand dollars

to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured;

(7) A provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he or she is entitled, to whom the insurance benefits are payable, a statement as to any dependent's coverage included in the certificate, and the rights and conditions set forth in subdivisions (8), (9), and (10) of this section;

(8) A provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him or her by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits if application for the individual policy is made and the first premium paid to the insurer within thirty-one days after such termination and if (a) the individual policy shall, at the option of such person, be on any one of the forms~~, except term insurance, then~~ customarily issued by the insurer at the age and for the amount applied for except that the group policy may exclude the option to elect term insurance, (b) the individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination, less the amount of any life insurance for which the person becomes eligible under the same or any other

group policy within thirty-one days after termination, except that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this subdivision, be included in the amount which is considered to cease because of such termination, ~~and~~ (c) the premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his or her age attained on the effective date of the individual policy, and (d) subject to the conditions set forth in subdivisions (8)(a) through (c) of this section, the conversion privilege shall also be available (i) to a spouse and a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy that terminates by reason of death and (ii) to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy;

(9) A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least five years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual

policy of life insurance, subject to the same conditions and limitations as are provided by subdivision (8) of this section, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one days after such termination, and ~~three~~ ten thousand dollars;

(10) A provision that if a person insured under the group policy or the insured dependent of a covered person dies during the period within which he or she would have been entitled to have an individual policy issued to him or her in accordance with subdivision (8) or (9) of this section and before such an individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued to him or her under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made; ~~and~~

(11) If active employment is a condition of insurance, a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium-paying basis for a period of six

months from the date on which the total disability started, but not beyond the earlier of:

(a) Approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain; or

(b) The discontinuance of the group insurance policy; and

~~(11)~~ (12) In the case of a policy ~~issued to a creditor to insure debtors of such creditor,~~ insuring the lives of debtors, a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a ~~form which will contain a statement that the life of the debtor is insured under the policy and~~ certificate of insurance describing the coverage and specifying that any death benefit ~~paid thereunder by reason of his or her death~~ shall first be applied to reduce or extinguish the indebtedness.

Sec. 17. Section 44-1607.01, Reissue Revised Statutes of Nebraska, is amended to read:

44-1607.01 Individual life insurance policies, uniform as to amounts of insurance for each reasonable class eligible therefor, may be issued on a franchise or wholesale basis to five or more employees of a common employer or ten or more members of any trade or professional association, of a labor union or similar employee organization, or of any other association having had an active existence for at least two years when such association or union or organization has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance. Nothing in this section shall be construed to prohibit the issuance

of individual life insurance policies on salary savings, bank draft, or similar type plans.

Sec. 18. Section 44-1613, Reissue Revised Statutes of Nebraska, is amended to read:

44-1613 If any individual insured under a group life insurance policy hereafter delivered in this state becomes entitled under the terms of such policy to have an individual policy of life insurance issued ~~to him~~ without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least fifteen days prior to the expiration date of such period, then in such event the individual shall have an additional period within which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire fifteen days ~~next~~ after the individual is given such notice but in no event shall such additional period extend beyond sixty days ~~next~~ after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the policyholder to the last-known address of the individual or mailed by the insurer to the last-known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this section.

Sec. 19. Section 44-1614, Reissue Revised Statutes of Nebraska, is amended to read:

44-1614 ~~(1)~~ Insurance~~, further referred to in subsection~~

~~(2) of this section,~~ under any group life insurance policy issued pursuant to section 44-1602, 44-1604, 44-1605, 44-1606, or 44-1606.01 or sections 14 and 15 of this act may be extended to insure the employees or members against loss due to the death of their spouse and dependent children, or any class or classes thereof. ~~, of each insured employee or member.~~ Premiums for the insurance ~~on such spouse and dependent children~~ shall be paid ~~by the policyholder~~ either from ~~the policyholder's fund or~~ funds contributed by ~~him or her~~ the employer, the labor union or similar employee organization, or other person to whom the policy has been issued or from funds contributed by the ~~insured employees or members,~~ covered persons, or from both. A policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by the covered persons shall insure all eligible employees or members with respect to their spouses and dependent children, or any class or classes of employees or members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer. The amount of insurance for any covered spouse or dependent child under the policy may not exceed fifty percent of the amount of insurance for which the employee or member is insured.

~~(2) Upon termination of the insurance, referred to in subsection (1) of this section, with respect to the spouse or dependent children of any employee or member by reason of termination of employment, termination of membership in the class or classes eligible for coverage under the policy, or death, the spouse shall be entitled to have issued by the insurer, without~~

~~evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits if application for the individual policy is made and the first premium paid to the insurer within thirty-one days after such termination, subject to the requirements of subdivision (8) of section 44-1607. If the group policy terminates or is amended so as to terminate the insurance of any class of employees or members and the employee or member is entitled to have issued an individual policy under subdivision (9) of section 44-1607, the spouse shall also be entitled to have issued by the insurer an individual policy subject to the conditions and limitations provided in this section. If the spouse dies within the period during which he or she would have been entitled to have an individual policy issued in accordance with this section, the amount of life insurance which he or she would have been entitled to have issued under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made. Notwithstanding subdivision (7) of section 44-1607 only one certificate need be issued for delivery to an insured person if a statement concerning any dependents' coverage is included in such certificate.~~

Sec. 20. Section 44-32,106, Reissue Revised Statutes of Nebraska, is amended to read:

44-32,106 Health maintenance organization producer shall mean a person licensed under subdivision (1)(b) of section 44-4054 who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for health maintenance organization

membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself or herself, or who advertises or otherwise holds himself or herself out to the public as such.

Sec. 21. Section 44-3901, Reissue Revised Statutes of Nebraska, is amended to read:

44-3901 The purpose of sections 44-3901 to 44-3908 is to establish requirements for continuing education of insurance ~~agents,~~ ~~brokers,~~ producers and consultants who are licensed in order to maintain and improve the quality of insurance services provided to the public.

Sec. 22. Section 44-3902, Reissue Revised Statutes of Nebraska, is amended to read:

44-3902 For purposes of sections 44-3901 to 44-3908, unless the context otherwise requires:

(1) Licensee shall mean a natural person who is licensed by the department as a resident ~~agent,~~ ~~broker,~~ insurance producer or consultant;

(2) Director shall mean the Director of Insurance;

(3) Department shall mean the Department of Insurance; and

(4) Two-year period shall mean the period commencing on the date of licensing and ending on the date of expiration of the licensee's first license effective for not less than two years and each succeeding twenty-four-month period.

