LEGISLATIVE BILL 192

Approved by the Governor February 26, 2009

Introduced by Pahls, 31.

FOR AN ACT relating to insurance; to amend sections 12-1116, 44-4065, 44-5223, 44-5225, 44-5260, 44-5904, and 44-5905, Reissue Revised Statutes of Nebraska, and sections 44-1988 and 44-5103, Revised Statutes Cumulative Supplement, 2008; to provide powers for the Director of Insurance under the Burial Pre-Need Sale Act; to change and eliminate provisions relating to reserves under the Title Insurers Act; to provide and change reporting requirements under the Insurance Producers Licensing Act; to change provisions relating to health benefit plans under the Small Employer Health Insurance Availability Act; to change examination and record retention requirements under the Insurers Examination Act; to define and redefine terms; to harmonize provisions; and to repeal the original sections.

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

Section 1. Section 12-1116, Reissue Revised Statutes of Nebraska, is amended to read:

12-1116 (1) The director may deny, revoke, or suspend any license of any pre-need seller or agent or may levy an administrative fine in accordance with subsection (3) of this section if the director finds that:

(a) The licensee has failed to pay the license fee prescribed for such license;

(b) The licensee, either knowingly or without the exercise of due care to prevent the same, has violated any of the provisions of the Burial Pre-Need Sale Act or any rule or regulation adopted and promulgated by the director pursuant to such act; ~~or~~

(c) An act or condition exists which, if it had existed at the time of the original application of such licensee, would have resulted in the director refusing to issue such license; or~~.~~

(d) The licensee, upon receipt of a written inquiry from the department, has failed to respond to such inquiry or has failed to request an additional reasonable amount of time to respond to such inquiry within fifteen business days after such receipt.

(2) Written notification shall be provided to the licensee upon the director's making such determination, and the notice shall be mailed by the director to the last address on file for the licensee by certified or registered mail, return receipt requested. The notice shall state the specific action contemplated by the director and the specific grounds for such action. The notice shall allow the licensee receiving such notice twenty days from the date of actual receipt to:

(a) Voluntarily surrender his or her license; or

(b) File a written notice of protest of the proposed action of the director. If a written notice of protest is filed by the licensee, the Administrative Procedure Act shall govern the hearing process and procedure, including all appeals. Failure to file a notice of protest within the twenty-day period shall be equivalent to a voluntary surrender of the licensee's license, and the licensee shall surrender the license to the director.

(3) In addition to or in lieu of any applicable denial, suspension, or revocation of a license, any person violating the Burial Pre-Need Sale Act may, after notice and hearing, be subject to an administrative fine of not more than one thousand dollars per violation. Such fine may be enforced in the same manner as civil judgments. Any person charged with a violation of the act may waive his or her right to a hearing and consent to such discipline as the director determines is appropriate. The Administrative Procedure Act shall govern all hearings held pursuant to the Burial Pre-Need Sale Act.

Sec. 2. Section 44-1988, Revised Statutes Cumulative Supplement, 2008, is amended to read:

44-1988 (1) In determining the financial condition of a title insurer transacting the business of title insurance under the Title Insurers Act, the general provisions of the insurance laws of this state requiring the establishment of reserves sufficient to cover all known and unknown liabilities, including allocated and unallocated loss adjustment expense, shall apply except as provided in subsections (2) through (4) of this section.

(2) A title insurer shall establish and maintain a known claim reserve in an amount estimated to be sufficient to cover all unpaid

losses, claims, and allocated loss adjustment expenses arising under title insurance policies, guaranteed certificates of title, guaranteed searches, and guaranteed abstracts of title and all unpaid losses, claims, and allocated loss adjustment expenses for which the title insurer may be liable and for which the title insurer has received notice by or on behalf of the insured, holder of a guarantee or escrow, or security depositor.

(3)(a) If a title insurer is a foreign or non-United-States title insurer, the title insurer shall establish and maintain a statutory or unearned premium reserve consisting of the amount of statutory or unearned premium reserve required by the laws of the domiciliary state of the title insurer.

(b)(i) If a title insurer is a domestic insurer of this state, the title insurer shall establish and maintain a statutory or unearned premium reserve ~~consisting of the amount of the statutory or unearned premium or reinsurance reserve on September 13, 1997, which balance shall be released in accordance with the law in effect at the time such sums were added to the reserve.~~ in an amount equal to seventeen cents per one thousand dollars of net retained liability for each insurance policy.

