LEGISLATIVE BILL 978

Approved by the Governor March 15, 1994

Introduced by Landis, 46

AN ACT relating to insurance; to amend section 48-144.03, Reissue Revised Statutes of Nebraska, 1943, sections 44-222, 44-322, 44-416.01, 44-710.19, 44-1540, 44-1643, 44-2002, 44-2143, 44-4417, and 44-5508, Revised Statutes Supplement, 1992, and sections 44-214, 44-219, 44-1523, 44-1525, 44-1538, 44-1640, 44-3904, 44-6001, 44-6002, 44-6003, 44-6008, 44-6009, 44-6015 to 44-6019, and 44-6021 to 44-6026, Revised Statutes Supplement, 1993; to adopt the Disclosure of Material Insurance Transactions Act; to require life insurance companies to submit an opinion on reserves; to define terms; to provide for rules and regulations; to change provisions regulating maximum risks; to provide penalties; to change provisions relating to groups of underwriters; to change provisions relating to coverage for newly born children; to prescribe certain unfair trade practices and certain unfair claims practices; to change internal references regarding group health coverage; to change continuing education requirements for title insurance licensees; to provide fees for purchasing groups; to rename the Life and Health Insurers Risk-Based Capital Act; to make the act applicable to property and casualty insurers; to redefine terms; to limit the liability of the Director of Insurance and Department of Insurance as prescribed; to change reporting provisions; to change provisions relating to notices of cancellation of workers' compensation insurance; to eliminate an exemption from certificate of authority requirements; to harmonize provisions; to provide a duty for the Revisor of Statutes; to provide operative dates; and to repeal the original sections.

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

Section 1. Sections 1 to 6 of this act shall be known and may be cited as the Disclosure of Material Insurance Transactions Act.

Sec. 2. For purposes of the Disclosure of Material Insurance Transactions Act:

(1) Director shall mean the Director of Insurance; and

(2) Insurer shall mean an insurer as defined in section 44-103 authorized to transact the business of insurance in this state, except that insurer shall include health maintenance organizations and insurer shall not include unincorporated mutual associations and assessment associations.

Sec. 3. (1) Every insurer domiciled in this state shall file a report with the director disclosing any of the following transactions: Material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements, unless such acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the director for review, approval, or information purposes pursuant to other provisions of the insurance laws of this state, rules and regulations adopted and promulgated thereunder, or other requirements.

(2) The report shall be filed within fifteen days after the end of the calendar month in which any of the transactions occur.

(3) One complete copy of the report, including any exhibits or other attachments filed as part thereof, shall also be filed with the National Association of Insurance Commissioners.

(4) All reports obtained by or disclosed to the director pursuant to the Disclosure of Material Insurance Transactions Act shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the director, the National Association of Insurance Commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the director, after giving the insurer who would be affected thereby, notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the director may publish all or any part thereof in such manner as he or she deems appropriate.

Sec. 4. (1) No acquisitions or dispositions of assets need be reported pursuant to section 3 of this act if the acquisitions or dispositions are not material. A material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period, or material disposition, or

the aggregate of any series of related dispositions during any thirty-day period, shall mean one that is nonrecurring and not in the ordinary course of business and involves more than five percent of the reporting insurer's total admitted assets as reported in its most recent financial statement filed with the director pursuant to section 44-322.

(2) Asset acquisitions subject to the Disclosure of Material Insurance Transactions Act shall include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose. Asset dispositions subject to the act shall include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(3) The following information shall be disclosed in any report of a material acquisition or disposition of assets:

(a) Date of the transaction;

(b) Manner of acquisition or disposition;

(c) Description of the assets involved;

(d) Nature and amount of the consideration given or received;

(e) Purpose of or reason for the transaction;

(f) Manner by which the amount of consideration was determined;

(g) Gain or loss recognized or realized as a result of the transaction; and

(h) Name of the person from whom the assets were acquired or to whom they were disposed.

(4) Insurers shall report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one-hundred-percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Sec. 5. (1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported pursuant to section 3 of this act if the nonrenewals, cancellations, or revisions are not material. A material nonrenewal, cancellation, or revision shall mean one that affects for property and casualty business, including sickness and accident business when written as such, more than fifty percent of an insurer's ceded written premium, or for life, annuity, and sickness and accident business, more than fifty percent of the total reserve credit taken for business ceded, on an annualized basis as indicated in the insurer's most recent financial statement filed with the director pursuant to section 44-322. No filing shall be required if the insurer's ceded written premium or the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of direct plus assumed written premium or ten percent of the statutory reserve requirement prior to any cession, respectively.

(2) Subject to the criteria in subsection (1) of this section, a report shall be filed without regard to which party has initiated the nonrenewal, cancellation, or revision of ceded reinsurance whenever one or more of the following conditions exist:

(a) The entire cession has been canceled, nonrenewed, or revised and ceded indemnity and loss-adjustment expense reserves after any nonrenewal, cancellation, or revision represent less than fifty percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation, or revision not occurred;

(b) An authorized reinsurer has been replaced on an existing cession by an unauthorized reinsurer; or

(c) Collateral requirements previously established for unauthorized reinsurers have been reduced.

Subject to the materiality criteria for purposes of subdivisions (2)(b) and (c) of this section, a report shall be filed if the result of the revision affects more than ten percent of the cession.

(3) The following information shall be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) The effective date of the nonrenewal, cancellation, or revision;

(b) The description of the transaction with an identification of the initiator thereof;

(c) The purpose of or reason for the transaction; and

(d) If applicable, the identity of the replacement reinsurers.

(4) Insurers shall report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one-hundred-percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Sec. 6. The director may adopt and promulgate rules and regulations to carry out the Disclosure of Material Insurance Transactions Act.

Sec. 7. For purposes of sections 7 to 14 of this act:

(1) Director shall mean the Director of Insurance; and

(2) Qualified actuary shall mean an individual who is a member in good standing of the American Academy of Actuaries and who meets all requirements as determined by the director by rule or regulation.

Sec. 8. Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state.

Sec. 9. Every life insurance company, except as exempted by the director by rule or regulation, shall also annually include in the opinion required by section 8 of this act an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including the benefits under and expenses associated with the policies and contracts.

Sec. 10. The director may provide for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by section 8 of this act.

Sec. 11. Every opinion required by section 8 of this act shall be governed by the following provisions:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994;

(2) The opinion shall apply to all business in force including individual and group sickness and accident insurance plans, in form and substance acceptable to the director;

(3) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the director may prescribe;

(4) In the case of an opinion required to be submitted by a foreign or alien company, the director may accept the opinion filed by that company with the insurance supervisory official of another state if the director determines that the opinion reasonably meets the requirements applicable to a domestic company; and

(5) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the director, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

Sec. 12. Every opinion required by section 8 of this act shall be governed by the following provisions in addition to the provisions of section 11 of this act:

(1) A memorandum, in form and substance acceptable to the director, shall be prepared to support each actuarial opinion and made available to the director upon request;

(2) If the insurance company fails to provide a supporting memorandum at the request of the director within a period specified by rule or regulation or the director determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed or is otherwise unacceptable to the director, the director may engage a qualified

actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the director; and

(3) Any memorandum in support of the opinion, and any other material provided by the company to the director in connection therewith, shall be kept confidential by the director and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by rules and regulations adopted and promulgated hereunder, except that the memorandum or other material may otherwise be released by the director (a) with the written consent of the company or (b) to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the director for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is released by the company to the news media or other governmental agency other than a state insurance department or is cited by the company in its marketing, all portions of the memorandum become public information and are no longer confidential.

