LEGISLATIVE BILL 1136

Approved by the Governor April 6, 1990

Introduced by Landis, 46

AN ACT relating to insurance; to amend sections 44-3,132, 44-4230, 60-574, 60-578, and 68-1030, Reissue Revised Statutes of Nebraska, 1943, and sections 44-2402, 44-4103, 44-4210, 44-4220, 44-4222, 44-4227, 44-4228, 44-4726, 44-4802, and 71-2069, Revised Statutes Supplement, 1989; to adopt the Health Maintenance Organization Act; to adopt the Motor Vehicle Service Contract Reimbursement Insurance Act; to adopt the Managing General Agents Act; to define and redefine terms; to change provisions relating to the Comprehensive Health Insurance Pool to provide coverage for persons who received medicaid assistance, change rate provisions, and provide for a right of subrogation; to change provisions relating to maximum liability for underinsured motorist coverage; to provide for the confidentiality of certain information and records of preferred providers and health care review committees as prescribed; to prohibit a restriction in medical benefit contracts regarding reimbursement for prescription drugs as prescribed; to provide a duty for the Revisor of Statutes; to eliminate the Model Health Maintenance Organization Act and provisions relating to service contracts; to harmonize provisions; to provide operative dates; and to repeal the original sections, and also sections 44-3201 to 44-3210, 44-3213 to 44-3230, 44-3232, 44-3234, 44-3235, 44-3237, 44-3238, 44-3240 to 44-3243, 44-3245, 44-3246, 44-3248 to 44-3254, 44-3258 to 44-3262, 44-3264 to 44-3269, 44-3271 to 44-3275, 44-3278 to 44-3284, 44-3286 to 44-3291, and 44-3504 to 44-3518, Reissue Revised Statutes of Nebraska, 1943, and sections 44-3211, 44-3231, 44-3233, 44-3236, 44-3239, 44-3244, 44-3247, 44-3263, 44-3270, 44-3276, 44-3277, 44-3285, 44-3501 to 44-3503, and 44-3519, Revised Statutes Supplement, 1989.

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

Section 1. Sections 1 to 89 of this act shall be known and may be cited as the Health Maintenance Organization Act.

Sec. 2. For purposes of the Health Maintenance Organization Act, the definitions found in sections 3 to 23 of this act shall be used.

Sec. 3. Basic health care services shall include as a minimum the following medically necessary services: Preventive care; emergency care; inpatient and outpatient hospital and physician care; diagnostic laboratory services; diagnostic and therapeutic radiological services; and out-of-area emergency services.

Sec. 4. Carrier shall mean a health maintenance organization, an insurer, or any other entity responsible for the payment of benefits or the provision of services under a group contract.

Sec. 5. Copayment shall mean an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

Sec. 6. Deductible shall mean the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs associated with treatment.

Sec. 7. Director shall mean the Director of Insurance.

Sec. 8. Enrollee shall mean an individual who is covered by a health maintenance organization and shall include both subscribers and dependents of subscribers.

Sec. 9. Evidence of coverage shall mean a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder.

Sec. 10. Extension of benefits shall mean the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.

Sec. 11. Grievance shall mean a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

Sec. 12. Group contract shall mean a contract

for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

Sec. 13. Group contract holder shall mean the person to which a group contract has been issued.

Sec. 14. Health maintenance organization shall mean any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments or deductibles.

Sec. 15. Health maintenance organization producer shall mean a person who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself or herself, or who advertises or otherwise holds himself or herself out to the public as such.

Sec. 16. Individual contract shall mean a contract for health care services issued to and covering an individual. The individual contract may include coverage for dependents of the subscriber.

Sec. 17. Insolvent or insolvency shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

Sec. 18. Net worth shall mean the excess of total admitted assets over total liabilities. Liabilities shall not include fully subordinated debt.

Sec. 19. Participating provider shall mean a provider who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

Sec. 20. Provider shall mean any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

Sec. 21. Replacement coverage shall mean the benefits provided by a succeeding carrier.

Sec. 22. Subscriber shall mean an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the individual in whose name the contract is issued.

Sec. 23. Uncovered expenditures shall mean

the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the director.

Sec. 24. Any person may apply to the director for a certificate of authority to establish and operate a health maintenance organization in compliance with the Health Maintenance Organization Act. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority under the act. Operating a health maintenance organization without a certificate of authority shall be a violation of the Uniform Unauthorized Insurers Act. A foreign corporation may qualify under the Health Maintenance Organization Act if it registers to do business in this state as a foreign corporation under the Nebraska Business Corporation Act and complies with the Health Maintenance Organization Act and other applicable state laws.

Sec. 25. Any health maintenance organization which has not received a certificate of authority to operate as a health maintenance organization under prior law as of the operative date of this section shall submit an application for a certificate of authority within ninety days of such date. Each such applicant may continue to operate until the director acts upon the application. If the application is denied, the applicant shall be treated as a health maintenance organization whose certificate of authority has been revoked.

Sec. 26. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the director, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto;

(2) A copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions and biographical information, on forms acceptable to the director, of the persons who are

to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee and the principal officers in the case of a corporation or the partners or members in the case of a partnership or association;

(4) A copy of any contract made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third-party administrators, marketing consultants, or persons listed in subdivision (3) of this section and the health maintenance organization;

(5) A copy of the form of evidence of coverage to be issued to subscribers;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent, regular, certified financial statement and an unaudited, current financial statement;

(8) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash-flow statements showing any capital expenditures, any purchase and sale of investments, and any deposits with the state, income and expense statements anticipated from the start of operations until the health maintenance organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

(9) A power of attorney duly executed by such applicant, if not domiciled in this state, appointing the director and his or her successors and duly authorized deputies as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) A statement or map reasonably describing the geographic area to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and

resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection-against-insolvency requirements in section 52 of this act;

(14) A list of the names, addresses, and license numbers, if any, of all providers with which the health maintenance organization has agreements; and

(15) Such other information as the director requires to make the determinations required in section 29 of this act.

Sec. 27. (1) The director may require a health maintenance organization, after receiving its certificate of authority, to submit the information, modifications, or amendments to the items described in section 26 of this act, for his or her approval or for information only, prior to the effectuation of the modification or amendment or may require the health maintenance organization to indicate the modifications at the time of the next succeeding site visit or examination.

(2) Any modification or amendment for which the approval of the director is required shall be deemed approved unless disapproved within thirty days, except that the director may postpone the action for such further time, not exceeding an additional thirty days, as necessary for proper consideration.

Sec. 28. (1) Upon receipt of an application for issuance of a certificate of authority, the Director of Insurance shall forthwith transmit copies of such application and accompanying documents to the Director of Health.

(2) The Director of Health shall determine whether the applicant has complied with sections 35 to 37 of this act with respect to health care services to be furnished.

(3) Within forty-five days of receipt of the application for issuance of a certificate of authority, the Director of Health shall certify to the Director of Insurance that the proposed health maintenance organization meets the requirements of such sections or notify the Director of Insurance that the health maintenance organization does not meet such requirements

and specify in what respects it is deficient.