Sec. 23. Section 44-3904, Reissue Revised Statutes of Nebraska, is amended to read:

44-3904 (1)(a)(i) Licensees qualified to solicit property and casualty insurance shall be required to complete ~~twenty-four hours of approved continuing education activities in each two-year period commencing before January 1, 2000, and~~ twenty-one hours of approved continuing education activities in each two-year period commencing ~~on or after~~ before January 1, ~~2000.~~ 2010. Licensees qualified to solicit life, accident and health or sickness, property, casualty, or personal lines property and casualty insurance shall be required to complete six hours of approved continuing education activities for each line of insurance, including each miscellaneous line, in which he or she is licensed in each two-year period commencing before January 1, 2010. Licensees qualified to solicit life, accident and health or sickness, property, casualty, or personal lines property and casualty insurance shall be required to complete twenty-one hours of approved continuing education activities in each two-year period commencing on or after January 1, 2010.

~~(ii) Licensees qualified to solicit assessment association insurance shall be required to complete twelve hours of approved continuing education activities in each two-year period.~~

~~(iii)~~ (ii) Licensees qualified to solicit only crop insurance ~~or only fidelity and surety insurance~~ shall be required to complete three hours of approved continuing education activities in each two-year period.

~~(iv)~~ (iii) Licensees qualified to solicit any lines of insurance other than those described in subdivisions (i) ~~through (iii)~~ and (ii) of subdivision (a) of this subsection shall be

required to complete six hours of approved continuing education activities in each two-year period for each line of insurance, including each miscellaneous line, in which he or she is licensed. Licensees qualified to solicit variable life and variable annuity products shall not be required to complete additional continuing education activities because the licensee is qualified to solicit variable life and variable annuity products.

(b) Licensees who are ~~neither agents nor brokers~~ not insurance producers shall be required to complete ~~twenty-four hours of continuing education activities in each two-year period commencing before January 1, 2000, and~~ twenty-one hours of approved continuing education activities in each two-year period commencing on or after January 1, 2000.

(c) In each two-year period, every licensee shall furnish evidence to the director that he or she has satisfactorily completed the hours of approved continuing education activities required under this subsection for each line of insurance in which he or she is licensed as a resident ~~agent or broker,~~ insurance producer, except that no licensee shall be required to complete more than twenty-four cumulative hours ~~required under this subsection in any two-year period commencing before January 1, 2000, and twenty-one cumulative hours~~ required under this subsection in any two-year period commencing on or after January 1, 2000.

(d) A licensee shall not repeat a continuing education activity for credit within a two-year period.

(2) In each two-year period, ~~commencing before January 1,~~

~~2000, licensees required to complete approved continuing education activities under subsection (1) of this section shall, in addition to such activities, be required to complete six hours of approved continuing education activities on insurance industry ethics, except that licensees qualified to solicit only crop insurance, only fidelity and surety insurance, or only title insurance shall be required to complete three hours of approved continuing education activities on insurance industry ethics, and in each two-year period commencing on or after January 1, 2000,~~ licensees required to complete approved continuing education activities under subsection (1) of this section shall, in addition to such activities, be required to complete three hours of approved continuing education activities on insurance industry ethics.

(3) When the requirements of this section have been met, the licensee shall furnish to the department evidence of completion for the current two-year period. ~~and a filing fee as established by the director not to exceed five dollars.~~

Sec. 24. Section 44-3909, Reissue Revised Statutes of Nebraska, is amended to read:

44-3909 Except as otherwise provided by the Insurance Producers Licensing Act, no individual shall be eligible to apply for a license as an insurance producer unless he or she has completed the following prelicensing education requirements:

(1) An individual seeking a ~~property and casualty insurance~~ qualification for a license in the life insurance line shall complete at least six hours of education on insurance industry ethics in addition to ~~thirty-four~~ fourteen hours of

education in the area of ~~property and casualty~~ life insurance;

(2) An individual seeking a ~~life insurance and annuities~~ qualification for a license in the accident and health or sickness insurance line shall complete at least six hours of education on insurance industry ethics in addition to fourteen hours of education in the area of ~~life insurance and annuities;~~ accident and health or sickness insurance;

(3) An individual seeking a ~~sickness, accident, and health insurance~~ qualification for a license in the property insurance line shall complete at least six hours of education on insurance industry ethics in addition to fourteen hours of education in the area of ~~sickness, accident, and health insurance of which at least six hours shall be in the area of medicare supplement insurance and long-term care~~ property insurance;

(4) An individual seeking a ~~combined life insurance and annuities and sickness, accident, and health insurance~~ qualification for a license in the casualty insurance line shall complete at least six hours of education on insurance industry ethics in addition to ~~thirty-four~~ fourteen hours of education in the area of ~~life~~ casualty insurance; ~~and annuities and sickness, accident, and health insurance and of such thirty-four hours at least seventeen hours shall be in the area of life insurance and annuities and seventeen hours shall be in the area of sickness, accident, and health insurance, and of such seventeen hours in the area of sickness, accident, and health insurance at least six hours shall be in the area of medicare supplement insurance and long-term care insurance;~~

(5) An individual seeking a qualification for a license in the personal lines property and casualty insurance line shall complete at least six hours of education on insurance industry ethics in addition to fourteen hours of education in the area of personal lines property and casualty insurance;

~~(5)~~ (6) An individual seeking a ~~title insurance~~ qualification for a license in the title insurance line shall complete at least six hours of education on insurance industry ethics in addition to six hours of education in the area of title insurance; and

~~(6) An individual seeking an assessment association insurance license shall complete at least six hours of education on insurance industry ethics in addition to six hours of education in the area of the kinds of insurance issued by an assessment association; and~~

(7) An individual seeking a ~~crop insurance~~ qualification for a license in the crop insurance line shall complete at least three hours of education on insurance industry ethics in addition to three hours of education in the area of crop insurance.