Sec. 13. The director may adopt and promulgate rules and regulations containing the minimum standards applicable to the valuation of sickness and accident policies.

Sec. 14. The director may adopt and promulgate rules and regulations to carry out the provisions of sections 7 to 14 of this act.

Sec. 15. That section 44-214, Revised Statutes Supplement, 1993, be amended to read as follows:

44-214. (1) Except as provided in section 44-202.01, no stock insurance company shall, on and after August 25, 1989, transact any line of insurance specified in section 44-201 in this state unless it maintains a capital stock, actually paid in cash or invested as provided by law, of at least one million dollars, nor shall it, on or after such date, transact the line or lines of insurance specified in subdivisions (1) and (2) of section 44-201 and in addition thereto one or more lines of insurance other than those specified in subdivisions (3) and (4) of such section in this state unless it maintains a capital stock, actually paid in cash or invested as provided by law, of at least two million dollars. No stock insurance company shall, on and after August 25, 1989, begin to transact any line of insurance as specified in section 44-201 unless it has a surplus of at least one million dollars, nor shall it, on and after such date, begin to transact the line or lines of insurance specified in subdivisions (1) and (2) of section 44-201 and in addition thereto one or more lines of insurance other than those specified in subdivisions (3) and (4) of such section in this state unless it has a surplus of at least two million dollars.

(2) The provisions of subsection (1) of this section shall be considered minimum requirements. Stock insurers holding a certificate of authority to transact business in this state shall also be subject to the requirements of the ~~Life and Health~~ Insurers Risk-Based Capital Act.

Sec. 16. That section 44-219, Revised Statutes Supplement, 1993, be amended to read as follows:

44-219. (1)(a) No domestic mutual insurance company shall begin to transact the business of insurance until (i) it has received not less than one hundred applications for insurance unless organized to write (A) workers' compensation and employers liability insurance, in which case it shall receive applications from at least twenty employers covering in the aggregate five hundred employees, or (B) the line or lines of insurance specified in subdivisions (13) and (14) of section 44-201, in which case no application shall be required, and in addition thereto (ii) it has received in cash one annual premium for each application for insurance.

(b) Except as provided in section 44-202.01, no mutual insurance company shall, on and after August 25, 1989, transact any line of insurance specified in section 44-201 in this state unless it has and maintains a minimum surplus, in cash or invested as provided by law, of at least one million dollars, nor shall it, on and after such date, transact the line or lines of insurance specified in subdivisions (1) and (2) of section 44-201 and in addition thereto one or more lines of insurance other than those specified in subdivisions (3) and (4) of such section in this state unless it has and maintains a minimum surplus, in cash or invested as provided by law, of at least two million dollars.

(2) The provisions of subsection (1) of this section shall be considered minimum requirements. Mutual insurers holding a certificate of authority to transact business in this state shall also be subject to the requirements of the ~~Life and Health~~ Insurers Risk-Based Capital Act.

Sec. 17. That section 44-222, Revised Statutes Supplement, 1992, be amended to read as follows:

44-222. ~~(1)~~ Except as otherwise provided by law, no insurance company shall expose itself to any loss on any one risk in an amount exceeding ten percent of its surplus to policyholders as reflected by the last annual statement of the company, except that domestic assessment associations organized for the primary purpose of writing insurance coverage on farm properties and which write such insurance in less than thirty-one counties in Nebraska shall not write any policy for an amount in excess of one-eighth of one percent of its insurance in force. The term loss shall mean the incremental decrease in surplus resulting from payment of a claim equal to the maximum liability of the insurer on any one risk. The term any one risk shall mean, in the case of property insurance, all properties insured by the same insurance company which are customarily considered by underwriters to be subject to loss or destruction from the same hazard or occurrence except hazards or occurrences of a catastrophic nature. The term surplus to policyholders shall mean the amount obtained by subtracting, from the admitted assets, actual liabilities, including any reserves which by law must be maintained. In the case of a stock company, surplus to policyholders shall also include the paid-up and outstanding capital stock. Any reinsurance taking effect simultaneously with the policy or bond shall be deducted in determining whether any one risk or policy exceeds the limitation of risk or policy prescribed in this section. This section shall not be applicable to ~~marine insurance, as distinguished from inland marine insurance, title insurance, or~~ workers' compensation or employers liability insurance~~, nor~~ or to any policy or type of coverage as to which the maximum possible loss to the insurance company is not ascertainable on issuance of the policy.

~~(2) Upon the written consent of the Director of Insurance, any insurance company chartered and licensed in Nebraska and writing coverage pursuant to the federal Liability Risk Retention Act of 1986 and the Risk Retention Act may be exempted from the provisions of this section. Prior to any approval of such exemption, such insurance company shall submit to the director an application setting forth its proposed plan of operation, as defined in section 44-4403, and detailing the reasons why such exemption should be granted. After review of the application and any other material the director may require, the director, upon a determination that the capital and surplus of such insurance company will be reasonable in relation to the insurer's outstanding liabilities and adequate to meet its financial needs, may grant such exemption.~~

Sec. 18. That section 44-322, Revised Statutes Supplement, 1992, be amended to read as follows:

44-322. (1) Every insurance company holding a certificate of authority to transact the business of insurance in this state shall file with the director on or before March 1 of each year an annual financial statement for the year ending December 31 immediately preceding on forms prescribed by the director which conform substantially to the forms adopted by the National Association of Insurance Commissioners. Unless the director provides otherwise, the financial statement shall be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners and shall include the salaries and compensation of the officers and any other information required by the director. Every insurance company subject to this section shall make such other periodic financial filings as the director may reasonably require.

The director shall suspend or shall not issue or renew the certificate of authority of an insurance company until it has complied with the requirements of this subsection and any rules and regulations or orders issued thereunder, except that for good and sufficient cause shown the director may grant a reasonable extension of time within which the financial statement may be filed, in no event to exceed thirty days. The director may order an insurance company which fails to file its annual financial statement as required under this subsection to pay an administrative penalty of five hundred dollars and an additional penalty of not to exceed five hundred dollars for each day thereafter such failure continues and the company continues to transact any business of insurance.