Sec. 29. The Director of Insurance shall, within forty-five days of receipt of certification or notice of deficiencies pursuant to section 28 of this act, issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and being satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) Any deficiencies identified by the Director of Health have been corrected and the Director of Health has certified to the Director of Insurance that the health maintenance organization's proposed plan of operation meets the requirements of sections 35 to 37 of this act;

(3) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles; and

(4) The health maintenance organization is in compliance with sections 47 to 57 of this act.

A certificate of authority shall be denied only after the Director of Insurance complies with the requirements of section 62 of this act.

Sec. 30. A certificate of authority issued pursuant to sections 28 and 29 of this act shall expire on April 30 in each year and shall be renewed annually if the health maintenance organization has continued to comply with the laws of this state and the rules and regulations.

Sec. 31. The powers of a health maintenance organization shall include, but not be limited to, the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, and ancillary equipment and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the health maintenance organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts, including provider and subscriber contracts, between affiliates or between the health maintenance organization and its parent;

(3) Furnishing of basic health care services

through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization;

(4) Contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(5) Contracting with an insurance company licensed in this state for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) Offering of other health care services in addition to basic health care services. Nonbasic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual; and

(7) The joint marketing of products with an insurance company licensed in this state as long as the company that is offering each product is clearly identified.

Sec. 32. A health maintenance organization shall file notice, with adequate supporting information, with the director prior to the exercise of any power granted in subdivision (1), (2), or (4) of section 31 of this act which may affect the financial soundness of the health maintenance organization. The director shall disapprove such exercise of power only if it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the director does not disapprove the exercise of the power within thirty days of the filing, it shall be deemed approved. The director may exempt activities having a de minimis effect from the filing requirement.

Sec. 33. Notwithstanding any differences provided by law between a health maintenance organization and an insurer as described in section 44-103, a health maintenance organization shall be deemed to assume, underwrite, and spread risk and otherwise transact the business of insurance.

Sec. 34. Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization shall be responsible for such funds in a fiduciary relationship to the health maintenance organization. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such individuals in an amount not less than two

hundred fifty thousand dollars for each health maintenance organization. The requirements of this section may be met for each of two or more health maintenance organizations owned by a common parent if the parent maintains the bond or insurance on behalf of the health maintenance organizations and any other carrier or carriers owned by the parent in an aggregate amount of not less than the lesser of (1) two hundred fifty thousand dollars times the number of such health maintenance organizations and such other carrier or carriers or (2) five million dollars.

Sec. 35. Each health maintenance organization shall establish procedures to assure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

Sec. 36. Each health maintenance organization shall have an ongoing, internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services across all institutional and noninstitutional settings. The quality assurance program shall include, but not be limited to, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan which describes the following:

(a) The health maintenance organization's scope and purpose in quality assurance;

(b) The organizational structure responsible for quality assurance activities;

(c) Contractual arrangements, when appropriate, for delegation of quality assurance activities;

(d) Confidentiality policies and procedures;

(e) A system of ongoing evaluation activities;

(f) A system of focused evaluation activities;

(g) A system for credentialing providers and performing peer review activities; and

(h) Duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) A written statement describing the system of ongoing quality assurance activities, including, but

not limited to, the following:

(a) Problem assessment, identification, selection, and study;

(b) Corrective action, monitoring, evaluation, and reassessment; and

(c) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation, and report format; and

(5) A written plan for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

Each health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the Director of Health. Each health maintenance organization shall also establish a mechanism for periodic reporting of quality assurance program activities to the governing body of the health maintenance organization, the providers, and appropriate staff.

Sec. 37. Each health maintenance organization shall ensure the use and maintenance of an adequate patient record system which facilitates documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees. Enrollee clinical records shall be available to the Director of Health or an authorized designee for examination and review to ascertain compliance with section 36 of this act or as deemed necessary by the Director of Health.

Sec. 38. Every group and individual contract holder shall be entitled to a group or individual contract. The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive or which encourage misrepresentation as described by section 44-1525. The contract shall contain a clear statement of the following:

(1) Name and address of the health maintenance organization;

(2) Eligibility requirements;

(3) Benefits and services within the service area;

(4) Emergency care benefits and services;

(5) Out-of-area benefits and services, if any;

(6) Copayments, deductibles, or other out-of-pocket expenses;

(7) Limitations and exclusions;

(8) Enrollee termination;

(9) Enrollee reinstatement, if any;

(10) Claims procedures;

(11) Enrollee grievance procedures;

(12) Continuation of coverage;

(13) Conversion;

(14) Extension of benefits, if any;

(15) Coordination of benefits, if applicable;

(16) Subrogation, if any;

(17) Description of the service area;

(18) Entire contract provision;

(19) Term of coverage;

(20) Cancellation of group or individual contract holder;

(21) Renewal;

(22) Reinstatement of group or individual contract holder, if any;

(23) Grace period; and

(24) Conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in subdivisions (1) through (17) of this section.

Sec. 39. (1) An individual contract shall provide a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period and the person returns the contract to receive a refund of the premium paid, he or she shall pay for such services.

(2) A group or individual contract shall permit enrollees to voluntarily terminate enrollment for any reason at any time.

(3) A group contract shall permit enrollees to convert to individual enrollment upon termination of enrollment in the group.

Sec. 40. Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization. The evidence of coverage shall not contain provisions or statements

which are unfair, unjust, inequitable, misleading, or deceptive or which encourage misrepresentation as described by section 44-1525. The evidence of coverage shall contain a clear statement of the provisions required in subdivisions (1) through (17) of section 38 of this act.

Sec. 41. The director may establish readability standards for individual contract, group contract, and evidence of coverage forms. No group or individual contract, evidence of coverage, or amendment thereto shall be delivered or issued for delivery in this state unless its form has been filed with and approved by the director. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage shall not need to be submitted to the director for approval. The director may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing.

Sec. 42. (1) Every form required to be filed with the director shall be filed not less than thirty days prior to delivery or issuance for delivery in this state. At any time during the thirty-day period, the director may extend the period for review for an additional thirty days. Notice of an extension shall be in writing. At the end of the review period, the form shall be deemed approved if the director has taken no action. The person filing shall notify the director in writing prior to using a form that is deemed approved. At any time, after thirty days' notice and for cause shown, the director may withdraw approval of any form. The withdrawal shall be effective at the end of the thirty days.

(2) When a filing is disapproved or approval of a form is withdrawn, the director shall give the health maintenance organization written notice of the reasons for disapproval or withdrawal and in the notice shall inform the health maintenance organization that within thirty days of receipt of the notice the health maintenance organization may request a hearing. A hearing shall be conducted within thirty days after the director has received the request for hearing.

Sec. 43. (1) Every health maintenance organization shall file annually, on or before March 1, a report with the Director of Insurance, with a copy to the Director of Health, covering the preceding calendar

year. The report shall be on forms prescribed by the Director of Insurance.

