NEBRASKA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

44-2701. Purpose of act.

The purpose of the Nebraska Life and Health Insurance Guaranty Association Act is to protect resident policyowners, insureds, including certificate holders under group insurance policies or contracts, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts of member insurers, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the member insurer issuing such policies or contracts and to assist in the detection and prevention of insurer insolvencies. To provide this protection, (1) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages, as limited in the act, and (2) members of the association are made subject to assessment to provide funds to carry out the purposes of the act.

Source: Laws 1975, LB 217, § 1; Laws 1986, LB 593, § 3.

Annotations

Resident employees, and not a nonresident trustee, are entitled to protection under this section. Unisys Corp. v. Nebraska Life & Health Ins. Guar. Assn., 267 Neb. 158, 673 N.W.2d 15 (2004).

44-2702. Terms, defined.

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

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

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

(3) Authorized, when used in the context of assessments, or authorized assessment means a resolution by the board of directors has passed whereby an

assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

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

(5) Director means the Director of Insurance;

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

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

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

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

(10) Member insurer means any person authorized to transact in this state any kind of insurance provided for under section 44-2703. Member insurer includes any person whose license or certificate of authority may have been suspended, revoked, not renewed, or voluntarily withdrawn. Member insurer does not include:

(a) A nonprofit hospital or medical service organization;

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

(c) A fraternal benefit society;

(d) A mandatory state pooling plan;

(e) An unincorporated mutual association;

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

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

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

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

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

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

(13) Person means any individual, corporation, partnership, limited liability company, association, or voluntary organization;

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

(a) Premiums on an unallocated annuity contract; or

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

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

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

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

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

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

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

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

(b) The principal place of business of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of

business of the employer or employee organization that has the largest investment in the benefit plan in question;

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

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

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

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

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

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

Source: Laws 1975, LB 217, § 2; Laws 1986, LB 593, § 4; Laws 1993, LB 121, § 244; Laws 2001, LB 360, § 14; Laws 2012, LB887, § 16.

Cross References

Viatical Settlements Act, see section 44-1101.

Annotations

A broker of viatical settlements was never a "member insurer" as defined in subsection (8) of this section under the Nebraska Life and Health Insurance Guaranty Association Act, and therefore, the Life and Health Insurance Guaranty Association was not obligated to guarantee agreements between the broker and investors under which the investors had agreed to purchase death benefits of life insurance policies after the broker breached the agreements. Harvey v. Nebraska Life & Health Ins. Guar. Assn., 277 Neb. 757, 765 N.W.2d 206 (2009).

Resident employees, and not a nonresident trustee, are entitled to protection under this section. Unisys Corp. v. Nebraska Life & Health Ins. Guar. Assn., 267 Neb. 158, 673 N.W.2d 15 (2004).

This section does not encompass the liability of an insolvent insurer arising under law rather than under the provisions of the policy such insurer issued. Nebraska Life & Health Ins. Guar. Assn. v. Dobias, 247 Neb. 900, 531 N.W.2d 217 (1995).

44-2703. Coverages authorized.

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

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

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

(A) Are residents; or

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

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

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

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

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

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

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

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

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

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

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

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

(2)(a) The act shall provide coverage to the persons specified in subsection (1) of this section for direct nongroup life, health, or annuity policies or contracts and supplemental contracts to any of these and for certificates under direct group policies and contracts, except as limited by the act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(b) The act shall not apply to:

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

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

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

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

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

(iv) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or other person under:

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

(B) A minimum premium group insurance plan;

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

(D) An administrative services only contract;

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

(A) Dividends or experience rating credits;

(B) Voting rights; or

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

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

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

(viii) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including:

(A) Claims based on marketing materials;

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

(C) Misrepresentations of or regarding policy benefits;

(D) Extra-contractual claims; or

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

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

(x) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external

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

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

(xii) Any such policy or contract issued by:

(A) A nonprofit hospital or medical service organization;

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

(C) A fraternal benefit society;

(D) A mandatory state pooling plan;

(E) An unincorporated mutual association;

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

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

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

(xiv) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Title 42, Chapter 7, Subchapter XVIII, Part C or D of the United States Code or any regulations issued pursuant thereto; or

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: Laws 1975, LB 217, § 3; Laws 1986, LB 593, § 5; Laws 2001, LB 360, § 15; Laws 2004, LB 1047, § 8; Laws 2012, LB887, § 17.

