LEGISLATIVE BILL 1035

Approved by the Governor April 18, 1998

Introduced by Landis, 46

AN ACT relating to insurance; to amend sections 44-2827.01 and 44-5904, Reissue Revised Statutes of Nebraska, section 44-416.01, Revised Statutes Supplement, 1996, and sections 44-319.01, 44-787, 44-1525, 44-4206.02, 44-4221, 44-4222, 44-4228, 44-5115, 44-5237.01, 44-6904, and 77-2734.03, Revised Statutes Supplement, 1997; to change provisions relating to credit for reinsurance; to define and redefine terms; to change risk-loss trust provisions; to change provisions relating to the Comprehensive Health Insurance Pool; to change examination requirements; to adopt the Unfair Discrimination Against Subjects of Abuse in Insurance Act; to eliminate investment provisions; to change income tax credit provisions; to harmonize provisions; to provide operative dates; to repeal the original sections; to outright repeal section 44-5150, Reissue Revised Statutes of Nebraska; and to declare an emergency.

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

Section 1. Section 44-319.01, Revised Statutes Supplement, 1997, is amended to read:

44-319.01. For purposes of sections 44-319.01 to 44-319.13, unless the context otherwise requires:

(1) Director shall mean the Director of Insurance or his or her authorized representative;

(2) Policyholders shall mean all persons having a legal or equitable right against a depositing insurer or assessment association arising out of or by reason of depositing insurer's or association's policies and obligees under its surety contracts;

(3) State shall mean any state of the United States, the government of Puerto Rico, and the District of Columbia;

(4) Eligible securities shall mean the investments authorized under the Insurers Investment Act other than investments authorized under sections 44-5134, 44-5143 to 44-5145, 44-5149, ~~44-5150,~~ 44-5152, and 44-5153, and unless otherwise provided by law, the values of such investments shall, for the purpose of sections 44-319.01 to 44-319.13, be an amount not exceeding the current market values thereof; and

(5) Insurer shall mean stock and mutual insurance companies and reciprocal exchanges.

Sec. 2. Section 44-416.01, Revised Statutes Supplement, 1996, is amended to read:

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. Except as otherwise provided in section 44-224.11, credit for reinsurance shall be allowed under subsection (2) or (3) of this section only as respects cessions of those kinds or classes of business in which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. 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)(a) 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.

(i) 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~~ reinsurance ceded by United States ceding insurers and, in addition, include a trusteed surplus of not less than twenty million dollars.

(ii) In the case of a group which includes incorporated and individual unincorporated underwriters, (A)(I) for reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group, and (II) for reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed on or after that date, notwithstanding the other provisions of sections 44-416 to 44-417, the trust shall consist of a trusteed account ~~representing~~ in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States and, (B) in addition, the trust shall include a trusteed surplus of not less than one hundred million dollars, which shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account. Within ninety days after its financial statement is due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, a financial statement, prepared by an independent public accountant, of each underwriter member of the group. ~~, 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.

(iii) 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. Within ninety days after its financial statement is due to be filed with the group's domiciliary regulator, the group shall make available to the director an annual certification of each underwriter member's solvency by the member's domiciliary regulator and a financial statement of each underwriter member of the group prepared by the member's independent public accountant. ~~, 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.~~

(b) 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~~ insurance regulator of the state where the trust is domiciled, or by the insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust. The form of trust and any trust amendments also shall be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. 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~~ the benefit of the assuming insurer's 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.

(7) If the assuming insurer does not meet the requirements of subsection (2) or (3) of this section, the credit for reinsurance permitted by subsection (4) of this section shall not be allowed unless the assuming insurer agrees in the trust instrument to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by subsection (4) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the insurance regulator with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance regulator with regulatory oversight all of the assets of the trust fund;

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance regulator with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

(c) If the insurance regulator with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the insurance regulator with regulatory oversight to the trustee for distribution in accordance with the trust instrument; and

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

Sec. 3. Section 44-787, Revised Statutes Supplement, 1997, is amended to read:

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

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

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

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

discontinuing such individual policy or contract shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) For purposes of this section:

(a) Director means the Director of Insurance;

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

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

(i) Health status;

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

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

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

(viii) Disability; ~~and~~

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

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

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

(C) Liability insurance, including general liability insurance and

automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for onsite medical clinics; and

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

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

(A) Limited-scope dental or vision benefits;

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

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

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

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

(B) Hospital indemnity or other fixed indemnity insurance.