The goodwill, prepaid expenses, leasehold improvements, and furniture and equipment of a health maintenance organization may be shown on the report as admitted assets to an extent not exceeding eighty percent for calendar year 1991, sixty percent for calendar year 1992, forty percent for calendar year 1993, and twenty percent for calendar year 1994. For calendar years commencing with 1995, the goodwill, prepaid expenses, leasehold improvements, and furniture and equipment of a health maintenance organization shall not be shown on the report as admitted assets. For calendar years commencing with 1995, admitted assets shall be shown on the report in accordance with what are known as statutory accounting principles.

(2) Every health maintenance organization shall file annually, on or before March 1, with the Director of Insurance, with a copy to the Director of Health:

(a) A list of the providers who have executed a contract that complies with section 50 of this act; and

(b) A description of the grievance procedures, the total number of grievances handled through such procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

(3) Every health maintenance organization shall file annually, on or before June 1, audited financial statements with the Director of Insurance, with a copy to the Director of Health.

(4) The Director of Insurance may require such additional reports as are deemed necessary and appropriate to carry out his or her duties under the Health Maintenance Organization Act.

Sec. 44. Each health maintenance organization shall provide a list of providers to its subscribers upon enrollment and reenrollment. Each health maintenance organization shall provide notice within thirty days of any material change in the operation of the health maintenance organization to its subscribers if the change affects the subscribers directly. An enrollee shall be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating provider. Each health

maintenance organization shall provide to subscribers information on how services may be obtained and where additional information on access to services can be obtained and a toll-free telephone number for calls within the service area.

Sec. 45. Each health maintenance organization shall establish and maintain a grievance procedure to provide for the resolution of grievances initiated by enrollees. The procedure shall be approved by the Director of Insurance after consultation with the Director of Health. The Director of Insurance or the Director of Health may examine the grievance procedure. The health maintenance organization shall maintain records regarding grievances received since the date of the last examination.

Sec. 46. With the exception of investments made in accordance with subdivision (1) of section 31 of this act, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the insurance laws of this state for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the director permits.

Sec. 47. (1) Before issuing a certificate of authority, the director shall require that the health maintenance organization have an initial net worth of one million five hundred thousand dollars and maintain the minimum net worth required under this section.

(2) Except as provided in subsection (3) of this section, a health maintenance organization shall maintain a minimum net worth equal to the greater of:

(a) One million dollars; or

(b) Two percent of annual premium revenue as reported on the most recent annual financial statement filed with the director on the first one hundred fifty million dollars of premium revenue and one percent of annual premium revenue on the premium revenue in excess of one hundred fifty million dollars.

(3) A health maintenance organization licensed under prior law before the operative date of this section shall maintain a minimum net worth of:

(a) Twenty-five percent of the amount required by subsection (2) of this section by December 31, 1990;

(b) Fifty percent of the amount required by subsection (2) of this section by December 31, 1991;

(c) Seventy-five percent of the amount required by subsection (2) of this section by December 31, 1992; and

(d) One hundred percent of the amount required

by subsection (2) of this section by December 31, 1993.

(4) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the director. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated. The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses. Any debt incurred by a note meeting the requirements of this subsection and otherwise acceptable to the director shall not be considered a liability and shall be recorded as equity.

Sec. 48. (1) Except as provided in subsection (2) of this section, each health maintenance organization shall deposit with the director, or at the discretion of the director with any organization or trustee acceptable to him or her through which a custodial or controlled account is utilized, cash, securities, or any combination of cash or securities or other measures that are acceptable to the director which at all times have a value of not less than three hundred thousand dollars.

(2) A health maintenance organization that is in operation under prior law on the operative date of this section shall make a deposit equal to one hundred fifty thousand dollars for the first year and three hundred thousand dollars for the second year.

(3) The deposit made pursuant to this section shall be an admitted asset of the health maintenance organization in the determination of net worth. All income from a deposit shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of cash or securities or other measures of equal amount and value. Any securities or other measures shall be approved by the director before being deposited or substituted.

(4) The deposit made pursuant to this section shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The director may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an

asset subject to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

(5) The director may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance commissioner, insurance director, insurance superintendent, or equivalent official of the state or jurisdiction of domicile for the protection of all subscribers and enrollees of such health maintenance organization, wherever located, cash, acceptable securities, or surety and delivers to the director a certificate to such effect duly authenticated by the appropriate official holding the deposit.

Sec. 49. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide (1) for any unearned premium, (2) for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid, and for which such organization is or may be liable, and (3) for the expense of adjustment or settlement of such claims. Such liabilities shall be computed in accordance with rules and regulations adopted and promulgated by the director upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

Sec. 50. Every contract between a health maintenance organization and a participating provider shall be in writing and shall provide that, if the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee will not be liable to the provider for any sum owed by the health maintenance organization. If the contract has not been reduced to writing or fails to contain the provision required by this section, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee of a participating provider, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

Sec. 51. An agreement to provide health care services between a provider and a health maintenance organization shall require that, if the provider terminates the agreement, the provider will give the health maintenance organization at least sixty days' notice of termination.

Sec. 52. The director shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. The director may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) Insolvency reserves;

(4) Acceptable letters of credit; and

(5) Any other arrangements to assure that benefits are continued as specified in this section.

Sec. 53. (1) If uncovered expenditures exceed ten percent of the total health care expenditures of a health maintenance organization for the previous calendar quarter, the health maintenance organization shall place an uncovered expenditures insolvency deposit of cash or securities that are acceptable to the director with the director or with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained. Such deposit shall at all times have a fair market value in an amount of one hundred twenty percent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims. The fair market value of the deposit shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(2) The deposit required under this section shall be in addition to the deposit required under section 48 of this act and shall be an admitted asset of the health maintenance organization in the determination of net worth. All income from such deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn quarterly with the

approval of the director.

(3) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if (a) a substitute deposit of cash or securities of equal amount and value is made, (b) the fair market value of the deposit exceeds the amount of the required deposit, or (c) the required deposit is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the director.

Sec. 54. The deposit required under section 53 of this act shall be in trust and may be used only by the director for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred uncovered expenses. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization. The director may prescribe the time, manner, and form for filing claims under this section.

Sec. 55. The director may require a health maintenance organization to file annual or quarterly, or more frequent, reports of uncovered expenditures and liability for uncovered expenditures. The director may require that the reports include an audit opinion.

Sec. 56. (1) If a health maintenance organization is determined to be insolvent and ordered liquidated by a court of competent jurisdiction, upon such order, all other carriers which participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period and which are providing coverage for enrollees on the date of the court order shall offer such group's subscribers of the insolvent health maintenance organization a thirty-day enrollment period commencing on the date of the court order. The subscribers transferring from the insolvent health maintenance organization shall be entitled to coverage on the same terms and at the same rates as they would have obtained had they elected the other carrier at the last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization or if the director determines that the other health benefit plans lack sufficient health care

delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, the director shall allocate equitably the insolvent health maintenance organization's group contracts for such groups among all health maintenance organizations which operate within any portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group is allocated shall offer such group the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The director shall also allocate equitably the insolvent health maintenance organization's individual enrollees who are unable to obtain other coverage among all health maintenance organizations which operate within any portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which individual enrollees are allocated shall offer such individual enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by his or her type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct individual enrollment may aggregate all of the allocated individual enrollees into one group for rating and coverage purposes.

