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LEGISLATIVE BILL 159

Approved by the Governor March 12, 2019

Introduced by Williams, 36.

A BILL FOR AN ACT relating to insurance; to amend sections 44-2706, 44-2707, 44-2708, 44-2709, 44-2713, 44-2718, and 44-2719.01, Reissue Revised Statutes of Nebraska, and sections 44-2702, 44-2703, and 44-2719.02, Revised Statutes Cumulative Supplement, 2018; to change provisions of the Nebraska Life and Health Insurance Guaranty Association Act; to harmonize provisions; to repeal the original sections; and to declare an emergency.

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

Section 1. Section 44-2702, Revised Statutes Cumulative Supplement, 2018, is amended to read:

44-2702 As used in the Nebraska Life and Health Insurance Guaranty Association Act, unless the context otherwise requires:

(1) Account means any of the three accounts created pursuant to section 44-2705;

(2) Association means the Nebraska Life and Health Insurance Guaranty Association created by section 44-2705;

(3) Authorized, when used in the context of assessments, or authorized assessment means a resolution by the board of directors has passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

(4) Called, when used in the context of assessments, or called assessment means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the timeframe set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;

(5) Director means the Director of Insurance;

(6) Contractual obligation means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, ~~of such policy or contract~~ for which coverage is provided under section 44-2703;

(7) Covered policy means any policy or contract or portion of such policy or contract for which coverage is provided under section 44-2703;

(8) Extra-contractual claims include, but are not limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs;

(9) Benefit plan means a specific employee, union, or association of natural persons benefit plan;

(10) Health benefit plan means any hospital or medical expense policy or certificate, health maintenance organization subscriber contract, or any other similar health contract. Health benefit plan does not include:

(a) Accident only insurance;

(b) Credit insurance;

(c) Dental only insurance;

(d) Vision only insurance;

(e) Medicare supplement insurance;

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

(g) Disability income insurance;

(h) Coverage for onsite medical clinics; or

(i) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates;

(11) ~~(8)~~ Impaired insurer means a member insurer which, after August 24, 1975, (a) is deemed by the director to be potentially unable to fulfill its contractual obligations and is not an insolvent insurer and ~~or~~ (b) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(12) ~~(9)~~ Insolvent insurer means a member insurer which, after August 24, 1975, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

(13) ~~(10)~~ Member insurer means an insurer or health maintenance organization licensed or that holds a certificate of authority ~~any person authorized~~ to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided for under section 44-2703. Member insurer includes any insurer or health maintenance organization ~~person~~ whose license or certificate of authority may have been suspended, revoked, not renewed, or voluntarily withdrawn. Member insurer does not include:

(a) A ~~nonprofit~~ hospital or medical service organization, whether profit or nonprofit;

~~(b) A health maintenance organization unless such organization is controlled by an insurance company licensed by the Department of Insurance under Chapter 44;~~

(b) ~~(c)~~ A fraternal benefit society;

(c) ~~(d)~~ A mandatory state pooling plan;

(d) A mutual assessment company or other person that operates on an assessment basis;

~~(e) An unincorporated mutual association;~~

(e) ~~(f)~~ An assessment association operating under Chapter 44 which issues only policies or contracts subject to assessment;

(f) An insurance exchange;

(g) An organization that has a certificate or license limited to the issuance of charitable gift annuities;

~~(g) A reciprocal or interinsurance exchange which issues only policies or contracts subject to assessment;~~

(h) A viatical settlement provider, a viatical settlement broker, or a financing entity under the Viatical Settlements Act; or

(i) An entity similar to any entity listed in subdivisions (13)(a) ~~(10)(a)~~ through (h) of this section;

(14) ~~(11)~~ Moody's corporate bond yield average means the monthly average of corporate bond yields published by Moody's Investment Service, Incorporated, or any successor to Moody's Investment Service, Incorporated;

(15) ~~(12)~~ Owner of a policy or contract, policyholder, policy owner, and contract owner mean ~~means~~ the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. Owner, policy owner, and contract owner do ~~does~~ not include persons with a mere beneficial interest in a policy or contract;

(16) ~~(13)~~ Person means any individual, corporation, partnership, limited liability company, association, government body or entity, or voluntary organization;

(17) Plan sponsor means:

(a) In the case of a benefit plan established or maintained by a single employer, the employer;

(b) In the case of a benefit plan established or maintained by an employee organization, the employee organization; or