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

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(B) Coverage supplemental to the coverage provided under 10 U.S.C. 5501 et seq.; and

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

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

Sec. 4. Section 44-1525, Revised Statutes Supplement, 1997, is amended to read:

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 misquoting 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, 44-2132, to 44-2134, 44-3606, 44-4809, 44-4812, 44-4817, or 44-5266 or the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

Sec. 5. Section 44-2827.01, Reissue Revised Statutes of Nebraska, is amended to read:

44-2827.01. (1) Any general acute hospital as defined in subdivision (3) of section 71-2017.01 or a psychiatric or mental hospital as defined in subdivision (7) of such section operated by the Board of Regents of the University of Nebraska or any physician employed by the Board of Regents of the University of Nebraska may, in addition to the methods of establishing financial responsibility provided in section 44-2827, establish financial responsibility by a risk-loss trust.

(2) In order to establish financial responsibility through the use of a risk-loss trust, the risk-loss trust shall be approved in writing by the director. Such approval shall expire on the last day of April in each year and shall be renewed annually thereafter if the risk-loss trust continues to comply with the requirements of the Nebraska Hospital-Medical Liability Act and any rules and regulations adopted and promulgated thereunder.

(3) The director shall approve the use of a risk-loss trust to establish financial responsibility if he or she determines from a review of the plan of operation or feasibility study for the risk-loss trust that (a) the risk-loss trust will comply with all of the applicable requirements of the act, (b) the risk-loss trust has a financial plan which provides for adequate funding and adequate reserves to establish and maintain financial responsibility, and (c) the risk-loss trust has a plan of management designed to provide for its competent operation and management.

(4) Any risk-loss trust shall be established and maintained only on an occurrence basis, shall maintain reserves for payment of claims, and shall process and act upon claims in accordance with guidelines acceptable for Nebraska domestic insurance companies. The funds, or any part thereof, of any

risk-loss trust may be invested as authorized under the Insurers Investment Act for any domestic property and casualty insurance company.

(5) Any risk-loss trust shall file with the director, on or before March 1 of each year, a financial statement under oath for the year ending December 31 immediately preceding which shall include an actuarial or loss reserve specialist's opinion. The trust shall annually be audited by an independent accountant, and such audit shall be filed with the director.

(6) The director may examine the business affairs, records, and assets of such risk-loss trust to assure that it will be able to establish and maintain financial responsibility. Any examination conducted by the director or his or her authorized representative shall be at the expense of the risk-loss trust.

(7) If the director finds after notice to the Board of Regents of the University of Nebraska and a hearing that the risk-loss trust is not maintaining financial responsibility, he or she may order the board to take such action as is necessary to establish financial responsibility and upon failure by the board to comply therewith may revoke approval of such trust.

(8) If any hospital or physician establishes financial responsibility as provided in subsection (1) of this section, the annual surcharge amount which shall be levied against the board pursuant to section 44-2829 shall be established annually by the director after giving consideration to the following factors:

(a) The surcharge rate for hospitals and physicians set by the director pursuant to such section;

(b) The average rates charged by insurers of Nebraska hospitals and physicians;

(c) Variations in coverage provisions, liability limits, or deductibles between insurance provided by private insurers and the coverage provided by the risk-loss trust; and

(d) The loss experience of the board.

(9) The director may adopt and promulgate reasonable rules and regulations necessary and proper to carry out this section.

Sec. 6. Section 44-4206.02, Revised Statutes Supplement, 1997, is amended to read:

44-4206.02. (1) Creditable coverage shall mean, with respect to an individual, coverage of the individual under any of the following:

~~(1)~~ (a) A group health plan;

~~(2)~~ (b) Health insurance coverage;

~~(3)~~ (c) Part A or Part B of Title XVIII of the Social Security Act;

~~(4)~~ (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 of the act;

~~(5)~~ (e) 10 U.S.C. 5501 et seq.;

~~(6)~~ (f) A medical care program of the Indian Health Service or of a tribal organization;

~~(7)~~ (g) A state health benefits risk pool;

~~(8)~~ (h) A health plan offered under 5 U.S.C. 8901 et seq.;

~~(9)~~ (i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

~~(10)~~ (j) A health benefit plan under 22 U.S.C. 2504.