(ii) The amount set aside in the reserve required under subdivision (3)(b)(i) of this section shall be released from the reserve and restored to net profits over a period of twenty years pursuant to the following formula: Thirty percent of the aggregate sum in the year next succeeding the year of addition; fifteen percent of the aggregate sum in the next succeeding year; ten percent of the aggregate sum in each of the next succeeding two years; five percent of the aggregate sum in each of the next succeeding two years; three percent of the aggregate sum in each of the next succeeding two years; two percent of the aggregate sum in each of the next succeeding seven years; and one percent of the aggregate sum in each of the next succeeding five years. For each year in which a release of statutory or unearned premium reserve is authorized under this subdivision, such reserve shall be released over the course of the year in twelve equal monthly amounts, beginning on July 1.

~~(ii)~~ (c)(i) If a title insurer that is organized under the laws of another state transfers its domicile to this state, the statutory or unearned premium reserve shall be that amount required by the laws of the state of the title insurer's former state of domicile as of the date of transfer of domicile. Thereafter, the aggregate of such statutory or unearned premium reserve shall be released from the reserve and restored to profits over a period of twenty years pursuant to the formula set forth in subdivision ~~(3)(b)(vi)~~ (3)(c)(iii) of this section.

(ii) Following the transfer of domicile to this state of the title insurer described in subdivision (3)(c)(i) of this section, for business written after the date of transfer of domicile, the title insurer shall add to and set aside in the statutory or unearned premium reserve such amount as provided in subdivision ~~(3)(b)(v)~~ (3)(b)(i) of this section.

~~(iii) Out of total charges for title insurance policies written or assumed commencing on September 13, 1997, and until December 31, 1998, a title insurer shall add to and set aside in the reserve required under subdivision (3)(b)(i) of this section an amount equal to six percent of the sum of the following items set forth in the title insurer's most recent annual statement on file with the director:~~

~~(A) Direct premiums written;~~

~~(B) Escrow, settlement, and closing fees;~~

~~(C) Other title fees and service charges, including fees for closing protection letters; and~~

~~(D) Premiums for reinsurance assumed less premiums for reinsurance ceded.~~

~~(iv) Additions to the reserve required under subdivision (3)(b)(i) of this section commencing on January 1, 1999, and until December 31, 2005, shall be made out of total charges for title insurance policies and guarantees written, equal to the sum of the following items, as set forth in the title insurer's most recent annual statement on file with the director:~~

~~(A) For each title insurance policy on a single risk written or assumed on or after January 1, 1999, and until December 31, 2005, twenty-five cents per one thousand dollars of net retained liability for title insurance policies under five hundred thousand dollars and twelve cents per one thousand dollars of net retained liability for title insurance policies of five hundred thousand dollars or greater; and~~

~~(B) Six percent of escrow, settlement, and closing fees collected in contemplation of the issuance of title insurance policies or guarantees.~~

~~(v) Out of total charges for title insurance policies written or assumed on or after January 1, 2006, a title insurer shall add to and set~~

~~aside in the reserve required under subdivision (3)(b)(i) of this section an amount equal to seventeen cents per one thousand dollars of net retained liability for each title insurance policy.~~

~~(vi)~~ (iii) The ~~aggregate of the~~ amounts set aside in the reserve required under subdivision ~~(3)(b)(i)~~ (3)(c)(i) of this section ~~in any calendar year pursuant to subdivisions (3)(b)(iii), (3)(b)(iv), and (3)(b)(v) of this section and the reserve required under subdivision (3)(b)(ii) of this section~~ shall be released from the reserve and restored to net profits over a period of twenty years pursuant to the following formula: ~~For an insurer that transfers its domicile to this state,~~ An initial release of thirty percent of the aggregate of such reserves on the forty-fifth day following the last day of the calendar quarter in which the insurer transfers its domicile; ~~and thereafter pursuant to the formula as set forth in this subdivision; and for all other insurers, thirty percent of the aggregate sum on July 1 of the year next succeeding the year of addition;~~ fifteen percent of the aggregate sum ~~on July 1 of~~ in the next succeeding year; ten percent of the aggregate sum ~~on July 1 of~~ in each of the next succeeding two years; five percent of the aggregate sum ~~on July 1 of~~ in each of the next succeeding two years; three percent of the aggregate sum ~~on July 1 of~~ in each of the next succeeding two years; two percent of the aggregate sum ~~on July 1 of~~ in each of the next succeeding seven years; and one percent of the aggregate sum ~~on July 1 of~~ in each of the next succeeding five years. For each year in which a release of statutory or unearned premium reserve is authorized under this subdivision, such reserve shall be released over the course of the year in twelve equal monthly amounts, beginning on July 1. ~~No release of statutory or unearned premium reserve shall occur if such release would result in the aggregate reserve falling below the actuarial level required by subsection (1) of this section.~~