Sec. 25. Section 44-3910, Reissue Revised Statutes of Nebraska, is amended to read:

44-3910 The prelicensing education requirements of section 44-3909 shall not apply to an individual who, at the time of application for an insurance producer license:

(1) Is applying for qualification for the life insurance line of authority and has the certified employee benefit specialist designation, the chartered financial consultant designation, the

certified insurance counselor designation, the certified financial planner designation, the chartered life underwriter designation, the fellow life management institute designation, or the Life Underwriter Training Council fellow designation;

(2) Is applying for qualification for the accident and health or sickness insurance line of authority and has the registered health underwriter designation, the certified employee benefit specialist designation, the registered employee benefit consultant designation, or the health insurance associate designation;

(3) Is applying for qualification for the property insurance, casualty insurance, or personal lines property and casualty insurance line of authority and has the accredited advisor in insurance designation, the associate in risk management designation, the certified insurance counselor designation, or the chartered property and casualty underwriter designation;

(4) Has ~~,~~ ~~has~~ ~~the~~ ~~chartered~~ ~~property~~ ~~and~~ ~~casualty~~ ~~underwriter~~ ~~designation,~~ ~~the~~ ~~chartered~~ ~~life~~ ~~underwriter~~ ~~designation,~~ ~~the~~ ~~registered~~ ~~health~~ ~~underwriter~~ ~~designation,~~ ~~the~~ ~~certified~~ ~~employee~~ ~~benefit~~ ~~specialist~~ ~~designation,~~ ~~the~~ ~~certified~~ ~~financial~~ ~~planner~~ ~~designation,~~ ~~the~~ ~~accredited~~ ~~adviser~~ ~~in~~ ~~insurance~~ ~~designation,~~ ~~the~~ ~~chartered~~ ~~financial~~ ~~consultant~~ ~~designation,~~ ~~or~~ a ~~master's~~ college degree with a concentration in insurance from an accredited educational institution;

(5) Is an ~~,~~ ~~to~~ ~~any~~ individual described in section 44-4056 or 44-4058; or

(6) Is a person who ~~,~~ ~~or~~ ~~to~~ ~~such~~ ~~other~~ ~~persons~~ ~~as~~ the

director may exempt pursuant to a rule or regulation adopted and promulgated pursuant to the Administrative Procedure Act.

Sec. 26. Section 44-3911, Reissue Revised Statutes of Nebraska, is amended to read:

44-3911 A certificate of completion of the prelicensing education requirements shall be filed with the director. ~~along with a filing fee as established by the director not to exceed ten dollars.~~

Sec. 27. Section 44-4064, Reissue Revised Statutes of Nebraska, is amended to read:

44-4064 (1) Before any license or appointment is issued or renewed under the Insurance Producers Licensing Act or before any appointment is terminated, the person requesting such license shall pay or cause to be paid to the director the following fee or fees, if applicable, as established by the director:

(a) For each ~~resident~~ insurance producer license, a fee not to exceed ~~forty~~ one hundred dollars;

~~(b) For each nonresident insurance producer license, a fee not to exceed eighty dollars;~~

~~(c)~~ (b) For each annual appointment, a fee not to exceed ten dollars;

~~(d)~~ (c) For each termination of an appointment, a fee not to exceed ten dollars;

~~(e)~~ (d) A late renewal fee not to exceed one hundred twenty-five dollars;

~~(f)~~ (e) A reinstatement fee not to exceed one hundred seventy-five dollars; and

~~(g)~~ (f) For each business entity license, a fee not to exceed fifty dollars.

(2) If a licensed person (a) desires to add a line or lines of insurance to his or her existing license, (b) seeks to change any other information contained in the license for any reason, or (c) applies for a duplicate license, such person shall pay to the director a fee established by the director to cover the expense of replacing the license.

(3) The director shall not prorate fees imposed pursuant to subsection (1) of this section, and shall not refund fees to any person in the event of a license denial. The director may refund fees paid pursuant to this section if the payment has been made in error.

Sec. 28. Section 44-4521, Revised Statutes Supplement, 2007, is amended to read:

44-4521 (1) ~~An~~ On or after August 1, 2008, an individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for health or sickness and accident insurance and has completed a one-time training course ~~on or before August 1, 2008,~~ and ongoing training every twenty-four months thereafter. All training shall meet the requirements of subsection (2) of this section.

(2) The one-time training course required by subsection (1) of this section shall be no less than eight hours in length, and the required ongoing training shall be no less than four hours in length. All training required under subsection (1) of this section shall consist of topics related to long-term care

insurance, long-term care services, and, if applicable, qualified state long-term insurance partnership programs, including, but not limited to:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(b) Available long-term care services and providers;

(c) Changes or improvements in long-term care services or providers;

(d) Alternatives to the purchase of private long-term care insurance;

(e) The effect of inflation on benefits and the importance of inflation protection; and

(f) Consumer suitability standards and guidelines.

Training required by subsection (1) of this section shall not include any sales or marketing information, materials, or training other than those required by state or federal law.

(3)(a) Insurers subject to the Long-Term Care Insurance Act shall obtain verification that the insurance producer receives training required by subsection (1) of this section before a producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products. Records shall be maintained in accordance with section 44-5905 and shall be made available to the director upon request.

(b) Insurers subject to the act shall maintain records with respect to the training of its producers concerning the

distribution of its partnership policies that will allow the director to provide assurance to the Department of Health and Human Services ~~Finance and Support~~ that producers have received the training required by subsection (1) of this section and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including medicaid, in this state. These records shall be maintained in accordance with section 44-5905 and shall be made available to the director upon request.

(4) The satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements of the State of Nebraska.

(5) The training requirements of subsection (1) of this section may be approved as continuing education courses pursuant to sections 44-3901 to 44-3913.

Sec. 29. Section 44-6009, Reissue Revised Statutes of Nebraska, is amended to read:

44-6009 Negative trend, with respect to a life and health insurer, means a negative trend over a period of time, as determined in accordance with the trend test calculation included in the life risk-based capital instructions.

Sec. 30. Section 44-6016, Reissue Revised Statutes of Nebraska, is amended to read:

44-6016 (1) Company action level event means any of the following events:

(a) The filing of a risk-based capital report by an insurer or a health organization which indicates that:

(i) The insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital; ~~or~~

(ii) If a life and health insurer, the insurer has total adjusted capital which is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 2.5 and has a negative trend; or

(iii) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions;

(b) The notification by the director to the insurer or health organization of an adjusted risk-based capital report that indicates an event described in subdivision ~~(1)(a)(i) or (ii)~~ (1)(a) of this section unless the insurer or health organization challenges the adjusted risk-based capital report under section 44-6020; or

(c) If, pursuant to section 44-6020, the insurer or health organization challenges an adjusted risk-based capital report that indicates an event described in subdivision ~~(1)(a)(i) or (ii)~~ (1)(a) of this section, the notification by the director to the insurer or health organization that the director has, after a

hearing, rejected the insurer's or health organization's challenge.

(2) In the event of a company action level event, the insurer or health organization shall prepare and submit to the director a risk-based capital plan which shall:

(a) Identify the conditions which contribute to the company action level event;

(b) Contain proposals of corrective actions which the insurer or health organization intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years in the case of an insurer or at least the two succeeding years in the case of a health organization, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and risk-based capital levels. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(d) Identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the insurer's or health organization's business, including, but not limited to, its assets, anticipated business growth and

associated surplus strain, extraordinary exposure to risk, and mix of business and use of reinsurance, if any, in each case.