(2) Creditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage.

(3) Creditable coverage shall not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on the operative date of this section.

Sec. 7. Section 44-4221, Revised Statutes Supplement, 1997, is amended to read:

44-4221. (1) To be eligible to purchase health insurance from the pool, a person shall:

(a) Be a resident of the state for a period of at least six months and shall:

(i) Have received, within six months prior to application to the pool, a rejection in writing, for reasons of health, from an insurer;

(ii) Currently have, or have been offered within six months prior to application to the pool, health insurance coverage by an insurer which includes a restrictive rider which limits insurance coverage for a preexisting medical condition for a period of time exceeding twelve months; or

(iii) Have been refused health insurance coverage comparable to the pool, or have been offered such coverage at a rate exceeding the premium rate for pool coverage, within six months prior to application to the pool; or

(b) Be a resident of the state for any length of time and be an individual:

(i) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(ii) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;

(iii) With respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(iv) Who, if such individual was ~~had~~ ~~been~~ offered the option of continuation coverage under COBRA or under a similar program, ~~who~~ both elected such continuation coverage~~,~~ and ~~who has~~ exhausted such continuation coverage.

(2) The board may adopt and promulgate a list of medical or health conditions for which a person would be eligible for pool coverage without applying for health insurance pursuant to this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list adopted and promulgated by the board shall be eligible to apply directly to the pool for insurance coverage.

Sec. 8. Section 44-4222, Revised Statutes Supplement, 1997, is amended to read:

44-4222. (1) A person shall not be eligible for initial or continued coverage under the pool if:

(a) He or she is eligible for medicare benefits by reason of age or medical assistance established pursuant to sections 68-1018 to 68-1025;

(b) He or she is a resident or inmate of a correctional facility, except that this subdivision shall not apply if such person is eligible for coverage under subdivision (1)(b) of section 44-4221;

(c) He or she has terminated coverage in the pool unless twelve months have elapsed since such termination, except that this subdivision shall not apply if such person has received and become ineligible for medical assistance pursuant to sections 68-1018 to 68-1025 during the immediately preceding twelve months, ~~or~~ if such person is eligible for coverage under subdivision (1)(b) of section 44-4221, or if such person is eligible for waiver of any waiting period or preexisting condition exclusions pursuant to section 44-4228;

(d) The pool has paid out one million dollars in claims for the person; or

(e) He or she is no longer a resident of Nebraska.

(2) Coverage under the Comprehensive Health Insurance Pool Act shall terminate for any person on the date the person becomes ineligible under subsection (1) of this section.

Sec. 9. Section 44-4228, Revised Statutes Supplement, 1997, is amended to read:

44-4228. (1) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition (a) which had manifested itself during the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment or (b) for which medical advice, care, or treatment was recommended or received during the six-month period immediately preceding the effective date of coverage.

(2) Any person whose health coverage is involuntarily terminated on or after January 1, 1992, and who is not eligible for a conversion policy or a continuation-of-coverage policy or contract available under state or federal law may apply for pool coverage but shall submit proof of eligibility pursuant to subdivision (1)(a) of section 44-4221. If such proof is supplied and if pool coverage is applied for under the Comprehensive Health Insurance Pool Act within sixty days after the involuntary termination and if premiums are paid to the pool for the entire coverage period, any waiting period or preexisting condition exclusions provided for under the pool shall be waived to the extent similar exclusions, if any, under the previous health coverage have been satisfied and the effective date of the pool coverage shall be the day following termination of the previous coverage. The board may assess an additional premium for pool coverage provided pursuant to this subsection notwithstanding the premium limitations stated in section 44-4227. For purposes of this section, a person whose health coverage is involuntarily

terminated shall mean a person whose health insurance or health plan is terminated by reason of the withdrawal by the insurer from this state, bankruptcy or insolvency of the employer or employer trust fund, or cessation by the employer of providing any group health plan for all of its employees.