~~(vii) The title insurer shall calculate an adjusted statutory or unearned premium reserve as of September 13, 1997. The adjusted reserve shall be calculated as if subdivisions (3)(b)(iii), (iv), and (vi) of this section had been in effect for all years beginning twenty years prior to September 13, 1997. For purposes of this calculation, the balance of the reserve as of that date shall be deemed to be zero. If the adjusted reserve so calculated exceeds the aggregate amount set aside for statutory or unearned premiums in the title insurer's annual statement on file with the director on September 13, 1997, the title insurer shall, out of total charges for title insurance policies, increase its statutory or unearned premium reserve by an amount equal to one-sixth of that excess in each of the succeeding six years, commencing with the calendar year that includes September 13, 1997, until the entire excess has been added.~~

~~(viii) The aggregate of the amounts set aside in the reserve required under subdivision (3)(b)(i) of this section in any calendar year as adjustments to the title insurer's statutory or unearned premium reserve pursuant to subdivision (3)(b)(vii) of this section shall be released from the reserve and restored to net profits, or equity if the additions required by such subdivision reduced equity directly, over a period not exceeding ten years pursuant to the following table:~~

~~Calendar Year of Addition~~	~~Release~~
~~1998~~	~~Equally over 10 years~~
~~1999~~	~~Equally over 9 years~~
~~2000~~	~~Equally over 8 years~~
~~2001~~	~~Equally over 7 years~~
~~2002~~	~~Equally over 6 years~~
~~2003~~	~~Equally over 5 years~~

(4) A title insurer shall establish and maintain a supplemental reserve consisting of any other reserves necessary, when taken in combination with the reserves required by subsections (2) and (3) of this section, to cover the title insurer's liabilities with respect to all losses, claims, and loss adjustment expenses. ~~The supplemental reserve required under this subsection shall be phased in as follows: Twenty-five percent of the otherwise applicable supplemental reserve will be required until December 31, 1998; fifty percent of the otherwise applicable supplemental reserve will be required until December 31, 1999; and seventy-five percent of the otherwise applicable supplemental reserve will be required until December 31, 2000.~~

(5) Each title insurer subject to the Title Insurers Act shall file with its annual financial statement required under section 44-322 a certification by a member in good standing of the American Academy of Actuaries. The actuarial certification required of a title insurer shall conform to the National Association of Insurance Commissioners' annual statement instructions for title insurers.

Sec. 3. Section 44-4065, Reissue Revised Statutes of Nebraska, is amended to read:

44-4065 (1) An insurance producer shall report to the director any administrative action taken against the producer in another jurisdiction, by a professional self-regulatory organization such as the Financial Industry Regulatory Authority or a similar organization, or by another governmental agency ~~in this state~~ within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

(2) An insurance producer shall report to the director any obligation regarding insurance premiums or fiduciary funds owed to a company, including a premium finance company, or a managing general agent within thirty days of the date of discharge or attempt to discharge such obligation in a personal or organizational bankruptcy proceeding.

~~(2)~~ (3) Within thirty days of the date of arraignment or date of waiver of arraignment, if waived, an insurance producer shall report to the director any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

(4) For purposes of this section, administrative action shall include, but not be limited to, any arbitration or mediation award, disciplinary action, civil action, or sanction taken against or involving an insurance producer.

Sec. 4. Section 44-5103, Revised Statutes Cumulative Supplement, 2008, is amended to read:

44-5103 For purposes of the Insurers Investment Act:

(1) Admitted assets means the investments authorized under the act and stated at values at which they are permitted to be reported in the insurer's financial statement filed under section 44-322, except that admitted assets does not include assets of separate accounts, the investments of which are not subject to the act;

(2) Agent means a national bank, state bank, trust company, or broker-dealer that maintains an account in its name in a clearing corporation or that is a member of the Federal Reserve System and through which a custodian participates in a clearing corporation including the Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, agent may include a corporation that is organized or existing under the laws of a foreign country and that is legally qualified under those laws to accept custody of securities;

(3) Business entity means a sole proprietorship, corporation, limited liability company, association, partnership, limited liability partnership, joint-stock company, joint venture, mutual fund, trust, joint tenancy, or other similar form of business organization, whether organized for profit or not for profit;