Sec. 57. (1) Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract

relating to active employment, hospital confinement, or pregnancy. Discontinuance shall mean the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization and shall not mean the termination of any agreement between any individual enrollee and the health maintenance organization.

(2) Except to the extent benefits for a condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

Sec. 58. (1) No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the director. A specific schedule of premium rates or a methodology for determining premium rates shall be established in accordance with actuarial principles for various categories of enrollees. The premium applicable to an enrollee shall not be individually determined based on the status of his or her health. The premium rates shall not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the director as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(2) The director shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of this section are met. If the director disapproves such filing, he or she shall notify the health maintenance organization. In the notice, the director shall specify the reasons for his or her disapproval. A hearing shall be conducted within thirty days after a request in writing by the person filing. If the director does not take action on such schedule or methodology within thirty days of the filing of such schedule or methodology, it shall be deemed approved.

Sec. 59. The Insurance Producers Licensing Act shall apply to health maintenance organization producers except to the extent that the director

determines that the nature of health maintenance organizations renders application of the act clearly inappropriate.

Sec. 60. (1) An insurer licensed in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the Health Maintenance Organization Act. Any two or more such insurers or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance shall include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) An insurer may contract with a health maintenance organization to provide insurance or similar protection against the cost of health care services provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization shall constitute a permissible group under the insurance laws of this state. An insurer may make benefit payments to health maintenance organizations for health care services rendered by providers under such contracts.

Sec. 61. (1) The Director of Insurance may make an examination of the affairs of any health maintenance organization and any provider with whom such health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every four years. The Director of Health may make an examination concerning the quality assurance program of any health maintenance organization and any provider with whom such health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

(2) Every health maintenance organization and provider shall submit its books and records for an examination and in every way facilitate the completion of the examination. For the purpose of an examination, the Director of Insurance and Director of Health may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of a provider concerning the business. An examination shall not involve the confidential communications between physicians and patients.

(3) The expenses of an examination shall be assessed against the health maintenance organization being examined and remitted to the Director of Insurance or Director of Health for whom the examination is being conducted in the manner provided in sections 44-107 and 44-107.03 for domestic insurance companies.

(4) In lieu of an examination, the Director of Insurance or Director of Health may accept the report of an examination made by the insurance commissioner, insurance director, insurance superintendent, or equivalent official or director of health or equivalent official of another state.

Sec. 62. If the Director of Insurance finds that any of the conditions listed in this section exist, any certificate of authority issued under the Health Maintenance Organization Act may be suspended or revoked or any application for a certificate of authority may be denied:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section 26 of this act unless amendments to such submissions have been filed with and approved by the director;

(2) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services which does not comply with the requirements of sections 38 to 42 and 58 of this act;

(3) The health maintenance organization does not provide or arrange for basic health care services;

(4) The Director of Health certifies to the Director of Insurance that:

(a) The health maintenance organization does not meet the requirements of subsection (2) of section 28 of this act; or

(b) The health maintenance organization is unable to fulfill its obligations to furnish health care services;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) The health maintenance organization has failed to correct, within the time prescribed by section 63 of this act, any deficiency occurring due to such health maintenance organization's prescribed minimum net worth being impaired;

(7) The health maintenance organization has

failed to implement grievance procedures in a reasonable manner to resolve valid complaints;

(8) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) The health maintenance organization has otherwise failed substantially to comply with the act.

Sec. 63. (1) Whenever the director finds that the net worth maintained by any health maintenance organization is less than the minimum net worth required to be maintained by section 47 of this act, he or she shall give written notice to the health maintenance organization of the amount of the deficiency and require (a) filing of a plan for correction of the deficiency acceptable to the director and (b) correction of the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the director. Such a deficiency shall be an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in supervision, rehabilitation, liquidation, or conservation.

(2) Unless allowed by the director, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue, or deliver any certificate, agreement, or contract of coverage in this state for which a premium is charged or collected when the health maintenance organization writing such coverage is impaired and the impairment is known to the health maintenance organization or such person. The existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

Sec. 64. A certificate of authority shall be suspended or revoked, an application for a certificate of authority denied, or an administrative penalty imposed pursuant to section 73 of this act only after compliance with the requirements of sections 65 to 67 of this act.

Sec. 65. Suspension or revocation of a certificate of authority, the denial of an application

for a certificate, or the imposition of an administrative penalty shall be by written order and shall be sent by the Director of Insurance to the health maintenance organization or applicant by certified or registered mail and to the Director of Health. The written order shall state the grounds, charges, or conduct on which the suspension, revocation, denial, or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty days from the date of mailing of the order. If no written request is made, such order shall be final upon the expiration of thirty days.

Sec. 66. (1) If the health maintenance organization or applicant requests a hearing pursuant to section 65 of this act, the Director of Insurance shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the Director of Health stating:

(a) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(b) A specific place for the hearing, which may be either in Lancaster County or in the county where the health maintenance organization's or applicant's principal place of business is located.

(2) If a hearing is requested, the Director of Health or his or her designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the Director of Health with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority shall be conclusive and binding upon the Director of Insurance.

(3) After the hearing or upon failure of the health maintenance organization to appear at such hearing, the Director of Insurance shall take whatever action he or she deems necessary based on written findings and shall mail his or her decision to the health maintenance organization or applicant with a copy to the Director of Health. The action of the Director of Insurance and the recommendation and findings of the Director of Health may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act. The act shall apply to proceedings under this section to the extent it is not in conflict with this section.

Sec. 67. (1) When the certificate of authority of a health maintenance organization is

suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees other than newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

(2) When the certificate of authority of a health maintenance organization is revoked, such health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such health maintenance organization. It shall engage in no further advertising or solicitation whatsoever. The director may, by written order, permit such further operation of the health maintenance organization as he or she finds to be in the best interest of enrollees to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Sec. 68. Whenever the director determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees or creditors or the general public or that it has violated the Health Maintenance Organization Act, he or she may, after notice and hearing, order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including, but not limited to, the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or another method acceptable to the director;

(2) Reduce the volume of new business being accepted;

(3) Reduce expenses by specified methods;

(4) Suspend or limit the writing of new business for a period of time;

(5) Increase the health maintenance organization's capital and surplus by contribution; or

(6) Take such other steps as the director deems appropriate under the circumstances.

The violation by a health maintenance organization of any law of this state to which such health maintenance organization is subject shall be deemed a violation of the act.