(c) In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan;

(18) ~~(14)~~ Premiums means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits, and less dividends and experience credits. Premiums does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under subsection (2) of section 44-2703, except that assessable premiums shall not be reduced on account of subdivision (2)(b)(iii) of section 44-2703 relating to interest limitations and subdivision (3)(b) of section 44-2703 relating to limitations with respect to one individual, one participant, and one policy or contract owner. Premiums does not include:

(a) Premiums on an unallocated annuity contract; or

(b) With respect to multiple nongroup life insurance policies owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, premiums exceeding five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

(19)(a) ~~(15)(a)~~ Principal place of business of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy or contract for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function. The association shall in its reasonable judgment determine the principal place of business considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors or similar governing person or persons of the entity conducts the majority of meetings;

(iv) The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors in subdivisions (19)(a)(i) ~~(15)(a)(i)~~ through (v) of this section, except that in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) The principal place of business of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association,

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committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

(20) ~~(16)~~ Receivership court means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer;

(21) ~~(17)~~ Resident means any person to whom a contractual obligation is owed who resides in this state at the date of entry of a court order that determines that a member insurer is an impaired or insolvent insurer, whichever occurs first. A person may be a resident of only one state. A person other than a natural person shall be a resident of its principal place of business. Citizens of the United States that are residents of foreign countries, or are residents of a United States possession, territory, or protectorate that does not have an association similar to the association created by the Nebraska Life and Health Insurance Guaranty Association Act, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

(22) ~~(18)~~ State means a state, the District of Columbia, Puerto Rico, and any United States possession, territory, or protectorate;

(23) ~~(19)~~ Structured settlement annuity means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

(24) ~~(20)~~ Supplemental contract means any agreement entered into between a member insurer and an owner or beneficiary for the distribution of policy or contract proceeds under a covered policy or contract; and

(25) ~~(21)~~ Unallocated annuity contract means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Sec. 2. Section 44-2703, Revised Statutes Cumulative Supplement, 2018, is amended to read:

44-2703 (1)(a) The Nebraska Life and Health Insurance Guaranty Association Act shall provide coverage for the policies and contracts specified in subsection (2) of this section:

(i) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subdivision (1)(a)(ii) of this section; and

(ii) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who:

(A) Are residents; or

(B) Are not residents and all of the following conditions apply:

(I) The member insurer that issued the policies or contracts is domiciled in this state;

(II) The states in which the persons reside have associations similar to the association created by the act; and

(III) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(b) For structured settlement annuities specified in subsection (2) of this section, subdivisions (1)(a)(i) and (ii) of this section do not apply. The act shall, except as provided in subdivisions (1)(c) and (d) of this section, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under the following conditions:

(A)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by the act; and

(B) The payee or beneficiary and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

(c) The act shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state if the payee or beneficiary is afforded any coverage by the association of another state.

(d) The act is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under the act is provided coverage under the laws of any other state, the person shall not be provided coverage under the act. In determining the application of the provisions of this subdivision in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, the act shall be construed in conjunction with other state laws to result in coverage by only one association.

(2)(a) The act shall provide coverage to the persons specified in

subsection (1) of this section for direct nongroup life insurance, health insurance, which for purposes of the act includes health maintenance organization subscriber contracts and certificates, or annuity policies or contracts and supplemental contracts to any of these and for certificates under direct group policies and contracts, except as limited by the act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(b) The act shall not apply to:

(i) Any portion of any policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract holder;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract, except any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits, to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) Averaged over the period of four years prior to the date on which the association ~~member insurer~~ becomes obligated with respect to the policy or contract ~~an impaired or insolvent insurer under the act, whichever is earlier~~, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated ~~member insurer becomes an impaired or insolvent insurer under the act, whichever is earlier~~; and

(B) On and after the date on which the association becomes obligated with respect to the policy or contract ~~member insurer becomes an impaired or insolvent insurer under the act, whichever is earlier~~, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement as described in 29 U.S.C. 1002(40);

(B) A minimum premium group insurance plan;

(C) A stop-loss group insurance plan; or

(D) An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) A portion of a policy or contract to the extent that the assessments required by section 44-2708 with respect to the policy or contract are preempted by federal or state law;

(viii) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, contract holder, contract owner, or policy owner, including, without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form, filing, or approval requirements;

