LEGISLATURE OF NEBRASKA

ONE HUNDREDTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 854

Introduced by Banking, Commerce and Insurance Committee: Pahls, 31, Chairperson; Carlson, 38; Christensen, 44; Gay, 14; Hansen, 42; Langemeier, 23; Pankonin, 2; Pirsch, 4.

Read first time January 11, 2008

Committee: Banking, Commerce and Insurance

A BILL

FOR AN ACT relating to insurance; to amend sections 44-6603 and 44-6604, Reissue Revised Statutes of Nebraska, and section 28-631, Revised Statutes Cumulative Supplement, 2006; to adopt the Discount Medical Plan Organization Act; to change provisions relating to fraudulent insurance acts; to provide penalties; to harmonize provisions; and to repeal the original sections.

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

Section 1. Section 28-631, Revised Statutes Cumulative Supplement, 2006, is amended to read:

28-631 (1) A person or entity commits a fraudulent insurance act if he or she:

(a) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any agent of an insurer, any statement as part of, in support of, or in denial of a claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim;

(b) Assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to or by an insurer or person in connection with or in support of any claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim;

(c) Makes any false or fraudulent representations as to the death or disability of a policy or certificate holder or a covered person in any statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;

(d) Knowingly and willfully transacts any contract, agreement, or instrument which violates this section;

(e) Receives money for the purpose of purchasing insurance and converts the money to the person's own benefit;

(f) Willfully embezzles, abstracts, purloins, misappropriates, or converts money, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance;

(g) Knowingly and with intent to defraud or deceive issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(h) Knowingly and with intent to defraud or deceive possesses fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(i) Knowingly and with intent to defraud or deceive makes any false entry of a material fact in or pertaining to any document or statement filed with or required by the Department of Insurance; ~~or~~

(j) Knowingly and with intent to defraud or deceive removes, conceals, alters, diverts, or destroys assets or records of an insurer or person engaged in the business of insurance or attempts to remove, conceal, alter, divert, or destroy assets or records of an insurer or person engaged in the business of insurance; ~~.~~

(k) Willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 9 of this act; or

(l) Willfully collects fees for purported membership in a discount medical plan organization but purposefully fails to provide the promised benefits.

(2)(a) A violation of subdivisions (1)(a) through (f) of this section is a Class III felony when the amount involved is one thousand five hundred dollars or more.

(b) A violation of subdivisions (1)(a) through (f) of this section is a Class IV felony when the amount involved is five hundred dollars or more but less than one thousand five hundred dollars.

(c) A violation of subdivisions (1)(a) through (f) of this section is a Class I misdemeanor when the amount involved is two hundred dollars or more but less than five hundred dollars.

(d) A violation of subdivisions (1)(a) through (f) of this section is a Class II misdemeanor when the amount involved is less than two hundred dollars.

(e) For any second or subsequent conviction under subdivision (2)(c) of this section, the violation is a Class IV felony.

(f) A violation of subdivisions (1)(g), (i), ~~and~~ (j), (k), and (l) of this section is a Class IV felony.

(g) A violation of subdivision (1)(h) of this section is a Class I misdemeanor.

(3) Amounts taken pursuant to one scheme or course of conduct from one person, entity, or insurer may be aggregated in

the indictment or information in determining the classification of the offense, except that amounts may not be aggregated into more than one offense.

(4) In any prosecution under this section, if the amounts are aggregated pursuant to subsection (3) of this section, the amount involved in the offense shall be an essential element of the offense that must be proved beyond a reasonable doubt.

(5) A prosecution under this section shall be in lieu of an action under section 44-6607.

(6) For purposes of this section:

(a) Insurer means any person or entity transacting insurance as defined in section 44-102 with or without a certificate of authority issued by the Director of Insurance. Insurer also means health maintenance organizations, legal service insurance corporations, prepaid limited health service organizations, dental and other similar health service plans, discount medical plan organizations, and entities licensed pursuant to the Intergovernmental Risk Management Act and the Comprehensive Health Insurance Pool Act. Insurer also means an employer who is approved by the Nebraska Workers' Compensation Court as a self-insurer; and

(b) Statement includes, but is not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical records,

X-rays, test result, or other evidence of loss, injury, or expense, whether oral, written, or computer-generated.