Sec. 69. The director may set uniform standards and criteria for early warning that the continued operation of any health maintenance

organization might be hazardous to its enrollees or creditors or the general public and standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in section 68 of this act. The remedies and measures available to the director under such section shall be in addition to, and not in lieu of, the remedies and measures available to the director under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Sec. 70. (1) Any supervision, rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the supervision, rehabilitation, liquidation, or conservation of an insurance company and shall be conducted pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. The director may apply for an order directing him or her to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in sections 44-4812 and 44-4817 or when in his or her opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by subdivision (3) of section 44-4842 for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have the same priority of distribution of the general assets as established by subdivision (4) of section 44-4842.

Sec. 71. The director shall adopt and promulgate rules and regulations to carry out the Health Maintenance Organization Act.

Sec. 72. Every health maintenance organization subject to the Health Maintenance Organization Act shall pay to the director the following fees:

(1) For filing an application for a

certificate of authority or amendment thereto, three hundred dollars;

(2) For filing an amendment to the organizational documents that requires approval, twenty dollars;

(3) For filing each annual report, two hundred dollars; and

(4) For renewing a certificate of authority, one hundred dollars.

Fees charged under this section shall be distributed one-half to the Director of Insurance and one-half to the Department of Health. All fees or other assessments transmitted to the Department of Health pursuant to the act shall be remitted to the state treasury for credit to the Department of Health-Health Care Facility Fund, which fund is hereby created and from which shall be appropriated such amounts as are available therefrom and considered incident to the administration of the act. Any money in the fund available for investment shall be invested by the state investment officer pursuant to sections 72-1237 to 72-1276.

Sec. 73. The director may, in lieu of suspension or revocation of a certificate of authority, levy an administrative penalty in an amount not less than five hundred dollars nor more than ten thousand dollars if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The director may augment a penalty by an amount equal to the sum that he or she calculates to be the damages suffered by enrollees or other members of the public.

Sec. 74. If the Director of Insurance or the Director of Health has for any reason cause to believe that any violation of the Health Maintenance Organization Act has occurred or is threatened, the Director of Insurance or Director of Health may give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation. Proceedings under this section shall not be

governed by any formal procedural requirements and may be conducted in such manner as the Director of Insurance or Director of Health deems appropriate under the circumstances. Unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section are satisfied.

Sec. 75. The director may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any action or practice in violation of the Health Maintenance Organization Act. Within ten days after service of the cease and desist order, the respondent may request a hearing on the question of whether actions or practices in violation of the act have occurred. Such hearings shall be conducted as provided by the Administrative Procedure Act. The respondent may appeal the decision of the director, and the appeal shall be in accordance with the Administrative Procedure Act. If the director elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order, the director may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lancaster County.

Sec. 76. If a health maintenance organization fails to comply with the net worth requirement of section 47 of this act, the director may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

Sec. 77. Except as otherwise provided in Chapter 44 or the Health Maintenance Organization Act, the insurance laws shall not be applicable to any health maintenance organization granted a certificate of authority under the act. This section shall not apply to an insurer licensed and regulated pursuant to the insurance laws except with respect to its activities authorized and regulated pursuant to the act.

Sec. 78. Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Sec. 79. Any health maintenance organization authorized under the Health Maintenance Organization Act shall not be deemed to be practicing medicine and shall be exempt from sections 71-1,102 to 71-1,107.14 relating to the practice of medicine.

Sec. 80. All applications, filings, and reports required under the Health Maintenance Organization Act shall be treated as public documents except those which are trade secrets or privileged or confidential quality assurance, commercial, or financial information other than any annual financial statement that may be required under section 43 of this act.

Sec. 81. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except (1) to the extent that it may be necessary to carry out the purposes of the Health Maintenance Organization Act, (2) upon the express consent of the enrollee or applicant, (3) pursuant to statute or court order for the production of evidence or the discovery thereof, or (4) in the event of a claim or litigation between such person and the health maintenance organization in which such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Sec. 82. A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee or who furnishes any records, information, or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the health maintenance organization which established such committee or the officers, directors, employees, or agents of such health maintenance organization be liable for the activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

Sec. 83. (1) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal from the committee's findings or recommendations. No member of a health care review committee, no officer, director, or other member of a health maintenance organization or its staff engaged in assisting such committee, and no person

assisting or furnishing information to such committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

(2) Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subsection (1) of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as the original information and records in the possession and control of a health care review committee.

Sec. 84. To fulfill its quality assurance obligations, a health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any enrollee.

Sec. 85. The Director of Health, in carrying out his or her obligations under the Health Maintenance Organization Act, may contract with qualified persons to make recommendations concerning the determinations required to be made by him or her. Such recommendations may be accepted in full or in part by the Director of Health.

Sec. 86. No person may (1) make a tender for or a request or invitation for tenders of, (2) enter into an agreement to exchange securities for, or (3) acquire in the open market or otherwise any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization unless, at the time any offer, request, or invitation is made or any agreement is entered into or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the director and has sent to the health maintenance organization information required by section 44-2105 and the offer, request, invitation, agreement, or acquisition has been approved by the director. Approval by the director shall be governed by sections 44-2101 to 44-2119.

Sec. 87. A health maintenance organization may, but shall not be required to, adopt coordination-of-benefits provisions to avoid

overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans. If a health maintenance organization adopts coordination-of-benefits provisions, the provisions shall be consistent with the coordination-of-benefits provisions that are in general use in the state for coordinating coverage between two or more group health insurance or health care plans. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are received from nonparticipating providers, provided outside their service areas, or not covered under the terms of their group contracts or evidence of coverage.

Sec. 88. Sections 44-1522 to 44-1535 shall apply to health maintenance organizations except to the extent that the director determines the nature of health maintenance organizations renders application of such sections clearly inappropriate.

Sec. 89. Any health maintenance organization subject to the Health Maintenance Organization Act shall also be subject to (1) the premium taxation provisions of Chapter 77, article 9, to the extent that the direct writing premiums are not otherwise subject to taxation under such article and (2) the retaliatory taxation provisions of section 44-150.

Sec. 90. That section 44-3,132, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

44-3,132. For purposes of this section and section 44-3,133, unless the context otherwise requires:

(1) Fraudulent insurance act shall mean an act committed by any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer any written statement as part or in support of an application for the issuance of or the rating of an insurance policy for commercial insurance or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he or she knows to contain materially false information concerning any fact material thereto or to conceal, for the purpose of misleading, information concerning any fact material thereto; and

(2) Insurer shall mean any insurance company, health maintenance organization, as defined in section 44-3208, adjuster, agent, or broker.

Sec. 91. For purposes of Chapter 44, insurance shall not include a service contract. For purposes of this section, service contract shall mean (1) a motor vehicle service contract as defined in section 93 of this act or (2) a contract or agreement, whether designated as a service contract, maintenance agreement, warranty, extended warranty, or similar term, whereby a person undertakes to furnish, arrange for, or, in limited circumstances, reimburse for service, repair, or replacement of any or all of the components, parts, or systems of any covered residential dwelling or consumer product when such service, repair, or replacement is necessitated by wear and tear, by inherent defect, or by the failure of an inspection to detect the likelihood of failure.