(2) Every insurance company holding a certificate of authority to transact the business of insurance in this state shall participate in the National Association of Insurance Commissioners Insurance Regulatory Information System, including the payment of all fees and charges of such system, except as exempted by the director. Each participating insurance company shall file with the National Association of Insurance Commissioners on or before March 1 of each year a copy of its annual financial statement along

with any additional filings required by the director for the immediately preceding year. The financial statement so filed shall be in the same format and scope as that required by subsection (1) of this section and shall include a signed jurat page and actuarial certification except as exempted by the director. Each participating insurance company shall file with the National Association of Insurance Commissioners any amendments and addendums to the financial statement and annual and quarterly financial statement information in computer readable format as required by the Insurance Regulatory Information System.

Sec. 19. That section 44-416.01, Revised Statutes Supplement, 1992, be amended to read as follows:

44-416.01. (1) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only if the reinsurer meets the requirements of subsection (2), (3), (4), or (5) of this section. If the requirements of subsection (3) or (4) of this section are met, the requirements of subsection (6) of this section shall also be met.

(2) Credit for reinsurance shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance in this state.

(3) Credit for reinsurance shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or, in the case of a United States branch of an alien assuming insurer, is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this section and the assuming insurer or branch of an alien assuming insurer (a) maintains policyholders surplus in an amount not less than twenty million dollars and (b) submits to this state's authority to examine its books and records. The surplus requirement of this subsection shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system, except that such insurers shall conform to the same standards of solvency which would be required if such insurers were licensed in this state, including the capital and surplus requirements of section 44-214 or 44-219.

(4) Credit for reinsurance shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in subdivision (1) of section 44-416, for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer shall report annually to the director information required by the director. The director may utilize the National Association of Insurance Commissioners Annual Statement form. This information shall enable the director to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of not less than twenty million dollars. In the case of a group ~~of~~ which includes incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, include a trusteed surplus of not less than one hundred million dollars, and the group shall make available to the director an annual certification by the group's domiciliary regulator and its independent public accountants of the solvency of each underwriter. The incorporated members of such a group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. In the case of a group of incorporated insurers under common administration which has continuously transacted an insurance business outside the United States for at least three years, submits to this state's authority to examine its books and records, bears the expense of the examination, and has aggregate policyholders surplus of ten billion dollars, the trust shall be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of such group, plus the group shall maintain a joint-trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities, and each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

Such trust shall be established in a qualified United States

financial institution, as defined in subdivision (1) of section 44-416, in a form approved by the director. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers and their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the director. Such trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year the trustees of the trust shall report to the director in writing the balance of the trust and the trust's investments at the end of the preceding year and shall certify the date of termination of the trust, if planned, or certify that the trust shall not expire prior to the following December 31.

(5) Credit for reinsurance shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (2), (3), or (4) of this section but only with respect to the insurance of risks located in jurisdictions other than the United States where such reinsurance is required by applicable law or regulation of such jurisdiction.

(6) If the assuming insurer is not licensed to transact insurance in this state, the credit permitted by subsections (3) and (4) of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements (a) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give such court jurisdiction, and shall abide by the final decision of such court or of any appellate court in the event of an appeal and (b) to designate the director or a designated attorney as its attorney upon whom may be served any lawful process in any action instituted by or on behalf of the ceding insurer. This subsection shall not conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

Sec. 20. That section 44-710.19, Revised Statutes Supplement, 1992, be amended to read as follows:

44-710.19. (1) All individual and group policies of sickness and accident insurance providing coverage on an expense-incurred basis ~~and individual and group service or indemnity type contracts~~ and health maintenance organization contracts shall provide benefits for newly born children ~~which provide coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the benefits applicable for children shall be payable, with respect to a newly born child~~ of the insured or subscriber, from the moment of birth.

(2) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) A policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees shall be furnished to the insurer or ~~nonprofit service or indemnity corporation~~ health maintenance organization within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period.

(4) The requirements of this section shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state on or after January 1, ~~1976~~ 1995.

Sec. 21. That section 44-1523, Revised Statutes Supplement, 1993, be amended to read as follows:

44-1523. For purposes of the Unfair Insurance Trade Practices Act:

(1) Department shall mean the Department of Insurance;

(2) Director shall mean the Director of Insurance;

(3) Insured shall mean the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy or certificate;

(4) Insurer shall mean any person, reciprocal exchange, interinsurer, Lloyds-type insurer or other similar group which includes incorporated and individual unincorporated underwriters, fraternal benefit society, and other legal entity engaged in the business of insurance, including agents, brokers, insurance consultants, adjusters, and third-party administrators. Insurer shall also mean health maintenance organizations, prepaid limited health service organizations, and dental, optometric, and other similar health service plans. For purposes of the act, all such insurers shall be deemed to be engaged in the business of insurance;

(5) Person shall mean any natural or artificial entity, including, but not limited to, an individual, partnership, limited liability company, association, trust, or corporation; and

(6) Policy or certificate shall include any contract of insurance, indemnity, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

Sec. 22. That section 44-1525, Revised Statutes Supplement, 1993, be amended to read as follows:

44-1525. Any of the following acts or practices, if committed in violation of section 44-1524, shall be unfair trade practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy;

(b) Misrepresents the dividends or share of the surplus to be received on any policy;

(c) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any policy;

(d) Misleads as to or misrepresents the financial condition of any insurer or the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any policy or class of policies which misrepresents the true nature thereof;

(f) Misrepresents for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion, or surrender of any policy, including intentionally misquotes any premium rate;

(g) Misrepresents for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(h) Misrepresents any policy as being shares of stock;

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any insurer in the conduct of his or her insurance business which is untrue, deceptive, or misleading;

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or derogatory to the financial condition of any insurer and which is calculated to injure such insurer;

(4) Entering into any agreement to commit or by any concerted action committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the business of insurance;

(5)(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer; or

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer;

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(7)(a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such policy or annuity;

(b) Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any sickness and accident

insurance policy or in the benefits payable thereunder, in any of the terms or conditions of such policy, or in any other manner, except that this subdivision shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113;

(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law, rule, or regulation;

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law, rule, or regulation;

(e) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual solely because of the sex or marital status of the individual. This subdivision shall not prohibit an insurer from taking marital status into account for the purpose of defining individuals eligible for dependent benefits; or

(f) Terminating or modifying coverage or refusing to issue or refusing to renew any property or casualty insurance policy solely because the applicant or insured or any employee of the applicant or insured is mentally or physically impaired unless:

(i) The termination, modification, or refusal is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The termination, modification, or refusal is required by law, rule, or regulation.

This subdivision (f) shall not apply to any sickness and accident insurance policy sold by a casualty insurer and shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any policy;

(8)(a) Except as otherwise expressly provided by law:

(i) Knowingly permitting or offering to make or making any life insurance policy, annuity, or sickness and accident insurance policy, or agreement as to any such policy or annuity, other than as plainly expressed in the policy or annuity issued thereon, or paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such policy or annuity, any rebate of premiums payable on the policy or annuity, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy or annuity; or

(ii) Giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith any stocks, bonds, or other securities of any insurer or other corporation, association, partnership, or limited liability company, or any dividends or profits accrued thereon, or anything of value not specified in the policy or annuity.