(3) The risk-based capital plan shall be submitted:

(a) Within forty-five days after the occurrence of the company action level event; or

(b) If the insurer or health organization challenges an adjusted risk-based capital report pursuant to section 44-6020, within forty-five days after the notification to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

(4) Within sixty days after the submission by an insurer or a health organization of a risk-based capital plan to the director, the director shall notify the insurer or health organization whether the risk-based capital plan shall be implemented or is, in the judgment of the director, unsatisfactory. If the director determines that the risk-based capital plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination and may set forth proposed revisions which will render the risk-based capital plan satisfactory in the judgment of the director. Upon notification from the director, the insurer or health organization shall prepare a revised risk-based capital plan which may incorporate by reference any revisions proposed by the director. The insurer or health organization shall submit the revised risk-based capital plan to the director:

(a) Within forty-five days after the notification from the director; or

(b) If the insurer or health organization challenges the notification from the director under section 44-6020, within forty-five days after a notification to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

(5) In the event of a notification by the director to an insurer or a health organization that the insurer's or health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the director may, at the director's discretion and subject to the insurer's or health organization's right to a hearing under section 44-6020, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer or domestic health organization that files a risk-based capital plan or revised risk-based capital plan with the director shall file a copy of the risk-based capital plan or revised risk-based capital plan with the insurance commissioner of any state in which the insurer or health organization is authorized to do business if:

(a) Such state has a law substantially similar to subsection (1) of section 44-6021; and

(b) The insurance commissioner of such state has notified the insurer or health organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the risk-based capital plan or revised risk-based capital plan in such state no later than the later of:

(i) Fifteen days after the receipt of notice to file a

copy of its risk-based capital plan or revised risk-based capital plan with the state; or

(ii) The date on which the risk-based capital plan or revised risk-based capital plan is filed under subsection (3) or (4) of this section.

Sec. 31. Section 44-6603, Reissue Revised Statutes of Nebraska, is amended to read:

44-6603 For purposes of the Insurance Fraud Act:

(1) Department means the Department of Insurance;

(2) Director means the Director of Insurance;

(3) Insurer means any person or entity transacting insurance as defined in section 44-102 with or without a certificate of authority issued by the director. Insurer also means health maintenance organizations, legal service insurance corporations, prepaid limited health service organizations, dental and other similar health service plans, discount medical plan organizations, and entities licensed pursuant to the Intergovernmental Risk Management Act and the Comprehensive Health Insurance Pool Act. Insurer also means an employer who is approved by the Nebraska Workers' Compensation Court as a self-insurer; and

(4) Statement includes, but is not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical records, X-rays, test result, or other evidence of loss, injury, or expense, whether oral, written, or computer-generated.

Sec. 32. Section 44-6604, Reissue Revised Statutes of

Nebraska, is amended to read:

44-6604 For purposes of the Insurance Fraud Act, a person or entity commits a fraudulent insurance act if he or she:

(1) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any agent of an insurer, any statement as part of, in support of, or in denial of a claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim;

(2) Assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to or by an insurer or person in connection with or in support of any claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim;

(3) Makes any false or fraudulent representations as to the death or disability of a policy or certificate holder or a covered person in any statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;

(4) Knowingly and willfully transacts any contract, agreement, or instrument which violates this section;

(5) Receives money for the purpose of purchasing insurance and converts the money to the person's own benefit;

(6) Willfully embezzles, abstracts, purloins,

misappropriates, or converts money, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance;

(7) Knowingly and with intent to defraud or deceive issues or possesses fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(8) Knowingly and with intent to defraud or deceive makes any false entry of a material fact in or pertaining to any document or statement filed with or required by the department; ~~or~~

(9) Knowingly and with intent to defraud or deceive removes, conceals, alters, diverts, or destroys assets or records of an insurer or person engaged in the business of insurance or attempts to remove, conceal, alter, divert, or destroy assets or records of an insurer or person engaged in the business of insurance; ~~.~~

(10) Willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 38 of this act; or

(11) Willfully collects fees for purported membership in a discount medical plan but purposefully fails to provide the promised benefits.

Sec. 33. Sections 33 to 48 of this act shall be known and may be cited as the Discount Medical Plan Organization Act.

Sec. 34. The purpose of the Discount Medical Plan Organization Act is to promote the public interest by establishing standards for discount medical plan organizations to protect

consumers from unfair or deceptive marketing, sales, or enrollment practices and to facilitate consumer understanding of the role and function of discount medical plan organizations in providing access to medical or ancillary services.

Sec. 35. For purposes of the Discount Medical Plan Organization Act:

(1) Affiliate means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the person specified;

(2) Ancillary services includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic, and podiatry services;

(3) Control or controlled by or under common control with means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person;

(4) Director means the Director of Insurance;

(5)(a) Discount medical plan means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, offers access for its members to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount medical plan from those providers.

(b) Discount medical plan does not include a plan that

does not charge a membership or other fee to use the plan's discount medical card;

(6) Discount medical plan organization means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It is the organization that contracts with providers, provider networks, or other discount medical plan organizations to offer access to medical or ancillary services at a discount and determines the charge to discount medical plan members;

(7) Facility means an institution providing medical or ancillary services or a health care setting. Facility includes, but is not limited to:

(a) A hospital or other licensed inpatient center;

(b) An ambulatory surgical or treatment center;

(c) A skilled nursing center;

(d) A residential treatment center;

(e) A rehabilitation center; and

(f) A diagnostic, laboratory, or imaging center;

(8) Health care professional means a physician, pharmacist, or other health care practitioner who is licensed, accredited, or certified to perform specified medical or ancillary services within the scope of his or her license, accreditation, certification, or other appropriate authority and consistent with state law;

(9) Health carrier means an entity certified under and

subject to the insurance laws and rules and regulations of this state or subject to the jurisdiction of the director that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or medical or ancillary services;

(10) Marketer means a person or entity that markets, promotes, sells, or distributes a discount medical plan including a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a marketing agreement with a discount medical plan organization;

(11) Medical services means any maintenance care of, or preventive care for, the human body or care, service, or treatment of an illness or dysfunction of, or injury to, the human body. Medical services includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services, and medical equipment and supplies. Medical services does not include pharmacy services or ancillary services;

(12) Member means any individual who pays fees, dues, charges, or other consideration for the right to receive the benefits of a discount medical plan;

(13) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, or any similar

entity or any combination of the foregoing;

(14) Provider means any health care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to provide medical or ancillary services to members; and

(15) Provider network means an entity that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider to provide medical or ancillary services to members.