(3) Any person whose health coverage under a continuation-of-coverage policy or contract available under state or federal law terminates or is involuntarily terminated on or after July 1, 1993, for any reasons other than nonpayment of premium may apply for pool coverage but shall submit proof of eligibility applied for within ninety days after the termination or involuntary termination. If premiums are paid to the pool for the entire coverage period, the effective date of the pool coverage shall be the day following termination of the previous coverage under the continuation-of-coverage policy or contract. Any waiting period or preexisting condition exclusions provided for under the pool shall be waived to the extent similar exclusions, if any, under any prior health coverage have been satisfied.

~~(4)(a)~~ Subsection (1) of this section shall not apply to a person who has received medical assistance pursuant to section 43-522 or sections 68-1018 to 68-1025 or an organ transplant recipient terminated from coverage under medicare during the six-month period immediately preceding the effective date of coverage.

(5) All waiting periods and preexisting conditions shall be waived for ~~(b) Subsection (1) of this section shall not apply to~~ a person eligible for pool coverage under subdivision (1)(b) of section 44-4221. ~~as long as application to the pool is made not later than sixty-three days following termination of the person's most recent prior creditable coverage and as long as proof of eligibility under subdivision (1)(b) of section 44-4221 is submitted.~~

Sec. 10. Section 44-5115, Revised Statutes Supplement, 1997, is amended to read:

44-5115. (1) Except as provided in subsections (2) through (4) of this section, an insurer's investments authorized under the Insurers Investment Act in any one person shall not exceed five percent of the insurer's admitted assets.

(2) Subsection (1) of this section shall not apply to:

(a) Investments authorized under sections 44-5123, 44-5125, 44-5142, ~~44-5150,~~ and 44-5153;

(b) Investments authorized under sections 44-5124, 44-5126 to 44-5129, and 44-5132 if collateralized by obligations or mortgages for which the full faith and credit of the United States or Canada is pledged for the payment of all principal and interest;

(c) Loans made pursuant to section 44-5106; and

(d) Real estate held pursuant to subsection (2) or (3) of section 44-5144.

(3)(a) An insurer's investments authorized under section 44-5124 or 44-5126 in any one agency or instrumentality of the United States or Canada shall not exceed twenty-five percent of the insurer's admitted assets, and (b) an insurer's investments authorized under section 44-5132 in any one person if collateralized by mortgages for which the full faith and credit of an agency or instrumentality of the United States or Canada is pledged for the payment of all principal and interest shall not exceed twenty-five percent of the insurer's admitted assets. An insurer's investments authorized under section 44-5124 or 44-5126 in any one agency or instrumentality of the United States or Canada and the insurer's investments authorized under section 44-5132 collateralized by mortgages for which the full faith and credit of such agency or instrumentality of the United States or Canada is pledged for the payment of all principal and interest, in the aggregate, shall not exceed twenty-five percent of the insurer's admitted assets.

(4)(a) An insurer's investments in any one person whose senior obligations have a 3 designation from the Securities Valuation Office, in the aggregate, shall not exceed three percent of the insurer's admitted assets.

(b) An insurer's investments in any one person whose senior obligations have a 4 designation from the Securities Valuation Office, in the aggregate, shall not exceed two percent of the insurer's admitted assets.

(c) An insurer's investments in any one person whose senior obligations have a 5 designation from the Securities Valuation Office, in the aggregate, shall not exceed one percent of the insurer's admitted assets.

(d) An insurer's investments in any one person whose senior obligations have a 6 designation from the Securities Valuation Office, in the aggregate, shall not exceed one-half percent of the insurer's admitted assets.

(5) For purposes of this section, person shall mean an individual or entity or group of individuals or entities so related as in fact to constitute

a single venture, institution, corporation, association, company, partnership, limited liability company, syndicate, trust, society, or other legal entity.