(C) Misrepresentations of or regarding policy or contract benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(ix) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(x) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture as of the date the member insurer becomes an impaired or insolvent insurer under the act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(xi) An unallocated annuity contract, a funding agreement, a guaranteed interest contract, a guaranteed investment contract, a synthetic guaranteed investment contract, or a deposit administration contract;

(xii) Any such policy or contract issued by:

(A) A ~~nonprofit~~ hospital or medical service organization, whether profit or nonprofit;

~~(B) A health maintenance organization unless such organization is controlled by an insurance company licensed by the Department of Insurance under Chapter 44;~~

(B) ~~(C)~~ A fraternal benefit society;

(C) ~~(D)~~ A mandatory state pooling plan;

(D) ~~(E)~~ An unincorporated mutual association;

(E) ~~(F)~~ An assessment association operating under Chapter 44 which issues only policies or contracts subject to assessment; ~~or~~

(F) An insurance ~~(G) A reciprocal or interinsurance~~ exchange ~~which issues only policies or contracts subject to assessment~~; or

(G) An organization that has a certificate or license limited to the issuance of charitable gift annuities;

(xiii) Any policy or contract issued by any person, corporation, or organization which is not licensed by the Department of Insurance under Chapter 44;

(xiv) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Title 42, Chapter 7, Subchapter XVIII, Part C or D, commonly known as Medicare Part C and D, or Title 42, Chapter 7, Subchapter XIX, commonly known as Medicaid, of the United States Code, ~~or~~ any regulations issued pursuant thereto, or any other policy or contract issued pursuant to the Medical Assistance Act; or

(xv) A viatical settlement contract as defined in section 44-1102 or a viaticated policy as defined in section 44-1102.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) With respect to one life, regardless of the number of policies or contracts:

(A) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(B) In health insurance benefits: (I) Five hundred thousand dollars for health benefit plans ~~basic hospital, medical, or surgical insurance or major medical insurance. For purposes of this subdivision: Basic hospital, medical, or surgical insurance means a policy which pays a certain portion of hospital room and board costs each day. This type of policy also pays for hospital services and supplies including X-rays, lab tests, medicine, and other items up to a stated amount; and major medical insurance means health insurance to finance the expense of major illness and injury characterized by large benefit maximums and reimburses the major part of all charges for hospitals, doctors, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs, and medicines above an initial deductible~~; (II) three hundred thousand dollars for disability insurance or long-term care insurance as defined in section 44-4509. For purposes of this subdivision, disability insurance means the type of policy which pays a monthly or weekly amount if an individual is disabled and cannot work; and (III) one hundred thousand dollars for coverages not defined as disability insurance, long-term care insurance, or health benefit plans ~~basic hospital, medical, or surgical insurance, or major medical insurance~~, including any net cash surrender and net cash withdrawal values; or

(C) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) With respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars in the present value of annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iii) The association shall not be obligated to cover more than:

(A) An aggregate of three hundred thousand dollars in benefits with respect to any one life under subdivisions (3)(b)(i) and (ii) of this section, except that with respect to benefits for health benefit plans ~~basic hospital, medical, or surgical insurance and major medical insurance~~ under subdivision (3)(b)(i)(B)(I) of this section, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or

(B) With respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits regardless of the number of policies and contracts held by the owner;

(iv) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under the act may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights; and ~~.~~

(v) For purposes of the act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(4) In performing its obligations to provide coverage under section 44-2707, the association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Sec. 3. Section 44-2706, Reissue Revised Statutes of Nebraska, is amended to read:

44-2706 (1) The board of directors of the association shall consist of not less than seven ~~five~~ nor more than eleven ~~nine~~ members serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the director. Vacancies on the board shall be filled for the remaining period of the term in the manner described in the plan of operation. To select the initial board of directors and initially organize the association, the director shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the director may appoint the initial members.

(2) In approving selections or in appointing members to the board, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board as provided in sections 81-1174 to 81-1177 for state employees but shall not otherwise be compensated by the association for their services.