Sec. 36. Control as used in the Discount Medical Plan Organization Act is presumed to exist if any person, directly or indirectly, owns, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in subsection (11) of section 44-2132 that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Sec. 37. (1) The Discount Medical Plan Organization Act applies to all discount medical plan organizations doing business in or from this state.

(2) A discount medical plan organization that is a health carrier is not required to obtain a certificate of registration under section 38 of this act, except that any of its affiliates that operates as a discount medical plan organization in this state

shall obtain a certificate of registration under section 38 of this act and comply with all other provisions of the act. The discount medical plan organization is required to comply with sections 40 to 43 of this act and report, in the form and manner as the director may require, any of the information described in subsection (2) of section 45 of this act that is not otherwise already reported.

(3) A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a certificate of registration under the act as a discount medical plan organization.

Sec. 38. (1) Before doing business in or from this state as a discount medical plan organization, a discount medical plan organization:

(a) May transact business in this state under Chapter 21; and

(b) Shall obtain a certificate of registration from the director to operate as a discount medical plan organization.

(2) Each application for a certificate of registration to operate as a discount medical plan organization shall:

(a) Be in a form prescribed by the director and verified by an officer or authorized representative of the applicant;

(b) Be accompanied by an application fee not to exceed five hundred dollars;

(c) Include information on whether:

(i) A previous application for a certificate of registration or licensure has been denied, revoked, suspended, or terminated for cause in any jurisdiction; and

(ii) The applicant is under investigation for or the subject of any pending action or has been found in violation of a statute or regulation in any jurisdiction within the previous five years; and

(d) Include information as the director may require that permits the director, after reviewing all of the information submitted pursuant to this subsection, to make a determination that the applicant:

(i) Is financially responsible;

(ii) Has adequate expertise or experience to operate a discount medical plan organization; and

(iii) Is of good character.

(3) After the receipt of an application filed pursuant to subsection (2) of this section, the director shall review the application and notify the applicant of any deficiencies in the application.

(4) No more than ninety days after the date of receipt of a completed application, the director shall issue a certificate of registration if the director is satisfied that the applicant has met the requirements of subsection (2) of this section or shall deny the application and state the grounds for denial.

(5) Prior to issuance of a certificate of registration by the director, each discount medical plan organization shall establish an Internet web site in order to conform to the requirements of subsection (2) of section 41 of this act.

(6)(a) A registration is effective for one year unless before its expiration it is renewed in accordance with this

subsection or suspended or revoked in accordance with subsection (7) of this section.

(b) At least ninety days before a certificate of registration is set to expire, the discount medical plan organization shall submit:

(i) A renewal application form; and

(ii) The renewal fee.

(c) The director shall renew the certificate of registration of each holder that meets the requirements of the Discount Medical Plan Organization Act and pays the renewal fee of three hundred dollars.

(7)(a) The director may suspend or revoke a certificate of registration after notice and hearing held in accordance with the Administrative Procedure Act if the director finds that any of the following conditions exist:

(i) The discount medical plan organization is not operating in compliance with the act;

(ii) The discount medical plan organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising;

(iii) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

(iv) The continued operation of the discount medical plan organization would be hazardous to its members.

(b) If the director has cause to believe that grounds for the denial or nonrenewal of a certificate of registration exists, the director shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to grant or renew the certificate of registration. The applicant or registrant has thirty days after receipt of such notification to demand a hearing. The hearing shall be held no more than thirty days after receipt of such demand by the director and shall be held in accordance with the Administrative Procedure Act.

(c)(i) The director shall, in his or her order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its certificate of registration to enroll members.

(ii) The director may rescind or modify the order of suspension prior to the expiration of the suspension period.

(iii) The certificate of registration of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The director shall not grant the request for reinstatement if the director finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(8) In lieu of suspending or revoking a discount medical plan organization's certificate of registration under subsection (7) of this section, if the discount medical plan organization has violated any provision of the act, the director may:

(a) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and

(b) Impose a monetary penalty of not more than one thousand dollars for each violation.

(9) Each registered discount medical plan organization shall notify the director immediately whenever the discount medical plan organization's certificate of registration or other form of authority to operate as a discount medical plan organization in another state is suspended, revoked, or not renewed in that state.

Sec. 39. (1) The director may examine or investigate the business and affairs of any discount medical plan organization to protect the interests of the residents of this state based on the following reasons, including, but not limited to, complaint indices, recent complaints, information from other states, or as the director deems necessary.

(2) An examination or investigation conducted as provided in subsection (1) of this section shall be performed in accordance with the provisions of the Insurers Examination Act.

(3) The director may:

(a) Order any discount medical plan organization or applicant that operates a discount medical plan organization to produce any records, books, files, advertising and solicitation materials, or other information; and

(b) Take statements under oath to determine whether the discount medical plan organization or applicant is in violation of

the law or is acting contrary to the public interest.

(4) The discount medical plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount medical plan organization or applicant to pay such expenses is grounds for denial of a certificate of registration to operate as a discount medical plan organization or revocation of a certificate of registration to operate as a discount medical plan organization.

Sec. 40. (1) A discount medical plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount medical plan.

(2)(a)(i) If a member cancels his or her membership in the discount medical plan organization within thirty days after the date of receipt of the written document for the discount medical plan described in subsection (4) of section 43 of this act, the member shall receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds thirty dollars upon return of the discount medical plan card to the discount medical plan organization.

(ii)(A) Cancellation occurs when notice of cancellation is given to the discount medical plan organization.

(B) Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed, and postage prepaid to the mailing address of the discount medical plan organization.

(iii) A discount medical plan organization shall return

any periodic charge charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

(b) If the discount medical plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

(3) When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the marketer or discount medical plan organization shall:

(a) Provide the charges for each discount medical plan in writing to the member; or

(b) Reimburse the member for all periodic charges for the discount medical plan if the member cancels his or her membership in accordance with subdivision (2)(a) of this section.

(4) Any discount medical plan organization that is a health carrier that provides a discount medical plan product that is incidental to the insured product is not subject to this section.

Sec. 41. (1)(a) A discount medical plan organization shall have a written provider agreement with all providers offering medical or ancillary services to its members. The written provider agreement may be entered into directly with the provider or indirectly with a provider network to which the provider belongs.

(b) A provider agreement between a discount medical plan organization and a provider shall provide the following:

(i) A list of the medical or ancillary services and

products to be provided at a discount;

(ii) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

(iii) That the provider will not charge members more than the discounted rates.