(b) Nothing in subdivision (7) or (8)(a) of this section shall be construed as including within the definition of discrimination or rebates any of the following acts or practices:

(i) In the case of any life insurance policy or annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance if such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the insurer and its policyholders;

(ii) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or

(iii) Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(9) Failing of any insurer to maintain a complete record of all the

complaints received since the date of its last examination conducted pursuant to the Insurers Examination Act. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subdivision, complaint shall mean any written communication primarily expressing a grievance;

(10) Making false or fraudulent statements or representations on or relative to an application for a policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual person;

(11) Failing of any insurer, upon receipt of a written inquiry from the department, to respond to such inquiry or request additional reasonable time to respond within fifteen working days; and

(12) Violating any provision of section 44-320, 44-348, 44-360, 44-361, 44-369, 44-392, 44-393, 44-515 to 44-518, 44-522, 44-523, 44-1951, 44-1953 to 44-1955, 44-1959, 44-1960, 44-1975, 44-2132 to 44-2134, 44-3606, 44-4809, 44-4812, or 44-4817.

Sec. 23. That section 44-1538, Revised Statutes Supplement, 1993, be amended to read as follows:

44-1538. (1) For purposes of the Unfair Insurance Claims Settlement Practices Act:

(a) Director shall mean the Director of Insurance;

(b) Insured shall mean the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy or certificate;

(c) Insurer shall mean any person, reciprocal exchange, interinsurer, Lloyds-type insurer or other similar group which includes incorporated and individual unincorporated underwriters, fraternal benefit society, and other legal entity engaged in the business of insurance, including agents, brokers, insurance consultants, adjusters, and third-party administrators. Insurer shall also mean health maintenance organizations, prepaid limited health service organizations, and dental, optometric, and other similar health service plans. For purposes of the act, all such insurers shall be deemed to be engaged in the business of insurance;

(d) Person shall mean any natural or artificial entity, including, but not limited to, an individual, partnership, limited liability company, association, trust, or corporation; and

(e) Policy or certificate shall include any contract of insurance, indemnity, or annuity issued, proposed for issuance, or intended for issuance by any insurer. Policy or certificate shall not include contracts of workers' compensation, fidelity, suretyship, or boiler and machinery insurance.

(2) The purpose of the definitions in this section is to include within the act and any rules and regulations adopted pursuant to the act all entities and activities to the extent not preempted by the federal Employee Retirement Income Security Act of 1974, as amended.

Sec. 24. That section 44-1540, Revised Statutes Supplement, 1992, be amended to read as follows:

44-1540. Any of the following acts or practices by an insurer, if committed in violation of section 44-1539, shall be an unfair claims settlement practice:

(1) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

(4) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

(5) Compelling insureds or beneficiaries to institute litigation to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in litigation brought by them;

(6) Refusing to pay claims without conducting a reasonable investigation;

(7) Failing to affirm or deny coverage of a claim within a reasonable time after having completed its investigation related to such claim;

(8) Attempting to settle a claim for less than the amount to which a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle claims on the basis of an application which

was materially altered without notice to or knowledge or consent of the insured;

(10) Making a claims payment to an insured or beneficiary without indicating the coverage under which each payment is being made;

(11) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof-of-loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof-of-loss form;

(12) Failing, in the case of the denial of a claim or the offer of a compromise settlement, to promptly provide a reasonable and accurate explanation of the basis for such action;

(13) Failing to provide forms necessary to present claims with reasonable explanations regarding their use within fifteen working days of a request;

(14) Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or affiliated with the insurer are performed in a skillful manner. For purposes of this subdivision, a repairer is affiliated with the insurer if there is a preexisting arrangement, understanding, agreement, or contract between the insurer and repairer for services in connection with claims on policies issued by the insurer; and

(15) Requiring the insured or claimant to use a particular company or location for motor vehicle ~~glass replacement or motor vehicle glass~~ repair. Nothing in this subdivision shall prohibit an insurer from entering into discount agreements with companies and locations for motor vehicle ~~glass replacement and motor vehicle glass~~ repair or otherwise entering into any business arrangements or affiliations which reduce the cost of motor vehicle ~~glass replacement and motor vehicle glass~~ repair if the insured or claimant has the right to use a particular company or reasonably available location for motor vehicle ~~glass replacement or motor vehicle glass~~ repair. If the insured or claimant chooses to use a particular company or location other than the one providing the lowest estimate for like kind and quality motor vehicle ~~glass replacement or like kind and quality motor vehicle glass~~ repair, the insurer shall not be liable for any cost exceeding the lowest estimate. For purposes of this subdivision, motor vehicle repair shall include motor vehicle glass replacement and motor vehicle glass repair.

Sec. 25. That section 44-1640, Revised Statutes Supplement, 1993, be amended to read as follows:

44-1640. An employer or employer trust group policy or contract delivered or issued for delivery in this state which provides coverage to a group which, based on the number of employees, is not a group subject to ~~sections 1161 through 1168~~ section 4980B of the Internal Revenue Code of 1986, as amended, and which provides hospital, surgical, or major medical coverage, or any combination of such coverages, on an expense-incurred or service basis by an insurance company or health maintenance organization for employees or their families, but not a policy or contract which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee whose hospital, surgical, or major medical coverage under the group policy or contract would otherwise be terminated because of the involuntary termination of employment of such employee, for reasons other than misconduct in connection with employment, shall be entitled to continue such coverage subject to the provisions of the group policy or contract and the following conditions:

(1) Such coverage shall be continued on a monthly renewal basis until the earliest of the following dates:

(a) The date of expiration of a period of six months following the date the coverage of the terminated employee would otherwise be terminated;

(b) The date the terminated employee becomes eligible for other group hospital, surgical, or medical coverage, whether insured or self-insured, or the date the terminated employee becomes eligible for medicare;

(c) The date of expiration of the monthly period for which premiums were paid in the event of a nonpayment of premium;

(d) The date the terminated employee exercises the privilege provided under the group policy or contract for conversion to an individual or family policy or contract; or

(e) The date on which the group insurance policy or health maintenance organization agreement is terminated or the date the employer or employer trust trustee terminates participation under such policy or agreement;

(2) The monthly premium rate to be charged for such coverage shall not exceed one hundred two percent of the total premium which would have been charged for such coverage had the terminated employee still been a member of

the insured group. Such total premium rate shall be paid by the terminated employee. The experience of such coverage shall be charged to the group policy or contract which is in force; and

(3) The interruption of employment due to a labor dispute shall not be considered to be an involuntary termination of employment.