Sec. 11. Section 44-5237.01, Revised Statutes Supplement, 1997, is amended to read:

44-5237.01. (1) Creditable coverage shall mean, with respect to an individual, coverage of the individual under any of the following:

~~(1)~~ (a) A group health plan;

~~(2)~~ (b) Health insurance coverage;

~~(3)~~ (c) Part A or Part B of Title XVIII of the Social Security Act;

~~(4)~~ (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 of the act;

~~(5)~~ (e) 10 U.S.C. 5501 et seq.;

~~(6)~~ (f) A medical care program of the Indian Health Service or of a tribal organization;

~~(7)~~ (g) A state health benefits risk pool;

~~(8)~~ (h) A health plan offered under 5 U.S.C. 8901 et seq.;

~~(9)~~ (i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

~~(10)~~ (j) A health benefit plan under 22 U.S.C. 2504.

(2) Creditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage.

(3) Creditable coverage shall not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on the operative date of this section.

Sec. 12. Section 44-5904, Reissue Revised Statutes of Nebraska, is amended to read:

44-5904. (1) The director or any of his or her examiners may conduct an examination under the Insurers Examination Act of any company incorporated in this state or in any other state or country admitted to or applying for admission to transact business in this state as often as the director in his or her sole discretion deems appropriate but shall at a minimum conduct an examination of every domestic insurer ~~authorized to transact business in this state~~ not less frequently than once every ~~five years for every foreign or alien insurer except as provided in subsection (3) of this section and once every~~ four years. ~~for every domestic insurer.~~ In scheduling and determining the nature, scope, and frequency of the examination of a company, the director shall consider such matters as the results of financial statement analyses and ratios, changes in the company's management or ownership, actuarial opinions, reports of independent certified public accountants, the company's ability to meet and fulfill its obligations, the company's compliance with provisions of law, other facts relating to the company's business methods, the company's management and its dealings with its policyholders, and other criteria as set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the director conducts an examination under this section.

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

~~(3)(a) Prior to January 1, 1994, the director may accept an examination report conducted on a foreign or alien company authorized to transact business in this state as prepared by the insurance department of the company's state of domicile or port-of-entry state in lieu of an examination under the act.~~

~~(b) On and after January 1, 1994, the director may accept an examination report conducted on a foreign or alien company licensed in this state only if:~~

~~(i) The examination is conducted by the insurance department of the company's state of domicile or port-of-entry state and such insurance department is at the time of the examination an accredited insurance department; or~~

~~(ii) The examination is conducted (A) under the supervision of an accredited insurance department or (B) with the participation of one or more examiners who are employed by an accredited insurance department and who, after a review of the examination workpapers and report, state under oath that~~

~~the examination was conducted in a manner consistent with the standards and procedures required by his, her, or their insurance department.~~

~~(c) For purposes of this subsection, accredited insurance department shall mean a state insurance department which is accredited under the Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners.~~

Sec. 13. Section 44-6904, Revised Statutes Supplement, 1997, is amended to read:

44-6904. (1) Creditable coverage means, with respect to an individual, coverage of the individual under any of the following:

~~(1)~~ (a) A group health plan;

~~(2)~~ (b) Health insurance coverage;

~~(3)~~ (c) Part A or Part B of Title XVIII of the Social Security Act;

~~(4)~~ (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 of the act;

~~(5)~~ (e) 10 U.S.C. 5501 et seq.;

~~(6)~~ (f) A medical care program of the Indian Health Service or of a tribal organization;

~~(7)~~ (g) A state health benefits risk pool;

~~(8)~~ (h) A health plan offered under 5 U.S.C. 8901 et seq.;

~~(9)~~ (i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

~~(10)~~ (j) A health benefit plan under 22 U.S.C. 2504.

(2) Creditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage.

(3) Creditable coverage shall not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on the operative date of this section.