44-2704. Act; how construed.

The Nebraska Life and Health Insurance Guaranty Association Act shall be construed to effect the purposes enumerated in section 44-2701.

Source: Laws 1975, LB 217, § 4; Laws 1986, LB 593, § 6; Laws 2012, LB887, § 18.

44-2705. Nebraska Life and Health Insurance Guaranty Association; created; members; board of directors; accounts; supervision.

(1) There is hereby created a nonprofit unincorporated legal entity to be known as the Nebraska Life and Health Insurance Guaranty Association. All member insurers shall be members of the association as a condition of their authority to transact the business of insurance in this state. The association shall perform its functions under the plan of operation established and approved according to section 44-2709 and shall exercise its powers through a board of directors established pursuant to the provisions of section 44-2706. For purposes of administration and assessment, the association shall maintain three accounts: (a) A health insurance account; (b) a life insurance account; and (c) an annuity account.

(2) The association shall be under the direct supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state.

Source: Laws 1975, LB 217, § 5; Laws 1989, LB 92, § 216.

44-2706. Board of directors; members; how selected; voting rights; represent insurers; expenses.

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

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

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board as provided in sections 81-

1174 to 81-1177 for state employees but shall not otherwise be compensated by the association for their services.

Source: Laws 1975, LB 217, § 6; Laws 1981, LB 204, § 72.

44-2707. Association; powers and duties; enumerated.

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) With respect to nongroup life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (2)(b)(iv) of this section if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class;

(iv)(A) In providing the substitute coverage required under subdivision (2)(b)(iii) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy.

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

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

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

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

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

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

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

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

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

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order;

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

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

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

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

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

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

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

(7) A deposit in this state which is held pursuant to law or required by the director for the benefit of creditors and policy owners and not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to section 44-4852, shall be promptly paid to the association. The association shall be entitled to retain a portion of such amount equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state

related to that insolvency. The association shall remit to the domiciliary receiver the amount so paid to the association and not retained pursuant to this subdivision. Any amount paid to the association less the amount not retained by it shall be treated as a distribution of estate assets pursuant to section 44-4834 or similar provision of the state of domicile of the impaired or insolvent insurer;

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

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

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

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

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

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

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

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

(12) The association may:

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

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 44-2708;

(c) Borrow money to effect the purposes of the act. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

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

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

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

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

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

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

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

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

(13)(a) At any time within one year after the coverage date, the association may elect to succeed to the rights and obligations of the member insurer that accrue on or after the coverage date and that relate to contracts covered, in whole or in part, by the association under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association, except that the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. For purposes of this section, coverage date means the date on which the association becomes responsible for the obligations of a member insurer. The election shall be effected by a notice to the receiver, rehabilitator, or liquidator and to the affected

reinsurers. If the association makes an election, subdivisions (13)(a)(i) through (iv) of this section apply to the agreements selected by the association:

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

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

(iii) Within thirty days after the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer, or its receiver, rehabilitator, or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. The association or indemnity reinsurer shall pay the net balance due the other within five days after the completion of such calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to subdivision (13)(a)(ii) of this section, the receiver, rehabilitator, or liquidator shall, as promptly as practicable, pay such amounts to the association; and

(iv) If the association, within sixty days after the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association in whole or in part, the reinsurer shall not be entitled to terminate the reinsurance agreements to the extent that the agreements relate to contracts covered by the association either wholly or partially and may not set off any unpaid premium due for periods prior to the coverage date against amounts due the association;

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

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

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

(iii) Subdivision (13)(b) of this section shall not apply if the association has previously stated in writing that it will not exercise the election referred to in subdivision (13)(a) of this section;

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

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

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

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

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

Source: Laws 1975, LB 217, § 7; Laws 1986, LB 593, § 7; Laws 2001, LB 360, § 16; Laws 2003, LB 216, § 11.