(4) Clearing corporation means a clearing corporation as defined in subdivision (a)(5) of section 8-102, Uniform Commercial Code, that is organized for the purpose of effecting transactions in securities by computerized book-entry, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, clearing corporation may include a corporation that is organized or existing under the laws of a foreign country and which is legally qualified under those laws to effect transactions in securities by computerized book-entry. Clearing corporation also includes Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system;

(5) Custodian means:

(a) A national bank, state bank, Federal Home Loan Bank, or trust company that shall at all times during which it acts as a custodian pursuant to the Insurers Investment Act be no less than adequately capitalized as determined by the standards adopted by ~~United States banking regulators~~ the regulator charged with establishing such standards and assessing the solvency of such institutions and that is regulated by ~~either~~ federal or state banking

laws or the Federal Home Loan Bank Act or is a member of the Federal Reserve System and that is legally qualified to accept custody of securities in accordance with the standards set forth below, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country, or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, custodian may include a bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as such by that country's government or an agency thereof that shall at all times during which it acts as a custodian pursuant to the Insurers Investment Act be no less than adequately capitalized as determined by the standards adopted by international banking authorities and that is legally qualified to accept custody of securities; or

(b) A broker-dealer that shall be registered with and subject to jurisdiction of the Securities and Exchange Commission, maintains membership in the Securities Investor Protection Corporation, and has a tangible net worth equal to or greater than two hundred fifty million dollars;

(6) Custodied securities means securities held by the custodian or its agent or in a clearing corporation, including the Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system;

(7) Direct when used in connection with the term obligation means that the designated obligor is primarily liable on the instrument representing the obligation;

(8) Director means the Director of Insurance;

(9) Insurer is defined as provided in section 44-103, and unless the context otherwise requires, insurer means domestic insurer;

(10) Mortgage means a consensual interest created by a real estate mortgage, a trust deed on real estate, or a similar instrument;

(11) Obligation means a bond, debenture, note, or other evidence of indebtedness or a participation, certificate, or other evidence of an interest in any of the foregoing;

(12) Policyholders surplus means the amount obtained by subtracting from the admitted assets (a) actual liabilities and (b) any and all reserves which by law must be maintained. In the case of a stock insurer, the policyholders surplus also includes the paid-up and issued capital stock;

(13) Securities Valuation Office means the Securities Valuation Office of the National Association of Insurance Commissioners or any successor office established by the National Association of Insurance Commissioners;

(14) Security certificate has the same meaning as defined in subdivision (a)(16) of section 8-102, Uniform Commercial Code;

(15) State means any state of the United States, the District of Columbia, or any territory organized by Congress;

(16) Tangible net worth means shareholders equity, less intangible assets, as reported in the broker-dealer's most recent Annual or Transition Report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934, S.E.C. Form 10-K, filed with the Securities and Exchange Commission; and

(17) Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system mean the book-entry securities systems established pursuant to 5 U.S.C. 301, 12 U.S.C. 391, and 31 U.S.C. 3101 et seq. The operation of the systems are subject to 31 C.F.R. part 357 et seq.

Sec. 5. Section 44-5223, Reissue Revised Statutes of Nebraska, is amended to read:

44-5223 Sections 44-5223 to 44-5267 and section 7 of this act shall be known and may be cited as the Small Employer Health Insurance Availability Act.

Sec. 6. Section 44-5225, Reissue Revised Statutes of Nebraska, is amended to read:

44-5225 For purposes of the Small Employer Health Insurance Availability Act, the definitions found in sections 44-5226 to 44-5255.01 and section 7 of this act shall be used.

Sec. 7. Bona fide association means, with respect to health insurance coverage offered in this state, an association that meets the following conditions:

(1) Has been actively in existence for at least five years;

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

(3) Does not condition membership in the association on a health-status-related factor of an individual, including an employee or a dependent of any employee;

(4) Makes health insurance coverage offered through the association available to any member regardless of a health-status-related factor of the member or individual eligible for coverage through a member; and

(5) Does not make available health insurance coverage offered through the association other than in connection with a member of the association.

Sec. 8. Section 44-5260, Reissue Revised Statutes of Nebraska, is amended to read:

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

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

(b)(i) Subject to subdivision (2)(a) of this section, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with the Small Employer Health Insurance Availability Act. However, no small employer carrier shall be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

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

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

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

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

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

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

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

(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic health benefit plan or

standard health benefit plan on the grounds that the plan does not meet the requirements of the act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Stated in writing at the time of the open enrollment period

that coverage under another health benefit plan was the reason for declining enrollment but only if the health benefit plan or health carrier required such a written statement and provided a notice of the consequences of such written statement;

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

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

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

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

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

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

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

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

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

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

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

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

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

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

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

(iii) A small employer carrier shall not place any restriction in regard to any health-status-related factor on an eligible employee or

dependent with respect to enrollment or plan participation.