Sec. 4. Section 44-2707, Reissue Revised Statutes of Nebraska, is amended to read:

44-2707 In addition to the powers and duties enumerated in the Nebraska Life and Health Insurance Guaranty Association Act:

(1) If a member insurer is an impaired insurer, the association may, at its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all the covered policies or contracts of the impaired insurer; and

(b) Provide such money, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision (1)(a) of this section and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1)(a) of this section;

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)(A) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the covered policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide such money, pledges, notes, guarantees, or other means as are reasonably necessary to discharge the association's duties; or

(b) Provide benefits in accordance with the following provisions:

(i) With respect to covered policies and contracts ~~life and health insurance policies and annuities~~, assure payment of benefits ~~for premiums identical to the premiums and benefits, except for terms of conversion and renewability,~~ that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(A) With respect to group policies and contracts, not later than the earlier of the next renewal date under these policies or contracts or forty-five days but not less than thirty days after the date on which the association becomes obligated with respect to the policies and contracts; and

(B) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date if any under the policies or contracts or one year but not less than thirty days after the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds, enrollees, or annuitants, for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty days' notice of the termination made pursuant to subdivision (2)(b)(i) of this section of the benefits provided;

(iii) With respect to nongroup ~~life and health insurance~~ policies and contracts ~~annuities~~ covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured, enrolled, or ~~formerly~~ an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (2)(b)(iv) of this section if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to

continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(iv)(A) In providing the substitute coverage required under subdivision (2)(b)(iii) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the director.

(B) Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

(C) The association may reinsure any alternative or reissued policy or contract;

(v)(A) Alternative policies or contracts adopted by the association shall be subject to the approval of the director ~~domiciliary insurance commissioner and the receivership court~~. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(C) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the director ~~domiciliary insurance commissioner and the receivership court~~;

(vii) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy owner, the insured, the enrollee, or the association; and

(viii) When proceeding under subdivision (2)(b) of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subdivision (2)(b)(iii) of section 44-2703;

(3) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under the act with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of the act;

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of the insolvent insurer requests, the association shall provide a report to the liquidator regarding such premiums collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order;

(5) The protection provided by the act shall not apply if guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state;

(6) In carrying out its duties under subdivision (2) of this section, the association may, subject to approval by a court in this state:

(a) Impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement if:

(i) The association finds that the amounts which can be assessed under the act are less than the amounts needed to assure full and prompt performance of the association's duties under the act; or

(ii) That the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(b) Impose temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts in addition to any contractual provisions for deferral of cash or policy loan value.

If the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court;

(7) A deposit in this state which is held pursuant to law or required by the director for the benefit of creditors, including ~~and~~ policy and contract owners, and not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to section 44-4852, shall be promptly paid to the association. The association shall be entitled to retain a portion of such amount equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency. The association shall remit to the domiciliary receiver the amount so paid to the association and not retained pursuant to this subdivision. Any amount paid to the association less the amount not retained by it shall be treated as a distribution of estate assets pursuant to section 44-4834 or similar provision of the state of domicile of the impaired or insolvent insurer;

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subdivision (2) of this section, the director shall have the powers and duties of the association under the act with respect to the insolvent insurer;

(9) At the request of the director, the association may give assistance and advice to the director concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer;

(10) The association shall have standing to appear before any court or administrative agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under the act or with jurisdiction over any person or property against which the association may have rights through subrogation or other basis. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts and contractual obligations of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person against whom the association may have rights through subrogation or otherwise;

(11)(a) Any person receiving benefits under the act shall be deemed to have assigned his or her rights under and any causes of action against any person for losses arising under the covered policy or contract to the association to the extent of the benefits received because of the act whether the benefits are payments of, or on account of, contractual obligations, ~~or~~ continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages ~~coverage~~. The association may require an assignment to it of such rights by any enrollee, payee, policy or contract owner, certificate holder, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by such act upon such person.

(b) The subrogation rights of the association under this subdivision shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under such act.

(c) In addition to subdivisions (11)(a) and (b) of this section, the association shall have all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts. Such common-law rights and equitable or legal remedies include, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to the act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor. Nothing in this subdivision shall include any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code.

(d) If the provisions of this subdivision are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portion of such amount covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in subdivision (11) of this section, the person shall pay to the association the portion of the recovery attributable to the policies or contracts or any portion of such recovery covered by the association;

(12) The association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of the act;

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 44-2708 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of the act. Any notes or other evidence of indebtedness of the association not in default shall be legal

investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association and to perform such other functions as become necessary or proper under the act;

(e) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association;

(f) Take such legal action as may be necessary to avoid or recover payment of improper claims;

(g) Exercise, for the purposes of the act and to the extent approved by the director, the powers of a domestic life or health insurer or health maintenance organization, but in no case may the association issue insurance policies or ~~annuity~~ contracts other than those issued to perform its ~~the contractual~~ obligations under the act ~~of the impaired or insolvent insurer~~;