Annotations

This section does not encompass the liability of an insolvent insurer arising under law rather than under the provisions of the policy such insurer issued. Nebraska Life & Health Ins. Guar. Assn. v. Dobias, 247 Neb. 900, 531 N.W.2d 217 (1995).

44-2708. Assessments against member insurers; procedure; effect; protest or appeal.

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

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

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

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

(3)(a) The amount of any Class A assessment for each account shall be determined by the board and may be authorized and called on a pro rata or non-pro-rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The total of all non-pro-rata assessments shall not exceed one hundred fifty dollars per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

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

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

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

rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a) Subject to the provisions of subdivision (b) of this subsection, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

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

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

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

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

(8) The association shall issue to each insurer paying a Class B assessment under the act a certificate of contribution in a form prescribed by the director for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue.

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

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

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

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

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

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

Source: Laws 1975, LB 217, § 8; Laws 1986, LB 593, § 8; Laws 2000, LB 930, § 7; Laws 2001, LB 360, § 17.

44-2709. Association; plan of operation; requirements.

(1)(a) The association shall submit to the director a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments shall become effective upon approval in writing by the director.

(b) If the association fails to submit a suitable plan of operation within one hundred eighty days following August 24, 1975, or if at any time thereafter the association fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the Nebraska Life and Health Insurance Guaranty Association Act. Such rules and regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

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

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

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

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

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

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

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

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

(4) The plan of operation may provide that any or all powers and duties of the association, except those under subdivision (12)(c) of section 44-2707 and section 44-2708, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation made under this subsection shall take effect only with the approval of both the board of

directors and the director and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 9; Laws 1986, LB 593, § 9; Laws 2001, LB 360, § 18.

44-2710. Director; powers and duties; enumerated.

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

(1) The director shall:

(a) Notify the board of directors of the existence of an impaired or insolvent insurer not later than three days after a determination of impairment or insolvency is made or he or she receives notice of impairment or insolvency;

(b) Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer;

(c) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under the act;

(d) In any liquidation or rehabilitation proceeding under Nebraska law involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the director shall be appointed conservator; and

(e) Transmit to the association all claims on covered policies timely filed with him or her pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. The association shall then be considered to have been designated as the director's representative pursuant to the act, and it shall proceed to investigate, hear, settle, and determine such claims unless the claimant shall, within thirty days from the date the claim is filed with the director, file with the director a

written demand that the claim be processed in the liquidation proceedings as a claim not covered by the Nebraska Life and Health Insurance Guaranty Association Act. In regard to those claims transmitted to the association by the director, the association and claimants shall have all of the rights and obligations and be subject to the same limitations and procedures as are specified in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act for the determination of claims;

(2) The director may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the director may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars per month;

(3) Any action of the board of directors or the association may be appealed to the director by any member insurer if such appeal is taken within thirty days of the action being appealed. Any final action or order of the director may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act; and

(4) The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 10; Laws 1986, LB 593, § 10; Laws 1988, LB 352, § 65; Laws 1989, LB 319, § 74.

Cross References

Administrative Procedure Act, see section 84-920.
Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-2711. Detection and prevention of insurer impairments or insolvencies; powers and duties of board and director.

To aid in the detection and prevention of insurer impairments or insolvencies:

(1) The board of directors shall, upon majority vote, notify the director of any information indicating any member insurer may be unable or potentially unable to fulfill its contractual obligations;

(2) The board of directors may, upon majority vote, request that the director order an examination of any member insurer which the board in good faith believes may be unable or potentially unable to fulfill its contractual obligations. The director may conduct such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the director may designate. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors of the association prior to its release to the public, but this shall not excuse the director from his or her obligation to comply with subdivision (3) of this section. The director shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the director, but it shall not be open to public inspection prior to the release of the examination report to the public and shall be released at that time only if the examination discloses that the examined insurer is unable or potentially unable to meet its contractual obligations;

(3) The director shall report to the board of directors when he or she has reasonable cause to believe that any member insurer examined at the request of the board of directors may be unable or potentially unable to fulfill its contractual obligations;

(4) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer. Such reports and recommendations shall not be considered public documents;

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer impairments or insolvencies; and

(6) The board of directors shall, at the conclusion of any insurer impairment or insolvency in which the association carried out its duties under the Nebraska Life and Health Insurance Guaranty Association Act or exercised any of its powers under such act, prepare a report on the history and causes of such impairment or insolvency based on the information available to the association and submit such report to the director.