Sec. 14. Sections 14 to 23 of this act shall be known and may be cited as the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

Sec. 15. For purposes of the Unfair Discrimination Against Subjects of Abuse in Insurance Act:

(1) Abuse means the occurrence of one or more of the following acts by a current or former family member or household member:

(a)(i) Attempting to cause or intentionally or knowingly causing another person, including a minor child, bodily injury, physical harm, rape, sexual assault, or involuntary sexual intercourse, or (ii) attempting to cause or recklessly causing another person, including a minor child, bodily injury, physical harm, severe emotional distress, or psychological trauma so as to intimidate or attempt to control the behavior of another person, including a minor child;

(b) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including a minor child, including following the person or minor child without proper authority, under circumstances that place the person or minor child in reasonable fear of bodily injury or physical harm;

(c) Subjecting another person, including a minor child, to false imprisonment; or

(d) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person, including a minor child;

(2) Abuse-related claim means a claim under a policy for a loss resulting from an act of abuse;

(3) Abuse-related medical condition means a medical condition sustained by a subject of abuse which arises in whole or in part out of an act or pattern of abuse;

(4) Abuse status means the fact or the perception on the part of the insurer that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions or incurred abuse-related claims;

(5) Confidential abuse information means information about acts of abuse or abuse status of a subject of abuse, the address and home and work telephone number of a subject of abuse or the status of an applicant or insured as a family member, employer, or associate of, or a person in a relationship with, a subject of abuse;

(6) Director means the Director of Insurance;

(7) Health benefit plan or plan means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan includes accident-only, credit accident and health, dental, vision, Medicare supplement, or long-term care insurance, coverage issued as a supplement to liability insurance, short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis. Health benefit plan does not include workers' compensation or similar insurance;

(8) Health carrier means an entity subject to the insurance laws and insurance rules and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, or any other entity providing a plan of health insurance, health benefits, or health services;

(9) Insured means a party named on a policy as the person with legal rights to benefits provided by such policy, except that for life insurance, insured means the person whose life is covered under the policy. For group plans and group insurance, insured includes a covered person;

(10) Insurer means a person or other legal entity engaged in the business of insurance in this state, including agents, brokers, adjusters, and third-party administrators. Insurer includes a health carrier;

(11) Policy means a contract or certificate of insurance, annuity, or indemnity, including endorsements, riders, and binders, issued, proposed for issuance, or intended for issuance in this state by an insurer. Policy includes a health benefit plan; and

(12) Subject of abuse means a person against whom an act of abuse has been directed (a) who has current or prior injuries, illnesses, or disorders that resulted from abuse or (b) who seeks, may have sought, or had reason to seek (i) medical or psychological treatment for abuse, or (ii) protection, court-ordered protection, or shelter from abuse.

Sec. 16. The purpose of the Unfair Discrimination Against Subjects of Abuse in Insurance Act is to prohibit unfair discrimination by insurers on the basis of abuse.

Sec. 17. The Unfair Discrimination Against Subjects of Abuse in Insurance Act applies to all insurers issuing, providing, delivering, arranging for, or renewing in this state any policy of insurance.

Sec. 18. An insurer shall not engage in an unfairly discriminatory act or practice against a subject of abuse.

Sec. 19. (1) The following acts or practices by an insurer are prohibited as unfairly discriminatory:

(a) Denying, refusing to issue, renew, or reissue, canceling, or otherwise terminating, restricting, or excluding coverage on or adding a premium differential to any policy on the basis of the applicant's or insured's abuse status;

(b) Excluding or limiting coverage for losses, denying benefits, or denying a claim incurred by an insured as a result of abuse on the basis of the insured's abuse status except as otherwise permitted or required by the laws of this state relating to acts of abuse committed by a life insurance beneficiary;

(c) Terminating group health coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abuser's coverage has terminated voluntarily or involuntarily;

(d) In the case of a property and casualty insurer, (i) denying or limiting payment for a covered loss or denying a covered claim incurred as a result of abuse by a person other than a coinsured or (ii) failing to pay losses arising out of abuse to an innocent first-party claimant to the extent of such claimant's legal interest in the covered property if the loss is caused by the intentional act of an insured or using other exclusions or limitations on coverage which the director has determined unreasonably restrict the ability of subjects of abuse to be indemnified for such losses. Subdivision (1)(d) of this section does not require payment in excess of the loss or policy limits. Nothing in subdivision (1)(d) of this section shall be construed to prohibit an insurer from applying reasonable standards of proof to claims under such subdivision;

(e) When the insurer has information in its possession that clearly indicates that the applicant, insured, or claimant is a subject of abuse, disclosing or transferring by a person employed by or contracting with the insurer of confidential abuse information for any purpose or to any person,

except:

(i) To a subject of abuse or a person specifically designated in writing by the subject of abuse;