Sec. 92. Sections 92 to 98 of this act shall be known and may be cited as the Motor Vehicle Service Contract Reimbursement Insurance Act.

Sec. 93. For purposes of the Motor Vehicle Service Contract Reimbursement Insurance Act:

(1) Director shall mean the Director of Insurance;

(2) Mechanical breakdown insurance shall mean a policy, contract, or agreement that undertakes to perform or provide repair or replacement service, or indemnification for such service, for the operational or structural failure of a motor vehicle due to defect in materials or workmanship or normal wear and tear and that is issued by an insurance company authorized to do business in this state;

(3) Motor vehicle shall mean any motor vehicle as defined in section 60-301;

(4) Motor vehicle service contract shall mean a contract or agreement given for consideration over and above the lease or purchase price of a motor vehicle that undertakes to perform or provide repair or replacement service, or indemnification for such service, for the operational or structural failure of a motor vehicle due to defect in materials or workmanship or normal wear and tear but shall not include mechanical breakdown insurance;

(5) Motor vehicle service contract provider shall mean a person who issues, makes, provides, sells, or offers to sell a motor vehicle service contract, except that motor vehicle service contract provider shall not include an insurer as defined in section 44-103;

(6) Motor vehicle service contract reimbursement insurance policy shall mean a policy of

insurance providing coverage for all obligations and liabilities incurred by a motor vehicle service contract provider under the terms of motor vehicle service contracts issued by the provider; and

(7) Service contract holder shall mean a person who purchases a motor vehicle service contract.

Sec. 94. No motor vehicle service contract shall be issued, sold, or offered for sale in this state unless:

(1) The motor vehicle service contract provider is insured under a motor vehicle service contract reimbursement insurance policy issued by an insurer authorized to do business in this state;

(2) True and correct copies of the motor vehicle service contract and the motor vehicle service contract reimbursement insurance policy have been filed with the director;

(3) The contract conspicuously states that the obligations of the motor vehicle service contract provider to the service contract holder are covered under the motor vehicle service contract reimbursement insurance policy; and

(4) The contract conspicuously states the name and address of the issuer of the motor vehicle service contract reimbursement insurance policy.

Sec. 95. No motor vehicle service contract reimbursement insurance policy shall be issued, sold, or offered for sale in this state unless the policy conspicuously states that the issuer of the policy will pay on behalf of the motor vehicle service contract provider all sums which the provider is legally obligated to pay in the performance of its contractual obligations under the motor vehicle service contracts issued or sold by the provider.

Sec. 96. The director may issue an order and notice of hearing instructing a motor vehicle service contract provider to cease and desist from selling or offering for sale motor vehicle service contracts if the director determines that the provider has failed to comply with the Motor Vehicle Service Contract Reimbursement Insurance Act. Upon the failure of a motor vehicle service contract provider to obey a cease and desist order issued by the director, the director may give notice in writing of the failure to the Attorney General who may commence an action against the provider to enjoin the provider from selling or offering for sale motor vehicle service contracts until the provider complies with the act. The district court may issue the injunction.

Sec. 97. The director may adopt and promulgate rules and regulations to carry out the Motor Vehicle Service Contract Reimbursement Insurance Act and to establish minimum standards for disclosure of the coverage limitations and exclusions of motor vehicle service contracts.

Sec. 98. The Motor Vehicle Service Contract Reimbursement Insurance Act shall not apply to motor vehicle service contracts (1)(a) issued by a motor vehicle manufacturer or importer for the motor vehicles manufactured or imported by that manufacturer or importer and (b) sold by a franchised motor vehicle dealer licensed pursuant to Chapter 60, article 14, or (2) issued and sold directly by a motor vehicle manufacturer or importer licensed pursuant to Chapter 60, article 14, for the motor vehicles manufactured or imported by that manufacturer or importer.

Sec. 99. That section 44-2402, Revised Statutes Supplement, 1989, be amended to read as follows:

44-2402. The Nebraska Property and Liability Insurance Guaranty Association Act shall apply to all kinds of direct insurance except ocean marine, motor vehicle service contract reimbursement, and those lines of insurance specified in subdivisions (1) through (4), (13) through (17), (19), and (20) of section 44-201.

Sec. 100. That section 44-4103, Revised Statutes Supplement, 1989, be amended to read as follows:

44-4103. Insurer shall mean any insurance company as defined by in section 44-103, fraternal benefit society as described in section 44-1072, prepaid dental service plan as defined in section 44-3802, or health maintenance organization as defined by in section 44-3208, 14 of this act authorized to transact health insurance business in the State of Nebraska.

Sec. 101. Any data or information pertaining to the diagnosis, treatment, or health of any insured or applicant obtained from such person or from any provider by any preferred provider organization shall be held in confidence and shall not be disclosed to any person except (1) upon the express consent of the insured or applicant, (2) pursuant to statute or court order for the production of evidence or the discovery thereof, or (3) in the event of a claim or litigation between such person and the preferred provider organization in which such data or information is pertinent. A preferred provider organization shall be entitled to claim any statutory privileges against such disclosure which the

provider who furnished such information to the preferred provider organization is entitled to claim.

Sec. 102. A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee or who furnishes any records, information, or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the preferred provider organization which established the committee or the officers, directors, employees, or agents of the preferred provider organization be liable for the activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

Sec. 103. (1) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal from the committee's findings or recommendations. No member of a health care review committee, no officer, director, or other member of a preferred provider organization or its staff engaged in assisting such committee, and no person assisting or furnishing information to such committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

(2) Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subsection (1) of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as the original information and records in the possession and control of a health care review committee.

Sec. 104. That section 44-4210, Revised Statutes Supplement, 1989, be amended to read as follows:

44-4210. Insurer shall mean any insurance company as defined by in section 44-103 or health maintenance organization as defined by in section 44-3208 14 of this act authorized to transact health insurance business in the State of Nebraska.

Sec. 105. That section 44-4220, Revised Statutes Supplement, 1989, be amended to read as

follows:

44-4220. The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the business of health insurance and, in addition thereto, the power to carry out the provisions and purposes of the Comprehensive Health Insurance Pool Act, including the specific authority to:

(1)(a) Enter into contracts as are necessary or proper, including the authority, with the approval of the director, to enter into contracts with similar pools from other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions; and

(b) Enter into contracts, with the approval of the director, with any physician, hospital, or other person licensed or otherwise authorized in this state to furnish health care services ~~for arranging a health care plan as defined in section 44-3206 or~~ for participating in an insurance arrangement as defined in section 44-4104;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(3) Take such legal action as necessary to avoid the improper issuance of coverage provided by or through the pool;

(4) Establish appropriate rates and rate schedules, expense allowances, agents' solicitation and referral fees, claim reserves and formulas, and any other actuarial functions appropriate to the operation of the pool;

(5) Assess members of the pool at the end of each calendar year and make advance interim assessments as may be reasonable and necessary to provide for losses resulting from claims incurred under the act and for administrative, organizational, and interim operating expenses to assure the financial stability of the pool. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year. Assessments shall be due and payable within thirty days of receipt of the assessment notice;

(6) Issue policies of insurance in accordance with the requirements of the plan of operation and the act and, with the approval of the director, refuse to renew all policy forms for a class of contract and offer a conversion privilege to any person insured by the

pool;

(7) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(8) Borrow money to effectuate the purposes of the act. Any notes or other evidence of indebtedness of the pool not in default shall be legal investment for insurers and may be carried as admitted assets; and

(9) Enter into reinsurance agreements and establish rules, conditions, and procedures for reinsuring risks under the act.