(c) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers that:

(i) Contain the provisions described in subdivision (1)(b) of this section;

(ii) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and

(iii) Require the provider network to maintain an up-to-date list of its contracted providers and to provide the list on a monthly basis to the discount medical plan organization.

(d) A provider agreement between a discount medical plan organization and an entity that contracts with a provider network shall require that the entity, in its contract with the provider network, require the provider network to have written agreements with its providers that comply with subdivision (1)(c) of this section.

(e) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.

(2) Each discount medical plan organization shall maintain on an Internet web site an up-to-date list of the names and addresses of the providers with which it has contracted

directly or through a provider network. The web site address shall be prominently displayed on all of its advertisements, marketing materials, brochures, and discount medical plan cards. This subsection applies to those providers with which the discount medical plan organization has contracted directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

(3) Each discount medical plan organization shall maintain a toll-free telephone number for members to obtain additional information about and assistance on the discount medical plan and an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The toll-free telephone number shall be prominently displayed on all of its advertisements, marketing materials, brochures, and discount medical plan cards. Capable and competent personnel shall staff the toll-free telephone number.

Sec. 42. (1) A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.

(2)(a) The discount medical plan organization shall have an executed written agreement with each marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan.

(b) The agreement between the discount medical plan organization and the marketer shall prohibit the marketer from using advertising, marketing materials, brochures, and discount medical plan cards without the discount medical plan

organizations's approval in writing.

(c) The discount medical plan organization shall be bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization.

(3) A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures, and discount cards used by marketers to market, promote, sell, or distribute the discount medical plan prior to their use.

(4) Upon request, a discount medical plan organization shall submit to the director all advertising, marketing materials, and brochures regarding a discount medical plan.

Sec. 43. (1)(a) All advertisements, marketing materials, brochures, discount medical plan cards, and any other communications of a discount medical plan organization provided to prospective members and members shall be truthful and not misleading in fact or in implication.

(b) Any advertisement, marketing material, brochure, discount medical plan card, or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.

(2)(a) Except as otherwise provided in the Discount Medical Plan Organization Act, as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount

medical plan, a discount medical plan organization shall not use in its advertisements, marketing material, brochures, or discount medical plan cards the term insurance;

(b) Except as otherwise provided in state law, a discount medical plan organization shall not describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance benefits are incidental to the discount medical plan benefits; and

(c) A discount medical plan organization shall not:

(i) Use in its advertisements, marketing material, brochures, or discount medical plan cards the terms health plan, coverage, copay, copayment, deductible, preexisting condition, guaranteed issue, premium, PPO, preferred provider organization, or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;

(ii) Use language in its advertisements, marketing material, brochures, or discount medical plan cards with respect to being licensed or registered by a state insurance department in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by a state;

(iii) Make misleading, deceptive, or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;

(iv) Have restrictions on access to discount medical plan providers, including waiting periods and notification periods,

except for hospital services; or

(v) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan unless the discount medical plan organization has an active certificate of authority to act as a third-party administrator in accordance with the Third-Party Administrator Act.

(3)(a) Each discount medical plan organization shall make the following general disclosures in writing in not less than twelve-point font on the first content page of any advertisement, marketing material, or brochure made available to the public relating to a discount medical plan together with any enrollment forms given to a prospective member:

(i) That the plan is a discount plan and is not insurance coverage;

(ii) That the range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;

(iii) Unless the discount medical plan organization has an active certificate of authority to act as a third-party administrator as described in subdivision (2)(c)(v) of this section, that the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

(iv) That the plan member is obligated to pay for all medical or ancillary services but will receive a discount from those providers that have contracted with the discount medical plan

organization; and

(v) The toll-free telephone number and Internet web site address for the registered discount medical plan organization for prospective members and members to obtain additional information about and assistance on the discount medical plan and an up-to-date list of providers participating in the discount medical plan.

(b) If the initial contact with a prospective member is by telephone, the disclosures required under subdivision (a) of this subsection shall be made orally and included in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

(4)(a) In addition to the general disclosures required under subsection (3) of this section, each discount medical plan organization shall provide to:

(i) Each prospective member, at the time of enrollment, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan; and

(ii) Each new member a written document that contains the terms and conditions of the discount medical plan.

(b) The written document required under subdivision (a)(ii) of this subsection shall be clear and include the following information:

(i) The name of the member;

(ii) The benefits to be provided under the discount medical plan;

(iii) Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

(iv) The frequency of payment of any processing fees and periodic charges and procedures for changing the frequency of payment;

(v) Any limitations, exclusions, or exceptions regarding the receipt of discount medical plan benefits;

(vi) Any waiting periods for certain medical or ancillary services under the discount medical plan;

(vii) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;

(viii) Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;

(ix) Renewal, termination, and cancellation terms and conditions;

(x) Procedures for adding new members to a family discount medical plan, if applicable;

(xi) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact his or her state insurance department; and

(xii) The name, toll-free telephone number, and mailing address of the discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices, and file complaints.

Sec. 44. Each discount medical plan organization shall provide the director notice of any change in the discount medical plan organization's name, address, telephone number, principal business address or mailing address, or Internet web site address no less than thirty days before such change is to occur.

Sec. 45. (1) If the information required in subsection (2) of this section is not provided at the time of renewal of a certificate of registration under section 38 of this act, a discount medical plan organization shall file an annual report with the director in the form prescribed by the director within three months after the end of each fiscal year.

(2) The report shall include:

(a) If different from the initial application for a certificate of registration or at the time of renewal of a certificate of registration, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with such persons and the discount medical plan organization, including any possible conflicts of interest;

(b) The number of discount medical plan members in the state; and

(c) Any other information relating to the performance of

the discount medical plan organization that may be required by the director.

(3)(a) Any discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall forfeit:

(i) Up to five hundred dollars each day for the first ten days during which the violation continues; and

(ii) Up to one thousand dollars each day after the first ten days during which the violation continues.

(b) Upon notice by the director, the discount medical plan organization described in subdivision (a) of this subsection shall lose its authority to enroll new members or to do business in this state if the violation continues.

Sec. 46. (1) A violation of the Discount Medical Plan Organization Act shall be an unfair trade practice under the Unfair Insurance Trade Practices Act.

(2) In addition to the penalties and other enforcement provisions of the Discount Medical Plan Organization Act, any person who willfully violates the act is subject to administrative penalties of up to one thousand dollars per violation.

(3) A person that willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 38 of this act commits a fraudulent insurance act under section 28-631.