Sec. 26. That section 44-1643, Revised Statutes Supplement, 1992, be amended to read as follows:

44-1643. An employer or employer trust group policy or contract delivered, issued for delivery, or renewed in this state which provides coverage to a group which, based on the number of employees, is not a group subject to section ~~162(k)~~ 4980B of the Internal Revenue Code of 1986, as amended, and which provides hospital, surgical, or major medical coverage, or any combination of such coverages, on an expense-incurred or service basis by an insurance company or health maintenance organization for employees and their dependents, but not including any policy or contract which provides benefits for specific diseases or for accidental injuries only, shall provide that the covered surviving spouse or covered surviving dependent children whose hospital, surgical, or major medical coverage under the group policy or contract would otherwise be terminated because of the death of such employee shall be entitled to continue such coverage subject to the provisions of the group policy or contract and the following conditions:

(1) Such coverage shall be continued on a monthly renewal basis until the earliest of the following dates:

(a) The date the covered surviving spouse or covered surviving dependent children become eligible for other group hospital, surgical, or major medical coverage, whether insured or self-insured, and with respect to the covered surviving spouse, the date such spouse remarries or the date such spouse becomes eligible for medicare or is covered by medicaid;

(b) The date of expiration of the monthly period for which premiums were paid for the covered surviving spouse or covered surviving dependent children in the event of nonpayment of premium;

(c) The date the covered surviving spouse or covered surviving dependent children exercise any privilege provided under the group policy or contract for conversion to an individual or family policy or contract;

(d) The date on which the group insurance policy or health maintenance organization agreement is terminated or the date the employer or employer trust trustee terminates participation under such policy or agreement; or

(e) The date of expiration of a period of one year following the date the coverage of the deceased employee would otherwise terminate; and

(2) The monthly premium rate to be charged for such coverage shall not exceed one hundred two percent of the total premium which would have been established for such coverage for the covered surviving spouse or covered surviving dependent children had the deceased employee still been a member of the insured group. Such total premium rate shall be paid by the covered surviving spouse or covered surviving dependent children. The experience of such coverage shall be charged to the group policy or contract which is in force.

Sec. 27. That section 44-2002, Revised Statutes Supplement, 1992, be amended to read as follows:

44-2002. (1) It shall be unlawful for any insurer to transact insurance business in this state, as set forth in subsection (2) of this section, without a certificate of authority from the director. This section shall not apply to:

(a) The lawful transaction of surplus lines insurance;

(b) The lawful transaction of reinsurance by insurers;

(c) Transactions in this state involving a policy lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy;

(d) Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses;

(e) Transactions in this state involving group life and group sickness and accident or blanket sickness and accident insurance or group annuities when the master policy of such groups was lawfully issued and delivered in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business, to a group organized for purposes other than the procurement of insurance, and when the policyholder is domiciled or otherwise has a bona fide situs; or

(f) Transactions in this state relative to a policy issued or to be issued outside this state involving insurance on vessels, craft or hulls,

cargoes, marine builder's risk, marine protection, and indemnity or other risk, including strikes and war risks commonly insured under ocean or wet marine forms of policy. ~~, or~~

~~(g) Transactions in this state involving contracts of insurance issued to one or more industrial insureds, which is hereby defined as an insured, which procures the insurance of any risk or risks other than life and annuity contracts by use of the services of a full-time employee acting as an insurance manager or buyer or the services of a regularly and continuously retained licensed insurance consultant, whose aggregate annual premiums for insurance on all risks, other than workers' compensation insurance, total at least one hundred thousand dollars and who has at least fifty full-time employees.~~

(2) Any of the following acts in this state effected by mail or otherwise by or on behalf of an unauthorized insurer shall constitute the transaction of an insurance business in this state. The venue of an act committed by mail shall be at the point where the matter transmitted by mail is delivered and takes effect. For purposes of this section, unless the context otherwise requires, insurer shall include all corporations, associations, partnerships, and individuals engaged as principals in the business of insurance and shall also include interinsurance exchanges and mutual benefit societies:

(a) The making of or proposing to make, as an insurer, an insurance contract;

(b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(c) The taking or receiving of any application for insurance;

(d) The receiving or collection of any premium, commission, membership fees, assessments, dues, or other consideration for any insurance or any part thereof;

(e) The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state;

(f) Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state. This subsection shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer;

(g) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance; or

(h) The transacting or proposing to transact any insurance business in substance equivalent to any of the provisions of subdivisions (a) through (g) of this subsection in a manner designed to evade the provisions of the statutes.

(3)(a) The failure of an insurer transacting insurance business in this state to obtain a certificate of authority shall not impair the validity of any act or contract of such insurer and shall not prevent such insurer from defending any action at law or suit in equity in any court of this state, but no insurer transacting insurance business in this state without a certificate of authority shall be permitted to maintain an action in any court of this state to enforce any right, claim, or demand arising out of the transaction of such business until such insurer shall have obtained a certificate of authority.

(b) In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of any insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of such insurance contract shall be liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of such insurance contract.

Sec. 28. That section 44-2143, Revised Statutes Supplement, 1992, be amended to read as follows:

44-2143. (1) Any insurer which fails, without just cause, to file any registration statement as required by section 44-2132 may be required by the director, after notice and hearing, to pay an administrative penalty of

one hundred dollars for each day's delay not to exceed an aggregate penalty of ten thousand dollars. The director may reduce the penalty if the insurer demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the insurer.

(2) Any insurer which fails to notify the director of any transaction, dividend, or distribution as required by sections 44-2132 to 44-2134 may be required by the director, after notice and hearing, to pay an administrative penalty of not more than two thousand five hundred dollars per violation.

(3) Any violation of sections 44-2132 to 44-2134 shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act in addition to any other remedies and penalties available under the laws of this state.

Sec. 29. That section 44-3904, Revised Statutes Supplement, 1993, be amended to read as follows:

44-3904. (1) Licensees qualified to solicit property and casualty insurance shall be required to complete twenty-four hours of approved continuing education activities in each two-year period. Licensees qualified to solicit assessment association insurance shall be required to complete twelve hours of approved continuing education activities in each two-year period. Licensees qualified to solicit only crop insurance or only fidelity and surety insurance shall be required to complete three hours of approved continuing education activities in each two-year period. Licensees qualified to solicit any other lines of insurance shall be required to complete six hours of approved continuing education activities in each two-year period for each line of insurance, including each miscellaneous line, in which he or she is licensed. Licensees who are neither agents nor brokers shall be required to complete twenty-four hours of continuing education activities in each two-year period. In each two-year period, every licensee shall furnish evidence to the director that he or she has satisfactorily completed the hours of approved continuing education activities required under this subsection for each line of insurance in which he or she is licensed as a resident agent or broker, except that no licensee shall be required to complete more than twenty-four cumulative hours required under this subsection in any two-year period.

(2) In each two-year period commencing on or after January 1, 1994, licensees required to complete approved continuing education activities under subsection (1) of this section shall, in addition to such activities, be required to complete six hours of approved continuing education activities on insurance industry ethics, except that licensees qualified to solicit only crop insurance, ~~or~~ only fidelity and surety insurance, or only title insurance shall be required to complete three hours of approved continuing education activities on insurance industry ethics.