(ii) To a health care provider for the direct provision of health care services;

(iii) To a licensed physician identified and designated by the subject of abuse;

(iv) When ordered by the director or a court of competent jurisdiction or otherwise required by law;

(v) When necessary for a valid business purpose to transfer information that includes confidential abuse information, confidential abuse information may be disclosed only to the following persons:

(A) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without such disclosure;

(B) A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurer;

(C) Medical or claims personnel contracting with the insurer, including parent or affiliate companies of the insurer that have service agreements with the insurer, only when necessary to process an application or perform the insurer's duties under the policy or to protect the safety or privacy of a subject of abuse; and

(D) With respect to address and telephone number, an entity with whom the insurer transacts business when the business cannot be transacted without the address and telephone number;

(vi) To an attorney who needs the information to represent the insurer effectively, if the insurer notifies the attorney of its obligations under the Unfair Discrimination Against Subjects of Abuse in Insurance Act and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer;

(vii) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about the abuse status; and

(viii) To any other entity deemed appropriate by the director; and

(f) Requesting information about acts of abuse or abuse status, or making use of such information, however obtained, except:

(i) For the limited purpose of complying with legal obligations;

(ii) When verifying a person's claim to be a subject of abuse or to have sustained an abuse-related medical condition or incurred an abuse-related claim; or

(iii) When cooperating with a subject of abuse in seeking protection from abuse or facilitating the treatment of an abuse-related medical condition.

(2) Nothing in subdivision (1)(c) of this section prohibits the health carrier from requiring the subject of abuse to provide satisfactory evidence that he or she is a subject of abuse, from requiring the subject of abuse to pay the full premium for coverage under the health benefit plan from the date of termination of the group coverage forward, or from requiring as a condition of coverage that the subject of abuse reside or work within its service area, if the requirements are applied to all insureds of the health carrier. The subject of abuse shall make application for the continuation coverage required by subdivision (1)(c) of this section within sixty days after termination of the group coverage. Any continuation coverage required by subdivision (1)(c) of this section shall cease upon termination of the underlying group coverage. The health carrier may terminate the continuation coverage required by subdivision (1)(c) of this section after it has been in force for eighteen months, if the health carrier offers conversion to an equivalent individual plan. The continuation coverage required by subdivision (1)(c) of this section shall be satisfied by coverage required under 29 U.S.C. 1161 et seq. provided to a subject of abuse and is not intended to be in addition to coverage provided under 29 U.S.C. 1161 et seq.

(3) Subdivision (1)(e) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(4) A subject of abuse may provide evidence of abuse to a health carrier for the limited purpose of facilitating treatment of an abuse-related medical condition or demonstrating that a medical condition is abuse-related, and this section does not authorize the health carrier to disregard that information.

(5) This section does not prohibit a life insurer from declining to issue a life insurance policy if the applicant or prospective owner of the policy is or would be designated as a beneficiary of the policy, and if:

(a) The applicant or prospective owner of the policy lacks an insurable interest in the prospective insured;

(b) The applicant or prospective owner of the policy is known, on the basis of medical, police, or court records, to have committed an act of abuse against the prospective insured; or

(c) The insured or prospective insured is a subject of abuse, and that person, or a person who has assumed the care of that person if a minor or incapacitated, has objected to the issuance of the policy on the ground that the policy would be issued to or for the direct or indirect benefit of the abuser.

(6) This section does not prohibit a property and casualty insurer from denying a property claim when the damage or loss is the result of intentional conduct by a named insured who commits an act of abuse, except that the property and casualty insurer shall make payment on such a claim to an innocent coinsured subject of abuse to the extent of the innocent coinsured's interest in the property and within the limits of coverage when the damage or loss was proximately related to and in furtherance of abuse. A property and casualty insurer paying such a claim shall be subrogated to the rights of the innocent coinsured subject of abuse to recover for any damages paid by the insurance.

(7) This section does not prohibit an insurer from asking an applicant or insured about a medical condition or a claim or from using information thereby obtained to underwrite or to evaluate and carry out its rights and duties under the policy, even if the information is related to a medical condition or claim that the insurer knows or has reason to know is abuse-related, to the extent otherwise permitted under the act and other applicable law.