Sec. 106. That section 44-4222, Revised Statutes Supplement, 1989, be amended to read as follows:

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 or medical assistance established pursuant to sections 68-1018 to 68-1025 or is a resident or inmate of a correctional facility;

(b) 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;

(c) The pool has paid out five hundred thousand dollars in claims for the person; or

(d) 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. 107. That section 44-4227, Revised Statutes Supplement, 1989, be amended to read as follows:

44-4227. Premium rates charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Rates shall directly relate to the coverage provided, risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age, sex, and area variation in claim costs in accordance with established actuarial and underwriting practices.

The pool shall determine the standard risk rate by calculating the average individual rate charged by the five insurers writing the largest amount of individual health insurance coverage in the state actuarially adjusted to be comparable with the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated risk experience and expenses for such coverage. The initial annual premium rate established for pool coverage shall not be more than one hundred thirty-five percent of rates established as applicable for individual standard risks, and subsequent annual pool rates shall not be less than one hundred twenty-five percent of the applicable standard risk rate. Commencing with calendar year 1990, the board shall not adjust or increase pool rates more than one time during any calendar year. In no event shall pool rates exceed one hundred ~~sixty-five~~ fifty-five percent of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the director for approval. The director shall hold a public hearing pursuant to the Administrative Procedure Act prior to approving an adjustment to or increase in pool rates.

Sec. 108. That section 44-4228, Revised Statutes Supplement, 1989, be amended to read as follows:

44-4228. Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition (1) 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 (2) for which medical advice, care, or treatment was recommended or received during the six-month period immediately preceding the effective date of coverage. This section shall not apply to a person who has received medical assistance pursuant to sections 68-1018 to 68-1025 during the six-month period immediately preceding the effective date of coverage.

Sec. 109. That section 44-4230, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

44-4230. The pool shall have a cause of action against a person insured by the pool for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be

reduced or refused as a setoff against any amount recoverable under this section. The pool shall have a right of subrogation to any payments made to a person insured by the pool by another person or his or her insurer on account of an injury caused by such other person's wrongful act or negligence.

Sec. 110. That section 44-4726, Revised Statutes Supplement, 1989, be amended to read as follows:

44-4726. The same taxes provided for in ~~subsection (3) of~~ section ~~44-3279~~ 89 of this act shall be imposed upon each prepaid limited health service organization, and such organizations also shall be entitled to the same tax deductions, reductions, abatements, and credits that health maintenance organizations are entitled to receive.

Sec. 111. That section 44-4802, Revised Statutes Supplement, 1989, be amended to read as follows:

44-4802. The proceedings authorized by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act may be applied to:

(1) All insurers who are doing or have done an insurance business in this state and against whom claims arising from that business may exist now or in the future;

(2) All insurers who purport to do an insurance business in this state;

(3) All insurers who have insureds who are residents of this state;

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this state;

(5) All nonprofit service plans and all fraternal benefit societies and beneficial societies subject to Chapter 44, article 10;

(6) All title insurance companies subject to Chapter 44, article 19;

(7) All health maintenance organizations subject to the ~~Model~~ Health Maintenance Organization Act;

(8) All legal service insurance corporations subject to Chapter 44, article 33;

~~(9) All service companies subject to Chapter 44, article 35;~~

(9) ~~(10)~~ All prepaid dental service corporations subject to Chapter 44, article 38; and

(10) ~~(11)~~ All prepaid limited health service organizations subject to the Prepaid Limited Health

Service Organization Act.

Sec. 112. Sections 112 to 121 of this act shall be known and may be cited as the Managing General Agents Act.

Sec. 113. For purposes of the Managing General Agents Act:

(1) Actuary shall mean a person who is a member in good standing of the American Academy of Actuaries;

(2) Director shall mean the Director of Insurance;

(3) Insurer shall mean any person, firm, association, or corporation duly licensed in this state as an insurance company pursuant to Chapter 44;

(4) Managing general agent shall mean any person, firm, association, or corporation who manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office, and acts as an agent for such insurer, whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites in any one quarter or year an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer and who (a) adjusts or pays claims in excess of an amount determined by the director or (b) negotiates reinsurance on behalf of the insurer. Managing general agent shall not include an attorney in fact for a reciprocal or interinsurance exchange, an employee of the insurer, a United States manager of the United States branch of an alien insurer, or an underwriting manager who, pursuant to contract, manages all the insurance operations of the insurer, is under common control with the insurer, and is subject to sections 44-2101 to 44-2119 and whose compensation is not based on the volume of premiums written; and

(5) Underwrite shall mean the authority to accept or reject risk on behalf of the insurer.

Sec. 114. No person, firm, association, or corporation shall act in the capacity of a managing general agent with respect to risks located in this state for an insurer licensed in this state unless such person, firm, association, or corporation is licensed in accordance with the Insurance Producers Licensing Act. No person, firm, association, or corporation shall act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks

located outside this state unless such person, firm, association, or corporation is licensed in accordance with such act. The director may require a bond in an amount acceptable to him or her for the protection of the insurer. The director may require a managing general agent to maintain an errors and omissions policy.

Sec. 115. No person, firm, association, or corporation acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, if both parties share responsibility for a particular function, specifies the division of such responsibilities and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

(2) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis;

(3) All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a bank which is a member of the federal reserve system. The account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months' estimated claims payments and allocated loss adjustment expenses;

(4) Separate records of business written by the managing general agent will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer, and the director shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the director. Such records shall be retained as determined by the director;

(5) The contract may not be assigned in whole or in part by the managing general agent;

(6) Appropriate underwriting guidelines, including:

(a) The maximum annual premium volume;

(b) The basis of the rates to be charged;

(c) The types of risks which may be written;

(d) Maximum limits of liability;

(e) Applicable exclusions;

(f) Territorial limitations;

(g) Policy cancellation provisions; and

(h) The maximum policy period. The insurer shall have the right to cancel or nonrenew any policy of insurance subject to applicable insurance statutes and regulations;

(7) Specific provisions relating to remuneration of the managing general agent by the insurer;

(8) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(a) All claims must be reported to the insurer in a timely manner;

(b) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed an amount determined by the director or exceeds the limit set by the insurer, whichever is less;

(ii) Involves a coverage dispute;

(iii) May exceed the managing general agent's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of an amount set by the director or an amount set by the insurer, whichever is less;

(c) All claim files will be the joint property of the insurer and the managing general agent. Upon an order of liquidation of the insurer, such files shall become the sole property of the insurer or its estate, and the managing general agent shall have reasonable access to and the right to copy the files on a timely basis; and

(d) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination;

(9) If electronic claims files are in existence, the contract must address the timely transmission of the data; and

(10) If the contract provides for a sharing of interim profits by the managing general agent and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments or in any other

manner, interim profits will not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to section 117 of this act.