(4) A person that collects fees for purported membership in a discount medical plan but purposefully fails to provide the promised benefits commits a fraudulent insurance act under

section 28-631. In addition, upon conviction, such person shall be ordered to pay restitution to persons aggrieved by the violation of the act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of such fine or imprisonment.

Sec. 47. (1) The director may issue an order directing a discount medical plan organization to cease and desist from engaging in any action or practice in violation of the Discount Medical Plan Organization Act. Within ten days after service of the cease and desist order, the organization may request a hearing on the question of whether an action or practice in violation of the act has occurred. Such hearing shall be conducted as provided by the Administrative Procedure Act. The organization may appeal the decision of the director. Such appeal shall be in accordance with the Administrative Procedure Act.

(2)(a) In addition to the penalties and other enforcement provisions of the act, the director may seek both temporary and permanent injunctive relief when:

(i) A discount medical plan is being operated by a person or entity that is not registered pursuant to the Discount Medical Plan Organization Act; or

(ii) Any person, entity, or discount medical plan organization has engaged in any activity prohibited by the act or any rules or regulations adopted and promulgated pursuant to the act.

(b) The district court of Lancaster County shall have exclusive jurisdiction over any proceeding brought pursuant to this section.

(3) The director's authority to seek relief under this section is not conditioned upon having conducted any proceeding pursuant to the provisions of the Administrative Procedure Act.

Sec. 48. The director may adopt and promulgate rules and regulations to carry out the provisions of the Discount Medical Plan Organization Act.

Sec. 49. Section 44-7508.02, Revised Statutes Cumulative Supplement, 2006, is amended to read:

44-7508.02 (1) For policy forms to which this section applies as provided in section 44-7508.01, each insurer shall file with the director every policy form and related attachment rule and every modification thereof which it proposes to use. For policy forms to which this section applies, 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 (10) or (11) 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 effective date, which shall not be prior to the date that the director receives such filing.

(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 so that such listings can be provided upon request.

(4) The director shall acknowledge receipt of a policy form filing as soon as practical. A review of the filing by the director is not required to issue this acknowledgment, and acknowledgment shall not constitute an approval by the director.

(5) The director may review a policy form filing at any time after it has been made. The director shall review a policy form filing for insurance covering risks of a personal nature, including insurance for homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs, within thirty days after the filing has been made. Following such review, 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.

(6) If, within thirty days after its receipt, the director disapproves a filing that requires disapproval pursuant to subsection (5) of this section, then a written disapproval notice shall be sent to the insurer. The disapproval notice shall specify in what respects the filing fails to meet these requirements. Upon receipt of the notice of disapproval, the insurer shall cease use of the filing as soon as practical but may use the form for policies that have already been issued or when pending coverage

proposals are outstanding.

(7) If, within thirty days after its receipt, the director requests additional information to complete review of a policy form filing, the thirty-day review period allowed in subsection (6) 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.~~ disapprove the filing based on the insurer's failure to provide the requested information. Disapproval shall be by written notice sent to the insurer ordering discontinuance of the filing within thirty days after the date of notice.

(8) An insurer whose filing is disapproved pursuant to subsection (6) of this section may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.

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

(10)(a) Subject to the requirements of this subsection, 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 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 filed with the director. 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 within sixty days after its second usage.

(d) The exemption provided by this subsection shall not apply 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 rule and regulation 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. Any such informational filings 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.

(11) The director may by rule and regulation 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 Property and Casualty Insurance Rate and Form Act.

(12) If, at any time after the expiration of the review period provided by subsection (6) of this section or any extension thereof, the director finds that a policy form, attachment rule, or modification thereof does not meet or no longer meets the requirements of subsection (5) of this section, the director shall hold a hearing in accordance with section 44-7532.

(13) Any insured aggrieved with respect to any policy form filing subject to this section 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.

(14) If, after a hearing held pursuant to subsection (12) or (13) of this section, the director finds that a filing does not meet the requirements of subsection (5) of this section, 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. 50. (1)(a) A financial conglomerate may submit to the jurisdiction of the Director of Insurance for supervision on a consolidated basis under this section. Supervision under this section shall be in addition to all statutory and regulatory requirements imposed on domestic insurers and shall be for the purpose of determining how the operations of the financial conglomerate impact insurance operations.

(b) For purposes of this section:

(i) Control has the same meaning as in section 44-2121; and

(ii) Financial conglomerate means either an insurance company domiciled in Nebraska or a person established under the laws of the United States, any state, or the District of Columbia which directly or indirectly controls an insurance company domiciled in Nebraska. Financial conglomerate includes the person applying for supervision under this section and all entities, whether insurance companies or otherwise, to the extent the entities are controlled by such person.

(2) The director may approve any application for supervision under this section that meets the requirements of this section and the rules and regulations adopted and promulgated under this section.

(3)(a) The director shall adopt and promulgate rules and regulations for supervision of a financial conglomerate, including all persons controlled by a financial conglomerate, that will permit the director to assess at the level of

the financial conglomerate the financial situation of the financial conglomerate, including solvency, risk concentration, and intra-group transactions.

(b) Such rules and regulations shall require the financial conglomerate to:

(i) Have in place sufficient capital adequacy policies at the level of the financial conglomerate;

(ii) Report to the director at least annually any significant risk concentration at the level of the financial conglomerate;

(iii) Report to the director at least annually all significant intra-group transactions of regulated entities within a financial conglomerate. Such reporting shall be in addition to all reports required under any other provision of Chapter 44; and

(iv) Have in place at the level of the financial conglomerate adequate risk management processes and internal control mechanisms, including sound administrative and accounting procedures.

(c) In adopting and promulgating the rules and regulations, the director:

(i) Shall consider the rules and regulations that may be adopted by a member state of the European Union, the European Union, or any other country for the supervision of financial conglomerates;

(ii) Shall require the filing of such information as the director may determine;

(iii) Shall include standards and processes for effective

qualitative group assessment, quantitative group assessment including capital adequacy, affiliate transaction, and risk concentration assessment, risks and internal capital assessments, disclosure requirements, and investigation and enforcement powers;

(iv) Shall state that supervision of financial conglomerates concerns how the operations of the financial conglomerate impact the insurance operations;

(v) Shall adopt an application fee in an amount not to exceed the amount necessary to recover the cost of review and analysis of the application; and

(vi) May verify information received under this section.