(3) When the requirements of this section have been met, the licensee shall furnish to the department evidence of completion for the current two-year period commencing before January 1, 1994, or commencing on or after January 1, 1994, and a filing fee as established by the director not to exceed five dollars.

Sec. 30. That section 44-4417, Revised Statutes Supplement, 1992, be amended to read as follows:

44-4417. (1) A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the director which shall:

(a) Identify the state in which the purchasing group is domiciled;

(b) Identify all other states in which the purchasing group intends to do business;

(c) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(d) Identify the insurance company from which the group intends to purchase its insurance and the domicile of such company;

(e) Specify the method by which and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(f) Identify the principal place of business of the group; and

(g) Provide such other information as may be required by the director to verify that the purchasing group is qualified under subdivision (12) of section 44-4403.

(2) A purchasing group which intends to do business in this state shall include an initial registration fee of one hundred dollars at the time it furnishes notice to the director pursuant to subsection (1) of this section. A purchasing group shall pay an additional fee of one hundred dollars to the director on October 1 of each year thereafter so long as such

registration continues. The fees required by this subsection shall be payable to the department and shall be remitted to the State Treasurer for credit to the Department of Insurance Cash Fund.

(3) A purchasing group shall, within ten days, notify the director of any changes in the items set forth in subsection (1) of this section.

~~(3)~~ (4) A purchasing group shall register with and designate the director as its agent solely for the purpose of receiving service of legal documents or process, except that such requirement shall not apply in the case of a purchasing group that:

(a) Was domiciled before April 1, 1986, and is domiciled on and after October 27, 1986, in any state of the United States;

(b) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state;

(c) Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state;

(d) Was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(e) Does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981 as in effect before October 27, 1986.

~~(4)~~ (5) Each purchasing group that is required to give notice pursuant to subsection (1) of this section shall also furnish such information as may be required by the director to:

(a) Verify that the entity qualifies as a purchasing group;

(b) Determine where the purchasing group is located; and

(c) Determine appropriate tax treatment.

Sec. 31. That section 44-5508, Revised Statutes Supplement, 1992, be amended to read as follows:

44-5508. (1) Every surplus lines licensee transacting business under the Surplus Lines Insurance Act shall ascertain the financial condition of each insurer before such licensee places any insurance with or procures any insurance from such insurer. If requested by the director, the licensee shall provide a copy of the current annual statement certified and sworn to by such insurer.

(2) No surplus lines licensee shall knowingly or without proper investigation place any insurance with or procure any insurance from any nonadmitted foreign or alien insurer that does not have surplus, capital, and reserves in amounts equal to or greater than the requirements of surplus, capital, and reserves placed on admitted insurers which write the same kinds of insurance.

(3) In addition to the requirements of subsection (2) of this section, no surplus lines licensee shall place any insurance with or procure any insurance from any nonadmitted alien insurer unless such insurer (a) maintains in the United States a trust fund in a qualified United States financial institution as defined in subdivision (1) of section 44-416 in an amount not less than two million five hundred thousand dollars for the protection of policyholders in the United States, consisting of cash in United States currency, readily marketable securities, or clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution as defined in subdivision (2) of section 44-416, and such trust fund shall have an expiration date which at no time shall be less than five years, or (b) is approved by the Nonadmitted Insurers Information Office of the National Association of Insurance Commissioners, and the director, in his or her discretion, has not independently determined such insurer to be in an unsound financial condition.

(4) No surplus lines licensee shall place any insurance with or procure any insurance from any nonadmitted Lloyd's plan or other similar ~~unincorporated group of individual insurers~~ group which includes incorporated and individual unincorporated underwriters unless such group maintains a trust fund of not less than fifty million dollars as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group and such trust complies with the terms and conditions established in subsection (3) of this section for nonadmitted alien insurers.

(5) Any surplus lines licensee violating this section shall be guilty of a Class III misdemeanor.

(6)(a) No nonadmitted foreign or alien insurer shall transact business under the act if it does not comply with the surplus, capital, and reserves requirements of subsection (2) of this section.

(b) In addition to the requirements of subdivision (a) of this subsection, no nonadmitted alien insurer shall transact business under the act if it does not comply with the requirements of subdivision (3)(a) or (b) of this section.

(c) No nonadmitted Lloyd's plan or other similar ~~unincorporated group of individual insurers~~ group which includes incorporated and individual unincorporated underwriters shall transact business under the act if it does not comply with the requirements of subsection (4) of this section.

Sec. 32. That section 44-6001, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6001. Sections 44-6001 to 44-6026 and section 45 of this act shall be known and may be cited as the ~~Life and Health~~ Insurers Risk-Based Capital Act.

Sec. 33. That section 44-6002, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6002. For purposes of the ~~Life and Health~~ Insurers Risk-Based Capital Act, the definitions found in sections 44-6003 to 44-6014 shall be used.

Sec. 34. That section 44-6003, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6003. Adjusted risk-based capital report shall mean a risk-based capital report which has been adjusted by the director in accordance with subsection ~~(3)~~ (5) of section 44-6015.

Sec. 35. That section 44-6008, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6008. Insurer shall mean an insurer as defined in section 44-103 authorized to transact the business of insurance, except that insurer shall not include unincorporated mutual associations, assessment associations, fraternal benefit societies, health maintenance organizations, prepaid dental service corporations, prepaid limited health service organizations, monoline mortgage guaranty insurers, monoline financial guaranty insurers, title insurers, prepaid legal corporations, intergovernmental risk management pools, and any other kind of insurer to which the application of the Insurers Risk-Based Capital Act, in the determination of the director, would be clearly inappropriate.

Insurer, when referring to life and health insurers, shall mean an insurer authorized to transact life insurance business and sickness and accident insurance business specified in subdivisions (1) through (4) of section 44-201, or any combination thereof.

Insurer, when referring to property and casualty insurers, shall mean an insurer authorized to transact property insurance business and casualty insurance business specified in subdivisions (5) through (14) and (16) through (20) of section 44-201, or any combination thereof, and shall also include an insurer authorized to transact insurance business specified in subdivision (4) of section 44-201 if also authorized to transact insurance business specified in subdivisions (5) through (14) and (16) through (20) of section 44-201. ~~Life insurance business or health insurance business, or both, except that insurer shall not include unincorporated mutual associations, assessment associations licensed pursuant to Chapter 44, article 8, fraternal benefit societies, health maintenance organizations, prepaid dental service corporations, and prepaid limited health service organizations.~~

Sec. 36. That section 44-6009, Revised Statutes Supplement, 1993, be amended to read as follows:

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

Sec. 37. That section 44-6015, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6015. (1) Every domestic insurer shall annually, on or prior to March ~~15~~ 1, referred to in this section as the filing date, prepare and submit to the director a risk-based capital report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing such information as is required by the risk-based capital instructions. In addition, every domestic insurer shall file its risk-based capital report:

(a) With the National Association of Insurance Commissioners in accordance with the risk-based capital instructions; and

(b) With the insurance commissioner in any state in which the insurer is authorized to do business if such insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its risk-based capital report not later than the later of:

(i) Fifteen days after the receipt of notice to file its risk-based capital report with such state; or

(ii) The filing date.