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

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

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

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

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

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

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

(7) A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection (2) of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of such subsection would place the small employer carrier in a financially impaired condition.

Sec. 9. Section 44-5904, Reissue Revised Statutes of Nebraska, is amended to read:

44-5904 (1) The director or any of his or her examiners may conduct an examination under the Insurers Examination Act of any company incorporated in this state or in any other state or country admitted to or applying for admission to transact business in this state as often as the director in his or her sole discretion deems appropriate but shall at a minimum conduct an examination of every domestic insurer not less frequently than once every ~~four~~ five years. In scheduling and determining the nature, scope, and frequency of the examination of a company, the director shall consider such matters as the results of financial statement analyses and ratios, changes in the company's management or ownership, actuarial opinions, reports of independent certified public accountants, the company's ability to meet and fulfill its obligations, the company's compliance with provisions of law, other facts relating to the company's business methods, the company's management and its dealings with its policyholders, and other criteria as set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the director conducts an examination under this section.

(2) For purposes of completing an examination of any company under the act, the director may examine or investigate any person, or the business of any person, insofar as such examination or investigation is, in the sole discretion of the director, necessary or material to the examination of the company.

Sec. 10. Section 44-5905, Reissue Revised Statutes of Nebraska, is amended to read:

44-5905 (1) Upon determining that an examination should be conducted, the director or his or her designee shall appoint one or more examiners to conduct the examination and instruct them as to the scope of the

examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The director may also employ such other guidelines or procedures as the director may deem appropriate.

(2)(a) Every company or person from whom information is sought and its officers, directors, employees, and agents shall provide to the examiners appointed under subsection (1) of this section timely, convenient, and free access to all books, records, accounts, papers, documents, and computer or other recordings relating to the property, assets, business, and affairs of the company being examined.

(b)(i)(A) Every company or person subject to the Insurers Examination Act shall retain all books, records, accounts, papers, documents, and computer or other recordings relating to the property, assets, financial accounts, and business of such company or person in a manner that permits examination of such books, records, accounts, papers, documents, and computer or other recordings for ~~four~~ five years, or until the period of time in which the transaction took place has undergone a financial examination by the director, whichever is later, following the completion of a transaction relating to the property, assets, financial accounts, and business of such company or person.

(B) Every company or person subject to the act shall retain market conduct records for ~~four~~ five years following the completion of a transaction relating to the insurance business and affairs of such company or person. For purposes of this subdivision, market conduct records means all books, records, accounts, papers, documents, and computer or other recordings relating to transactions with insureds, certificate holders, claimants, insurance producers, other insurers, subrogees, and subrogors and recordings related to its trade practices, underwriting, rate and form practices, advertising, regulatory matters, and other affairs of such company or person.

(ii) The books, records, accounts, papers, documents, and computer or other recordings described in subdivisions (2)(b)(i)(A) and (B) of this section and maintained in electronic, computer, micrographic, or other form shall be maintained in a form capable of accurate duplication on paper.

(c) The officers, directors, employees, and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the director's jurisdiction. Any such proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to the Administrative Procedure Act.

(d) For purposes of this subsection, officers, directors, employees, and agents shall include general agents, managing agents, attorneys in fact, organizers, promoters, loss adjusters, and any persons having a contract, written or oral, pertaining to the management or control of a company or any function thereof.

(3) The director or any of his or her examiners shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the director may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in the district court with mileage to be computed at the rate provided in section 81-1176, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

(4) When conducting an examination under the Insurers Examination Act, the director may retain attorneys, appraisers, independent actuaries, independent certified public accountants, loss-reserve specialists, or other professionals and specialists, the cost of which shall be borne by the company which is the subject of the examination.

(5) Nothing in the act shall be construed to limit the director's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(6) Nothing contained in the act shall be construed to limit the director's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the director may, in his or her sole discretion, deem appropriate.

Sec. 11. Original sections 12-1116, 44-4065, 44-5223, 44-5225, 44-5260, 44-5904, and 44-5905, Reissue Revised Statutes of Nebraska, and sections 44-1988 and 44-5103, Revised Statutes Cumulative Supplement, 2008, are repealed.