Sec. 116. The managing general agent shall not:

(1) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines, including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(2) Commit the insurer to participate in insurance or reinsurance syndicates;

(3) Appoint any agent or broker without assuring that the agent or broker is lawfully licensed to transact the type of insurance for which he or she is appointed;

(4) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent of the insurer's policyholder's surplus as of December 31 of the last-completed calendar year;

(5) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer;

(6) Permit subagents or subbrokers of the insurer appointed by the managing general agent to serve on the insurer's board of directors;

(7) Jointly employ an individual who is employed by the insurer; or

(8) Appoint a submanaging general agent.

Sec. 117. (1) The insurer shall have on file an independent audit or financial examination in a form acceptable to the director of each managing general agent with which it has done business.

(2) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. The

opinion shall be in addition to any other required loss reserve certification.

(3) The insurer shall periodically, at least semiannually conduct an onsite review of the underwriting and claims-processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer who is not affiliated with the managing general agent.

(5) Within thirty days of entering into or termination of a contract with a managing general agent, the insurer shall provide written notification of such appointment or termination to the director. Notices of appointment of a managing general agent shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the director may request.

(6) An insurer shall each quarter review its books and records to determine if any agent or broker has become a managing general agent. If the insurer determines that an agent or broker has become a managing general agent, the insurer shall promptly notify the agent or broker and the director of such determination and the insurer and agent or broker shall fully comply with the Managing General Agents Act within thirty days.

(7) No officer, director, employee, or controlling shareholder of the insurer's managing general agent shall be appointed to its board of directors. This subsection shall not apply to relationships governed by sections 44-2101 to 44-2119.

Sec. 118. A managing general agent may be examined by the department as if it were the insurer.

Sec. 119. If the director finds after a hearing conducted in accordance with the Administrative Procedure Act that any person has violated any provision of the Managing General Agents Act, the director may order:

(1) For each separate violation, a penalty in an amount of five thousand dollars;

(2) Revocation or suspension of the agent's or broker's license; and

(3) The managing general agent to reimburse the insurer, the rehabilitator, or the liquidator of the insurer for any losses incurred by the insurer caused by a violation of the act committed by the managing general agent.

The decision, determination, or order of the

director may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act. This section shall not affect the right of the director to impose any other penalties provided for in Chapter 44. The Managing General Agents Act shall not be construed to limit or restrict the rights of policyholders, claimants, and auditors.

Sec. 120. The director shall adopt and promulgate reasonable rules and regulations for the implementation and administration of the Managing General Agents Act.

Sec. 121. No insurer may continue to utilize the services of a managing general agent on and after January 1, 1991, unless such utilization is in compliance with the Managing General Agents Act.

Sec. 122. A medical benefit contract which provides reimbursement for prescription drugs, including contracts by health maintenance organizations and preferred provider organizations, shall not require a person to obtain prescription drugs from a mail-order pharmacy as a condition to obtaining reimbursement for such drugs. This section shall apply to contracts delivered, issued for delivery, or renewed in this state on or after the operative date of this section.

Sec. 123. That section 60-574, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

60-574. Underinsured motor vehicle shall mean a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is bodily injury liability insurance or a bond applicable at the time of the accident and the amount of the insurance or bond ~~(1)~~ is less than or ~~the limit for underinsured motorist coverage under the insured's policy or (2)~~ has been reduced by payments to persons, other than an insured, injured in the accident to less than the ~~limit for underinsured motorist coverage under the insured's policy~~ damages for bodily injury, sickness, disease, or death sustained by the insured.

Sec. 124. That section 60-578, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

60-578. ~~(1)~~ The maximum liability of the insurer under the underinsured motorist coverage shall be ~~the lesser of:~~

~~(a) The difference between the limit of underinsured motorist coverage and~~ the amount of damages for bodily injury, sickness, disease, or death sustained by the insured less the amount paid to the insured by or

for any person or organization which may be held legally liable for the bodily injury, sickness, disease, or death, but in ; or

(b) The amount of damages sustained but not recovered.

(2) In no event shall the maximum liability of the insurer under such coverage be more than the limits of the underinsured motorist coverage provided.

Sec. 125. That section 68-1030, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

68-1030. Under the authority provided in section 68-1021, the Director of Social Services may enter into contracts on a bid or negotiated basis with vendors to provide goods and services on behalf of recipients of medical assistance as set forth in section 68-1019. Such contracts may provide for the method of payment, including, but not limited to, a negotiated reimbursement rate, fee-for-service, capitation, retainer, prepaid, or other basis. Such contracts may also be entered into with health maintenance organizations. established under section 44-3270.

Sec. 126. That section 71-2069, Revised Statutes Supplement, 1989, be amended to read as follows:

71-2069. Insurer shall mean any insurance company as defined by in section 44-103, fraternal benefit society as described in section 44-1072, or health maintenance organization as defined by in section 44-3208, 14 of this act authorized to transact health insurance business in the State of Nebraska.

Sec. 127. The Revisor of Statutes shall assign sections 101 to 103 of this act within sections 44-4101 to 44-4113, and any reference to such sections shall be construed to include sections 101 to 103 of this act.

Sec. 128. Sections 92 to 98 and 112 to 121 of this act shall become operative on January 1, 1991. Sections 123, 124, and 129 of this act shall become operative on July 1, 1991. The other sections of this act shall become operative on their effective date.

Sec. 129. That original sections 60-574 and 60-578, Reissue Revised Statutes of Nebraska, 1943, are repealed.

Sec. 130. That original sections 44-3,132, 44-4230, and 68-1030, Reissue Revised Statutes of Nebraska, 1943, and sections 44-2402, 44-4103, 44-4210, 44-4220, 44-4222, 44-4227, 44-4228, 44-4726, 44-4802, and 71-2069, Revised Statutes Supplement, 1989, and also

sections 44-3201 to 44-3210, 44-3213 to 44-3230, 44-3232, 44-3234, 44-3235, 44-3237, 44-3238, 44-3240 to 44-3243, 44-3245, 44-3246, 44-3248 to 44-3254, 44-3258 to 44-3262, 44-3264 to 44-3269, 44-3271 to 44-3275, 44-3278 to 44-3284, 44-3286 to 44-3291, and 44-3504 to 44-3518, Reissue Revised Statutes of Nebraska, 1943, and sections 44-3211, 44-3231, 44-3233, 44-3236, 44-3239, 44-3244, 44-3247, 44-3263, 44-3270, 44-3276, 44-3277, 44-3285, 44-3501 to 44-3503, and 44-3519, Revised Statutes Supplement, 1989, are repealed.