(2) ~~An~~ A life and health insurer's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital

instructions. The formula shall take into account and may adjust for the covariance between:

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

Such risks shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(3) A property and casualty insurer's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance between:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

Such risks shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in the Insurers Risk-Based Capital Act and the formulas, schedules, and instructions referenced in the act is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the risk-based capital levels required by the act. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in the act.

(5) If a domestic insurer files a risk-based capital report which in the judgment of the director is inaccurate, the director shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment.

Sec. 38. That section 44-6016, Revised Statutes Supplement, 1993, be amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

(e) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, and mix of business and use of reinsurance, if any, in each case. ~~, if any~~

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

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

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

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

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

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

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

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

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

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

(i) Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or

(ii) The date on which the risk-based capital plan or revised risk-based capital plan is filed under subsection (3) of section 44-6017.

Sec. 39. That section 44-6017, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6017. (1) Regulatory action level event shall mean any of the following events:

(a) The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital;

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

(c) If, pursuant to section 44-6020, the insurer challenges an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section, ~~under section 44-6020,~~ the notification by the director to the insurer that the director has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to file a risk-based capital report by the filing date prescribed in section 44-6015 unless the insurer has provided an explanation for such failure which is satisfactory to the director and has cured the failure within ten days after the filing date;

(e) The failure of the insurer to submit a risk-based capital plan to the director within the time period set forth in subsection (3) of section 44-6016;

(f) Notification by the director to the insurer that:

(i) The risk-based capital plan or revised risk-based capital plan submitted by the insurer is, in the judgment of the director, unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to the insurer unless the insurer has challenged the determination under section 44-6020;

(g) If, pursuant to section 44-6020, the insurer challenges a determination by the director under subdivision (1)(f) of this section, ~~pursuant to section 44-6020,~~ the notification by the director to the insurer that the director has, after a hearing, rejected such challenge;

(h) Notification by the director to the insurer that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the ~~regulatory~~ company action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the director has so stated in the notification unless the insurer has challenged the determination under section 44-6020; or

(i) If, pursuant to section 44-6020, the insurer challenges a determination by the director under subdivision (1)(h) of this section, ~~pursuant to section 44-6020,~~ the notification by the director to the insurer that the director has, after a hearing, rejected the challenge. ~~unless the failure of the insurer to adhere to its risk-based capital plan or revised risk-based capital plan has no substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event with respect to the insurer.~~

(2) In the event of a regulatory action level event, the director shall:

(a) Require the insurer to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;

(b) Perform such examination or analysis as the director deems necessary of the assets, liabilities, and operations of the insurer including a review of its risk-based capital plan or revised risk-based capital plan; and

(c) Subsequent to the examination or analysis, issue a corrective order.

(3) In determining corrective actions, the director may take into account such factors as are deemed relevant with respect to the insurer based upon the director's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan shall be submitted:

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

(b) If the insurer challenges an adjusted risk-based capital report pursuant to section 44-6020 and the challenge is not frivolous in the judgment of the director, ~~frivolous,~~ within forty-five days after the notification to the insurer that the director has, after a hearing, rejected the insurer's challenge; or

(c) If the insurer challenges a revised risk-based capital plan ~~under~~ pursuant to section 44-6020 and the challenge is not frivolous in the judgment of the director, within forty-five days after the notification to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(4) The director may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the director to review the insurer's risk-based capital plan or revised risk-based capital plan, to examine or analyze the assets, liabilities, and operations of the insurer, and to formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the director.

Sec. 40. That section 44-6018, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6018. (1) Authorized control level event shall mean any of the following events:

(a) The filing of a risk-based capital report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized

control level risk-based capital;

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

(c) If, pursuant to section 44-6020, the insurer challenges an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section, ~~under section 44-6020,~~ the notification by the director to the insurer that the director has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to respond, in a manner satisfactory to the director, to a corrective order unless the insurer has challenged the corrective order under section 44-6020; or

(e) If the insurer has challenged a corrective order under section 44-6020 and the director has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the director, to the corrective order subsequent to rejection or modification by the director.

(2) In the event of an authorized control level event the director shall:

(a) Take such actions as are required under section 44-6017 regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) If the director deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. In the event the director takes such actions, the authorized control level event shall be deemed sufficient grounds for the director to take action under the act, and the director shall have the rights, powers, and duties with respect to the insurer as are set forth in the act. In the event the director takes actions under this subdivision pursuant to an adjusted risk-based capital report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of the act pertaining to summary proceedings.

Sec. 41. That section 44-6019, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6019. (1) Mandatory control level event shall mean any of the following events:

(a) The filing of a risk-based capital report which indicates that the insurer's total adjusted capital is less than its mandatory control level risk-based capital;

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

(c) If, pursuant to section 44-6020, the insurer challenges an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section, ~~under section 44-6020,~~ the notification by the director to the insurer that the director has, after a hearing, rejected the insurer's challenge.

(2) In the event of a mandatory control level event, the director shall take such actions as are necessary to ~~cause~~ place the insurer ~~to be placed~~ under regulatory control under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act or, in the case of a property and casualty insurer which is writing no business and which is running off its existing business, may allow the insurer to continue its run-off under the supervision of the director. In the event the director takes such actions, the mandatory control level event shall be deemed sufficient grounds for the director to take action under the act, and the director shall have the rights, powers, and duties with respect to the insurer as are set forth in the act. In the event the director takes actions under this subsection pursuant to an adjusted risk-based capital report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of the act pertaining to summary proceedings. Notwithstanding the provisions of this subsection, the director may forego action for up to ninety days after the mandatory control level event if he or she finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

Sec. 42. That section 44-6021, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6021. (1) All risk-based capital reports, to the extent the information in the reports is not required to be set forth in a publicly

available annual statement schedule and risk-based capital plans, including the results or reports of any examination or analysis of an insurer performed pursuant to the ~~Life and Health~~ Insurers Risk-Based Capital Act and any corrective order issued by the director pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer which are filed with the director shall constitute information that might be damaging to the insurer if made available to its competitors and therefor shall be kept confidential by the director and shall not be public records subject to disclosure pursuant to sections 84-712 to 84-712.09. This information shall not be made public or be subject to subpoena other than by the director and then only for the purpose of enforcement actions taken by the director pursuant to the act or any other provision of the insurance laws of this state. Nothing in the act shall prevent or be construed to prohibit the director from disclosing risk-based capital reports and risk-based capital plans to the National Association of Insurance Commissioners and to the insurance department of any other state or country if the association or department agrees in writing to keep them confidential.