Source: Laws 1975, LB 217, § 11; Laws 1986, LB 593, § 11.

44-2712. Association; recommend special deputy.

The association may recommend a natural person to serve as a special deputy to act for the director and under his supervision in the liquidation, rehabilitation, or conservation of any member insurer.

Source: Laws 1975, LB 217, § 12.

44-2713. Impaired or insolvent insurer; effect; procedure.

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

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

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

(4)(a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of

the impaired or insolvent insurer, and any other party with a bona fide interest in making an equitable distribution of the ownership rights of such impaired or insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

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

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

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

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

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

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

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

Source: Laws 1975, LB 217, § 13; Laws 1986, LB 593, § 12; Laws 1989, LB 92, § 217; Laws 2001, LB 360, § 19.

44-2714. Association; subject to examination and regulation; annual report.

The association shall be subject to examination and regulation by the director. The board of directors shall submit to the director, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the director and a report of its activities during the preceding calendar year.

Source: Laws 1975, LB 217, § 14.

44-2715. Association; exempt from fees and taxes; exception.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Source: Laws 1975, LB 217, § 15.

44-2716. Insurer; offset against tax liability; handling of refund sums.

(1) The insurer may offset against its premium and related retaliatory tax liability to this state pursuant to sections 44-150 and 77-908 accrued with respect to business transacted in such year an amount equal to twenty percent of the original face amount of the certificate of contribution, beginning with the first calendar year after the year of issuance through the fifth calendar year of issuance.

(2) Any sums acquired by refund pursuant to subsection (6) of section 44-2708 from the association which have previously been written off by contributing insurers and offset against premium and related retaliatory taxes as provided in subsection (1) of this section and are not then needed for purposes of Chapter 44 shall be paid by the association to the director who shall handle such funds in the same manner as provided for in section 77-912.

Source: Laws 1975, LB 217, § 16; Laws 1986, LB 1114, § 6; Laws 1987, LB 302, § 6; Laws 2000, LB 930, § 8.

44-2717. Exemption from liability.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its directors, officers, agents, or employees, the association or its agents or employees, members of its board of directors, or the director or his or her representatives for any action taken by them in the performance of their powers and duties under the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 17; Laws 1986, LB 593, § 13.

44-2718. Stay of proceedings against impaired insurer; purpose; association; apply to set aside judgment or defend.

All proceedings in which the impaired insurer is a party in any court in this state shall be stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

Source: Laws 1975, LB 217, § 18.

44-2719. Assessments made by associations of other states; effect.

Assessments made by the insurance guaranty associations, or similar entities, pursuant to the laws of any other state shall not be considered taxes, licenses, other fees, other material obligations, prohibitions, or restrictions as defined in section 44-150.

Source: Laws 1975, LB 217, § 19.

44-2719.01. Using name of association; when prohibited.

No person, including an insurer, agent, or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio station or television station, or in any

other way any advertisement, announcement, or statement, written or oral, which uses the existence of the Nebraska Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Nebraska Life and Health Insurance Guaranty Association Act, except that this section shall not apply to the Nebraska Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance.

Source: Laws 1986, LB 593, § 14.

44-2719.02. Insurer under court order; provisions applicable; act; applicability.

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

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

Source: Laws 1986, LB 593, § 15; Laws 2012, LB887, § 19.

44-2720. Act, how cited.

Sections 44-2701 to 44-2720 shall be known and may be cited as the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 21; Laws 1986, LB 593, § 16.