(8) An insurer shall not be held civilly or criminally liable for the death of or injury to an insured resulting from any action taken in a good faith effort to comply with the requirements of the act. However, this subsection does not prevent an action by the director to investigate or enforce a violation of the act or to assert any other claims authorized by law.

(9) An insurer shall not be liable for a violation of the act by a person who is a contractor with the insurer unless the insurer directed the act, practice, or omission that constitutes the violation.

Sec. 20. An insurer that takes an action that adversely affects a subject of abuse on the basis of a medical condition or on the basis of claims history or other underwriting information that the insurer knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable policy provision:

(1) Does not treat abuse status as a medical condition or underwriting criterion;

(2) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or a similar claim or claims history without regard to whether the condition is or the claims are abuse-related; and

(3) Except for claims actions, is based on a determination, made in conformance with sound actuarial principles or otherwise supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

Sec. 21. In addition to any other remedies available under the laws of this state, each violation of the Unfair Discrimination Against Subjects of Abuse in Insurance Act and any rules and regulations adopted and promulgated thereunder shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Sec. 22. The director may adopt and promulgate rules and regulations to carry out the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

Sec. 23. The Unfair Discrimination Against Subjects of Abuse in Insurance Act applies to all actions taken on or after the operative date of this section, except as otherwise explicitly stated. Nothing in the act shall require an insurer to conduct a comprehensive search of its contract files existing on the operative date of this section solely to determine which applicants or insureds are subjects of abuse.

Sec. 24. Section 77-2734.03, Revised Statutes Supplement, 1997, is amended to read:

77-2734.03. (1)(a) For taxable years commencing prior to January 1, 1997, any (i) insurer paying a tax on premiums and assessments pursuant to section 77-908 or 81-523, (ii) electric cooperative organized under the Joint Public Power Authority Act, or (iii) credit union shall be credited, in the

computation of the tax due under the Nebraska Revenue Act of 1967, with the amount paid during the taxable year as taxes on such premiums and assessments and taxes in lieu of intangible tax.

(b) For taxable years commencing on or after January 1, 1997, any insurer paying a tax on premiums and assessments pursuant to section 77-908 or 81-523, any electric cooperative organized under the Joint Public Power Authority Act, or any credit union shall be credited, in the computation of the tax due under the Nebraska Revenue Act of 1967, with the amount paid during the taxable year as (i) taxes on such premiums and assessments included as Nebraska premiums and assessments under section 77-2734.05~~, (ii) assessments allowed as an offset against premium and related retaliatory tax liability pursuant to section 44-4233, and (iii)~~ and (ii) taxes in lieu of intangible tax.

(c) For taxable years commencing or deemed to commence prior to, on, or after January 1, 1998, any insurer paying a tax on premiums and assessments pursuant to section 77-908 or 81-523 shall be credited, in the computation of the tax due under the Nebraska Revenue Act of 1967, with the amount paid during the taxable year as assessments allowed as an offset against premium and related retaliatory tax liability pursuant to section 44-4233.

(2) There shall be allowed to corporate taxpayers a credit for nonhighway use motor vehicle fuels as provided in section 66-4,124.

(3) There shall be allowed to corporate taxpayers a tax credit for contributions to community betterment programs as provided in the Community Development Assistance Act.

Sec. 25. Sections 4, 14 to 23, and 26 of this act become operative three calendar months following the adjournment of this legislative session. The other sections of this act become operative on their effective date.

Sec. 26. Original section 44-1525, Revised Statutes Supplement, 1997, is repealed.

Sec. 27. Original sections 44-2827.01 and 44-5904, Reissue Revised Statutes of Nebraska, section 44-416.01, Revised Statutes Supplement, 1996, and sections 44-319.01, 44-787, 44-4206.02, 44-4221, 44-4222, 44-4228, 44-5115, 44-5237.01, 44-6904, and 77-2734.03, Revised Statutes Supplement, 1997, are repealed.

Sec. 28. The following section is outright repealed: Section 44-5150, Reissue Revised Statutes of Nebraska.

Sec. 29. Since an emergency exists, this act takes effect when passed and approved according to law.