(2) It is the judgment of the Legislature that the comparison of an insurer's total adjusted capital to any of its risk-based capital levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Therefor, except as otherwise required under the act, the making, publishing, disseminating, circulating, or placing before the public or the causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefor prohibited. If any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to any of its risk-based capital levels or an inappropriate comparison of any other amount to the insurers' risk-based capital levels is published in any written publication and the insurer is able to demonstrate to the director with substantial proof the falsity of such statement or the inappropriateness, as the case may be, the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) It is the further judgment of the Legislature that the risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans are intended solely for use by the director in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the director for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the director to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

Sec. 43. That section 44-6022, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6022. The provisions of the ~~Life and Health~~ Insurers Risk-Based Capital Act are supplemental to any other provisions of the laws of this state and shall not preclude or limit any other powers or duties of the director under such laws, including, but not limited to, the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Sec. 44. That section 44-6023, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6023. (1) Any foreign insurer shall, upon the written request of the director, submit to the director a risk-based capital report as of the end of the calendar year just ended not later than the later of:

(a) The date a risk-based capital report would be required to be filed by a domestic insurer under section 44-6015; or

(b) Fifteen days after the request is received by the foreign insurer.

Any foreign insurer shall, at the written request of the director, promptly submit to the director a copy of any risk-based capital plan that is filed with the insurance commissioner of any other state.

(2) In the event of a company action level event, a ~~or~~ regulatory action level event, or an authorized control level event with respect to any foreign insurer as determined under the risk-based capital law applicable in

the state of domicile of the insurer or, if no risk-based capital law is in force in that state, under the ~~Life and Health~~ Insurers Risk-Based Capital Act, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under the risk-based capital law applicable in the state of domicile of the insurer or, if no risk-based capital law is in force in the state of domicile of the insurer, under section 44-6016, the director may require the foreign insurer to file a risk-based capital plan with the director. In such event, the failure of the foreign insurer to file a risk-based capital plan with the director shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation law applicable in the state of domicile of the foreign insurer, the director may make application to the district court of Lancaster County under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

Sec. 45. There shall be no liability on the part of, and no cause of action shall arise against, the director, the Department of Insurance, or its employees or agents for any action taken by them in the performance of their powers and duties under the Insurers Risk-Based Capital Act.

Sec. 46. That section 44-6024, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6024. All notices by the director to an insurer which may result in regulatory action under the ~~Life and Health~~ Insurers Risk-Based Capital Act shall be effective upon dispatch if transmitted by registered or certified mail or, in the case of any other transmission, shall be effective upon the insurer's receipt of such notice.

Sec. 47. That section 44-6025, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6025. For risk-based capital reports required to be filed by life and health insurers with respect to 1993 only, and for risk-based capital reports required to be filed by property and casualty insurers with respect to 1994 only, the following requirements shall apply in lieu of the provisions of sections 44-6016 to 44-6019:

(1) In the event of a company action level event with respect to a domestic insurer, the director shall take no regulatory action under the ~~Life and Health~~ Insurers Risk-Based Capital Act;

(2) In the event of a regulatory action level event under subdivisions (1)(a) through (c) of section 44-6017, the director shall take the actions required under section 44-6016;

(3) In the event of a regulatory action level event under subdivisions (1)(d) through (i) of section 44-6017 or an authorized control level event, the director shall take the actions required under section 44-6017 with respect to the insurer; and

(4) In the event of a mandatory control level event with respect to an insurer, the director shall take the actions required under section 44-6018 with respect to the insurer.

Sec. 48. That section 44-6026, Revised Statutes Supplement, 1993, be amended to read as follows:

44-6026. The director may adopt and promulgate rules and regulations to carry out the ~~Life and Health~~ Insurers Risk-Based Capital Act.

Sec. 49. That section 48-144.03, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

48-144.03. (1)(a) If ~~the~~ an insurer ~~or employer~~ intends to cancel a contract or policy of insurance issued by the insurer under the Nebraska Workers' Compensation Act within the contract or policy period, ~~he or she~~ the insurer shall give notice to such effect in writing to the Nebraska Workers' Compensation Court and to the ~~other party~~ employer, fixing the date on which it is proposed that such cancellation be effective. Such notices shall ~~be served personally on or~~ contain a brief statement of the insurer's reasons for cancellation and shall be sent by certified mail to the compensation court and the ~~other party~~ employer. No such cancellation shall be effective until ~~ten~~ sixty days after the mailing of such ~~notice, unless~~ notices, except that such cancellation may be effective ten days after mailing of such notices if such cancellation is based on (i) nonpayment of premium, (ii) failure of the employer to reimburse deductible losses as required under the contract or policy, or (iii) failure of the employer, if covered pursuant to section 48-146.01, to comply with sections 48-443 to 48-445. If the employer has

secured insurance with another ~~carrier~~ insurer which would cause double coverage, such ~~.~~ ~~In such event the~~ cancellation shall be made effective as of the effective date of such other insurance.

(b) In any case when the employer gives notice to the insurer that he or she intends to cancel a contract or policy of insurance issued by the insurer under the Nebraska Workers' Compensation Act within the contract or policy period, the insurer shall immediately ~~notify~~ give notice in writing to the Nebraska Workers' Compensation Court that such contract or policy is being canceled by the employer and the date on which it is proposed that such cancellation be effective. Such notice shall be sent by certified mail to the compensation court. No such cancellation shall be effective until ten days after the mailing of such notice. If the employer has secured insurance with another insurer which would cause double coverage, such cancellation shall be made effective as of the effective date of such other insurance.

(2) If an insurer intends to nonrenew a contract or policy of insurance issued under the Nebraska Workers' Compensation Act, the insurer shall give notice to such effect in writing to the Nebraska Workers' Compensation Court and to the employer. Such notices shall contain a brief statement of the insurer's reasons for nonrenewal and shall be sent by certified mail to the compensation court and the employer. No such nonrenewal shall be effective until sixty days after the mailing of such notices. This subsection shall not apply to contracts or policies of insurance issued pursuant to section 48-146.01.

Sec. 50. The Revisor of Statutes shall assign sections 7 to 14 of this act to Chapter 44, article 4.

Sec. 51. Sections 1 to 6, 20, and 52 of this act shall become operative on January 1, 1995. The other sections of this act shall become operative on their effective date.

Sec. 52. That original section 44-710.19, Revised Statutes Supplement, 1992, is repealed.

Sec. 53. That original section 48-144.03, Reissue Revised Statutes of Nebraska, 1943, sections 44-222, 44-322, 44-416.01, 44-1540, 44-1643, 44-2002, 44-2143, 44-4417, and 44-5508, Revised Statutes Supplement, 1992, and sections 44-214, 44-219, 44-1523, 44-1525, 44-1538, 44-1640, 44-3904, 44-6001, 44-6002, 44-6003, 44-6008, 44-6009, 44-6015 to 44-6019, and 44-6021 to 44-6026, Revised Statutes Supplement, 1993, are repealed.