(h) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(i) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under the act with respect to the person, and the person shall promptly comply with the request;

(j) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under the act;

(k) ~~(j)~~ Take other necessary or appropriate action to discharge its duties and obligations under the act or to exercise its powers under the act; and

(l) ~~(k)~~ Join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association;

(13)(a) At any time within one hundred eighty days ~~one year~~ after the coverage date, the association may elect to succeed to the rights and obligations of the ceding member insurer that accrue on or after the coverage date and that relate to policies, contracts, or annuities covered, in whole or in part, by the association under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association~~, except that the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement~~. For purposes of this section, coverage date means the date on which the association becomes responsible for the obligations of a member insurer. The election shall be effected by the association, or the National Organization of Life and Health Insurance Guaranty Associations on behalf of the association, sending written notice, return receipt requested, to the affected reinsurers. To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association, or the National Organization of Life and Health Insurance Guaranty Associations on behalf of the association, as soon as possible after commencement of formal delinquency proceedings copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts ~~a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers~~. If the association makes an election, subdivisions (13)(a)(i) through (vi) ~~(iv)~~ of this section apply to the reinsurance contracts ~~agreements~~ selected by the association:

(i) The association shall be responsible for all unpaid premiums due under the reinsurance contracts ~~agreements~~ for periods both before and after the coverage date and shall be responsible for the performance of all other obligations to be performed after the coverage date in each case that relates to policies, contracts, or annuities covered, either in whole or in part, by the association. The association may charge policies, contracts, or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

(ii) The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts ~~agreements~~ with respect to losses or events that occur in periods after the coverage date and that relate to policies, contracts, or annuities covered by the association, in whole or in part, except that on receiving such amounts, the association shall pay to the beneficiary under the policy, ~~or~~ contract, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser ~~excess~~ of: (A) The amount received by the association, and ~~over~~ (B) the excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contract, or annuity, less the retention by the insurer applicable to the loss or event ~~benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event~~;

(iii) Within thirty days after the association's election, the association and each ~~indemnity~~ reinsurer under the contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election with respect

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to policies, contracts, or annuities covered, in whole or in part, by the association, giving full credit to all items paid by either the member insurer, or its receiver, rehabilitator, or liquidator, or the ~~indemnity~~ reinsurer during the period between the coverage date and the date of the association's election. The association or ~~indemnity~~ reinsurer shall pay the net balance due the other within five days after the completion of such calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to subdivision (13)(a)(ii) of this section, the receiver, rehabilitator, or liquidator shall, as promptly as practicable, pay such amounts to the association. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law; ~~and~~

(iv) If the association, or receiver on behalf of the association, within sixty days after the election, pays the unpaid premiums due for periods both before and after the coverage date that relate to policies, contracts, or annuities covered by the association in whole or in part, the reinsurer shall not be entitled to terminate the reinsurance agreements for failure to pay premiums to the extent that the agreements relate to policies, contracts, or annuities covered by the association either wholly or partially and may not set off any unpaid amounts ~~premium~~ due under other contracts, or unpaid amounts due from parties other than the association, ~~for periods prior to the coverage date~~ against amounts due the association;

(v) During the period from the coverage date until the election date or, if the election date does not occur, one hundred eighty days after the date of the order of liquidation, (A) neither the association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the association has the right to assume under subdivision (13)(a) of this section, whether for periods prior to or after the date of the order of liquidation, and (B) the reinsurer, the receiver, and the association shall, to the extent practicable, provide each other data and records upon reasonable request, provided that once the association has elected to assume a reinsurance contract, the rights and obligations of the parties shall be governed by subdivision (13)(a) of this section; and

(vi) If the association does not elect to assume a reinsurance contract by the election date pursuant to subdivision (13)(a) of this section, the association shall have no rights or obligations, in each case for periods both before and after the coverage date, with respect to the reinsurance contract;

(b) When policies, contracts, or annuities or covered obligations with respect thereto are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the association, in the case of contracts assumed under subdivision (13)(a) of this section, subject to the following:

(i) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

~~(b) If the association transfers its obligations to another insurer and if the association and the other insurer agree, such insurer shall succeed to the rights and obligations of the association under subdivision (13)(a) of this section effective as of the date agreed upon by the association and such insurer and regardless of whether the association has made the election referred to in subdivision (13)(a) of this section except that:~~