(4)(a) If it appears to the director that a financial conglomerate that submits to the jurisdiction of the director under this section, or any director, officer, employee, or agent thereof willfully violates this section or the rules and regulations adopted and promulgated under this section, the director may order the financial conglomerate to cease and desist immediately any such activity. After notice and hearing, the director may order the financial conglomerate to void any contracts between the financial conglomerate and any of its affiliates or among affiliates of the financial conglomerate and restore the status quo if such action is in the best interest of policyholders, creditors, or the public.

(b) If it appears to the director that any financial conglomerate that submits to the jurisdiction of the director under this section, or any director, officer, employee, or agent thereof has committed or is about to commit a violation of this section or the rules and regulations adopted and promulgated

under this section, the director may apply to the district court of Lancaster County for an order enjoining such financial conglomerate, director, officer, employee, or agent from violating or continuing to violate this section or the rules and regulations adopted and promulgated under this section and for such other equitable relief as the nature of the case and the interest of the financial conglomerate's policyholders, creditors, or the public may require.

(c)(i) Any financial conglomerate that fails, without just cause, to provide information which may be required under the rules and regulations adopted and promulgated under this section may be required by the director, after notice and hearing, to pay an administrative penalty of one hundred dollars for each day's delay not to exceed an aggregate penalty of ten thousand dollars. The director may reduce the penalty if the financial conglomerate demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the financial conglomerate.

(ii) Any financial conglomerate that fails to notify the director of any action for which such notification may be required under the rules and regulations adopted and promulgated under this section may be required by the director, after notice and hearing, to pay an administrative penalty of not more than two thousand five hundred dollars per violation.

(iii) Any violation of this section or the rules and regulations adopted and promulgated under this section shall be an unfair trade practice under the Unfair Insurance Trade Practices

Act in addition to any other remedies and penalties available under the laws of this state.

(d) Any director or officer of a financial conglomerate that submits to the jurisdiction of the director under this section who knowingly violates or assents to any officer or agent of the financial conglomerate to violate this section or the rules and regulations adopted and promulgated under this section may be required by the director, after notice and hearing, to pay in his or her individual capacity an administrative penalty of not more than five thousand dollars per violation. In determining the amount of the penalty, the director shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

(e) After notice and hearing, the director may terminate the supervision of any financial conglomerate under this section if it ceases to qualify as a financial conglomerate under this section or the rules and regulations adopted and promulgated under this section.

(f) If it appears to the director that any person has committed a violation of this section or the rules and regulations adopted and promulgated under this section which so impairs the financial condition of a domestic insurer that submits to the jurisdiction of the director under this section as to threaten insolvency or make the further transaction of business by such financial conglomerate hazardous to its policyholders or the public, the director may proceed as provided in the Nebraska

Insurers Supervision, Rehabilitation, and Liquidation Act to take possession of the property of such domestic insurer and to conduct the business thereof.

(g) If it appears to the director that any person that submits to the jurisdiction of the director under this section has committed a violation of this section or the rules and regulations adopted and promulgated under this section which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the director may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew such insurer's license or authority to do business in this state for such period as the director finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

(h)(i) Any financial conglomerate that submits to the jurisdiction of the director under this section that willfully violates this section or the rules and regulations adopted and promulgated under this section shall be guilty of a Class IV felony.

(ii) Any director, officer, employee, or agent of a financial conglomerate that submits to the jurisdiction of the director under this section who willfully violates this section or the rules and regulations adopted and promulgated under this section or who willfully and knowingly subscribes to or makes or causes to be made any false statements, false reports, or false filings with the intent to deceive the director in the

performance of his or her duties under this section or the rules and regulations adopted and promulgated under this section shall be guilty of a Class IV felony.

(iii) Any person aggrieved by any act, determination, order, or other action of the director pursuant to this section or the rules and regulations adopted and promulgated under this section may appeal. The appeal shall be in accordance with the Administrative Procedure Act.

(iv) Any person aggrieved by any failure of the director to act or make a determination required by this section or the rules and regulations adopted and promulgated under this section may petition the district court of Lancaster County for a writ in the nature of a mandamus or a peremptory mandamus directing the director to act or make such determination forthwith.

(i) The powers, remedies, procedures, and penalties governing financial conglomerates under this section shall be in addition to any other provisions provided by law.

(5)(a) The director may contract with such qualified persons as the director deems necessary to allow the director to perform any duties and responsibilities under this section.

(b) The reasonable expenses of supervision of a financial conglomerate under this section shall be fixed and determined by the director who shall collect the same from the supervised financial conglomerate. The financial conglomerate shall reimburse the amount upon presentation of a statement by the director. All money collected by the director for supervision of financial conglomerates pursuant to this section shall be remitted in

accordance with section 44-116.

(c) All information, documents, and copies thereof obtained by or disclosed to the director pursuant to this section shall be held by the director in accordance with sections 44-154 and 44-2138.

Sec. 51. Section 44-7613, Reissue Revised Statutes of Nebraska, is amended to read:

44-7613 (1) On an annual basis and within ninety days after the last day of the fiscal year of a multiple employer welfare arrangement, each multiple employer welfare arrangement holding a certificate of registration shall file with the director a financial statement, attested to by at least two members of the board of trustees, one of whom shall be the chairperson or president of 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 and within ninety days after the last day of the fiscal year of a multiple employer welfare arrangement, 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 44-7609 is in force. The actuarial statement shall meet the requirements of

any rules or regulations which shall be adopted and promulgated by the director.

(3) On an annual basis and within ninety days after the last day of the fiscal year of a multiple employer welfare arrangement, each multiple employer welfare arrangement holding a certificate of registration shall file with the director a certificate of compliance signed by at least two members of the board of trustees, one of whom shall be the chairperson or president of the board of trustees, certifying that the multiple employer welfare arrangement, to the best of their knowledge, information, and belief, has been conducted in accordance with applicable provisions of Nebraska law and rules and regulations relating to multiple employer welfare arrangements.

Sec. 52. Sections 5 and 53 of this act become operative on January 1, 2009. The other sections of this act become operative on their effective date.

Sec. 53. Original section 44-789, Reissue Revised Statutes of Nebraska, is repealed.

Sec. 54. Original sections 44-349, 44-356, 44-1521, 44-1601, 44-1603, 44-1604, 44-1605, 44-1606.01, 44-1607, 44-1607.01, 44-1613, 44-1614, 44-32,106, 44-3901, 44-3902, 44-3904, 44-3909, 44-3910, 44-3911, 44-4064, 44-6009, 44-6016, 44-6603, 44-6604, and 44-7613, Reissue Revised Statutes of Nebraska, sections 13-206, 28-631, 44-1602, and 44-7508.02, Revised Statutes Cumulative Supplement, 2006, and section 44-4521, Revised Statutes Supplement, 2007, are repealed.