~~(i) The indemnity reinsurance agreements shall automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;~~

(ii) The obligations described in ~~the exception set forth in~~ subdivision (13)(a) ~~(13)(a)(ii)~~ of this section shall not apply on and after the date the ~~indemnity~~ reinsurance contract ~~agreement~~ is transferred to the third party insurer; and

(iii) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty days prior to the effective date of the transfer ~~Subdivision (13)(b) of this section shall not apply if the association has previously stated in writing that it will not exercise the election referred to in subdivision (13)(a) of this section~~;

(c) The provisions of subdivision (13) of this section shall supersede the provisions of any law of this state or of any affected reinsurance contract ~~agreement~~ that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the coverage date to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance contract ~~agreement~~ with respect to losses or events that occur in periods prior to the coverage date, subject to applicable setoff provisions; and

(d) Except as otherwise expressly set forth in subdivision (13) of this section, nothing in such subdivision shall alter or modify the terms and conditions of any ~~the indemnity~~ reinsurance contract ~~agreements of the insolvent member insurer~~. Nothing in the subdivision shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract ~~agreement~~. Nothing in such subdivision shall give a policyowner, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a ~~an indemnity~~ reinsurer that is not otherwise set forth in the ~~indemnity~~ reinsurance contract. Nothing in this section shall limit or affect the association's rights as a creditor of the

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estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks ~~agreement~~;

(14) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of the act in an economical and efficient manner;

(15) If the association has arranged or offered to provide the benefits of the act to a covered person under a plan or arrangement that fulfills the association's obligations under the act, such person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement; and

(16) Venue in an action against the association arising under the act shall be in the district court of Lancaster County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the act.

Sec. 5. Section 44-2708, Reissue Revised Statutes of Nebraska, is amended to read:

44-2708 (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such times and for such amounts as the board finds necessary. The board shall collect the assessments after thirty days' written notice to the member insurers before payment is due, and the assessments shall accrue interest at the rate calculated pursuant to section 45-103 on and after the due date.

(2) There shall be two classes of assessments as follows:

(a) Class A assessments shall be authorized and called ~~made~~ for the purpose of meeting administrative costs and other general expenses, including expenses for examinations conducted under the authority of subdivision (3) ~~(2)~~ of section 44-2711. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer; and

(b) Class B assessments shall be authorized and called ~~made~~ to the extent necessary to carry out the powers and duties of the association under section 44-2707 with regard to an impaired or insolvent domestic insurer.

(3)(a) The amount of any Class A assessment for each account shall be determined by the board and may be authorized and called on a pro rata or non-pro-rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. ~~The total of all non-pro-rata assessments shall not exceed one hundred fifty dollars per member insurer in any one calendar year.~~ The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances. The amount of any Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the director. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

(b) Class B assessments against member insurers for each account ~~and subaccount~~ shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account bears, for the three most recent calendar years for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired, to such premiums received on business in this state for such calendar years by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called ~~made~~ until necessary to implement the purposes of the Nebraska Life and Health Insurance Guaranty Association Act. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth pursuant to this subsection, the amount by which such assessment is abated or deferred shall be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a) Subject to the provisions of subdivision (b) of this subsection, the total of all assessments authorized by the association with respect to a member insurer for ~~each subaccount of~~ the life insurance account, the ~~and~~

annuity account, and ~~for~~ the health account shall not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the ~~subaccount or~~ account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(b) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision (a) of this subsection shall be equal and limited to the higher of the three-year average annual premiums for the applicable ~~subaccount or~~ account as calculated pursuant to this section.

(c) If the maximum assessment, together with the other assets of the association in an ~~either~~ account, does not provide in any one year in an ~~either~~ account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by the act.

(d) The board may provide in the plan of operation a method of allocating funds among other claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(e) If the maximum assessment for an account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then the board shall access the other accounts for the necessary additional amount, subject to the provisions of subdivision (5)(a) of this section.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers in proportion to the contribution of each insurer to that account the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that amount, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

(7) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance or health maintenance organization business within the scope of ~~specified under~~ the act, to consider the amount reasonably necessary to meet its assessment obligations under the ~~such~~ act.

(8) The association shall issue to each insurer paying a Class B assessment under the act a certificate of contribution in a form prescribed by the director for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. A statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest shall accompany the payment.

(b) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days after receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with a request.

Sec. 6. Section 44-2709, Reissue Revised Statutes of Nebraska, is amended to read:

44-2709 (1)(a) The association shall submit to the director a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments shall become effective upon approval in writing by the director or, if it has not been disapproved by the director, thirty days after submission.

(b) If the association fails to submit a suitable plan of operation within one hundred eighty days following August 24, 1975, or if at any time thereafter the association fails to submit suitable amendments to the plan, the director

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shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the Nebraska Life and Health Insurance Guaranty Association Act. Such rules and regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated in the Nebraska Life and Health Insurance Guaranty Association Act:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under section 44-2706;

(c) Establish regular places and times for meetings of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(e) Establish the procedures whereby selections for the board of directors shall be made and submitted to the director;

(f) Establish any additional procedures for assessments pursuant to section 44-2708; ~~and~~

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association; ~~.~~

(h) Establish procedures whereby a member of the board of directors may be removed for cause including, but not limited to, instances in which a member insurer becomes an impaired or insolvent insurer; and

(i) Require the board of directors to establish a policy and procedures for addressing conflicts of interest.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under subdivision (12)(c) of section 44-2707 and section 44-2708, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation made under this subsection shall take effect only with the approval of both the board of directors and the director and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by the Nebraska Life and Health Insurance Guaranty Association Act.

Sec. 7. Section 44-2713, Reissue Revised Statutes of Nebraska, is amended to read:

44-2713 (1) Nothing in the Nebraska Life and Health Insurance Guaranty Association Act shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties pursuant to section 44-2707. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities as provided in section 44-2714.

(3) For the purpose of carrying out its obligations under the Nebraska Life and Health Insurance Guaranty Association Act, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subdivision (11) of section 44-2707. All assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by the act. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserve that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4)(a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of the impaired or insolvent insurer, and any other party with a bona fide interest in making an equitable distribution of the ownership rights of such impaired or insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(b) No distribution to shareholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of assessments levied by the association with respect to such insurer have been fully recovered by the association.

(5) It shall be a prohibited unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act for any person to make use in any manner of the protection afforded by the Nebraska Life and Health Insurance Guaranty Association Act in the sale of insurance.

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(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subdivisions (b), (c), and (d) of this subsection.

(b) No such dividend shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate of the insurer at the time the distributions were paid shall be liable up to the amount of distributions such person received. Any person who was an affiliate of the insurer at the time the distributions were declared shall be liable up to the amount of distributions such person would have received if they had been paid immediately. If two persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer.

(e) If any person liable under subdivision (c) of this subsection is insolvent, all affiliates of such person at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Sec. 8. Section 44-2718, Reissue Revised Statutes of Nebraska, is amended to read:

44-2718 All proceedings in which the impaired insurer is a party in any court in this state shall be stayed one hundred eighty ~~sixty~~ days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits. Nothing in this section shall be deemed to limit the powers of a receiver appointed pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, or to stay any proceeding brought pursuant to such act.

Sec. 9. Section 44-2719.01, Reissue Revised Statutes of Nebraska, is amended to read:

44-2719.01 No person, including an insurer, agent, or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio station or television station, or in any other way any advertisement, announcement, or statement, written or oral, which uses the existence of the Nebraska Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Nebraska Life and Health Insurance Guaranty Association Act, except that this section shall not apply to the Nebraska Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

Sec. 10. Section 44-2719.02, Revised Statutes Cumulative Supplement, 2018, is amended to read:

44-2719.02 (1) Any insurer under an order of liquidation, rehabilitation, or conservation on February 12, 1986, shall be subject to the provisions of the Nebraska Life and Health Insurance Guaranty Association Act in effect on the day prior to February 12, 1986.

(2) Notwithstanding any other provision of law, the provisions of the Nebraska Life and Health Insurance Guaranty Association Act in effect on the date the association first becomes obligated for the policies or contracts of an insolvent or impaired member govern the association's rights or obligations to the policyowners, contract owners, or enrollees of the insolvent or impaired member insurer.

Sec. 11. Original sections 44-2706, 44-2707, 44-2708, 44-2709, 44-2713, 44-2718, and 44-2719.01, Reissue Revised Statutes of Nebraska, and sections 44-2702, 44-2703, and 44-2719.02, Revised Statutes Cumulative Supplement, 2018, are repealed.

Sec. 12. Since an emergency exists, this act takes effect when passed and approved according to law.