Sec. 2. Section 44-6603, Reissue Revised Statutes of Nebraska, is amended to read:

44-6603 For purposes of the Insurance Fraud Act:

(1) Department means the Department of Insurance;

(2) Director means the Director of Insurance;

(3) Insurer means any person or entity transacting insurance as defined in section 44-102 with or without a certificate of authority issued by the director. Insurer also means health maintenance organizations, legal service insurance corporations, prepaid limited health service organizations, dental and other similar health service plans, discount medical plan organizations, and entities licensed pursuant to the Intergovernmental Risk Management Act and the Comprehensive Health Insurance Pool Act. Insurer also means an employer who is approved by the Nebraska Workers' Compensation Court as a self-insurer; and

(4) Statement includes, but is not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical records, X-rays, test result, or other evidence of loss, injury, or expense, whether oral, written, or computer-generated.

Sec. 3. Section 44-6604, Reissue Revised Statutes of Nebraska, is amended to read:

44-6604 For purposes of the Insurance Fraud Act, a person or entity commits a fraudulent insurance act if he or she:

(1) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any agent of an insurer, any statement as part of, in support of, or in denial of a claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim;

(2) Assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to or by an insurer or person in connection with or in support of any claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim;

(3) Makes any false or fraudulent representations as to the death or disability of a policy or certificate holder or a covered person in any statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;

(4) Knowingly and willfully transacts any contract, agreement, or instrument which violates this section;

(5) Receives money for the purpose of purchasing insurance and converts the money to the person's own benefit;

(6) Willfully embezzles, abstracts, purloins, misappropriates, or converts money, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance;

(7) Knowingly and with intent to defraud or deceive issues or possesses fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(8) Knowingly and with intent to defraud or deceive makes any false entry of a material fact in or pertaining to any document or statement filed with or required by the department; ~~or~~

(9) Knowingly and with intent to defraud or deceive removes, conceals, alters, diverts, or destroys assets or records of an insurer or person engaged in the business of insurance or attempts to remove, conceal, alter, divert, or destroy assets or records of an insurer or person engaged in the business of insurance; ~~.~~

(10) Willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 9 of this act; or

(11) Willfully collects fees for purported membership in a discount medical plan but purposefully fails to provide the promised benefits.

Sec. 4. Sections 4 to 19 of this act shall be known and may be cited as the Discount Medical Plan Organization Act.

Sec. 5. The purpose of the Discount Medical Plan Organization Act is to promote the public interest by establishing standards for discount medical plan organizations to protect consumers from unfair or deceptive marketing, sales, or enrollment practices and to facilitate consumer understanding of the role and function of discount medical plan organizations in providing access to medical or ancillary services.

Sec. 6. For purposes of the Discount Medical Plan Organization Act:

(1) Affiliate means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the person specified;

(2) Ancillary services includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic, and podiatry services;

(3) Control or controlled by or under common control with means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person;

(4) Director means the Director of Insurance;

(5)(a) Discount medical plan means a business arrangement or contract in which a person, in exchange for fees, dues, charges,

or other consideration, offers access for its members to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount medical plan from those providers.

(b) Discount medical plan does not include a plan that does not charge a membership or other fee to use the plan's discount medical card;

(6) Discount medical plan organization means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It is the organization that contracts with providers, provider networks, or other discount medical plan organizations to offer access to medical or ancillary services at a discount and determines the charge to discount medical plan members;

(7) Facility means an institution providing medical or ancillary services or a health care setting. Facility includes, but is not limited to:

(a) A hospital or other licensed inpatient center;

(b) An ambulatory surgical or treatment center;

(c) A skilled nursing center;

(d) A residential treatment center;

(e) A rehabilitation center; and

(f) A diagnostic, laboratory, or imaging center;

(8) Health care professional means a physician, pharmacist, or other health care practitioner who is licensed, accredited, or certified to perform specified medical or ancillary services within the scope of his or her license, accreditation, certification, or other appropriate authority and consistent with state law;

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

(10) Marketer means a person or entity that markets, promotes, sells, or distributes a discount medical plan including a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a marketing agreement with a discount medical plan organization;

(11) Medical services means any maintenance care of, or preventive care for, the human body or care, service, or treatment of an illness or dysfunction of, or injury to, the human body. Medical services includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services,

ambulance services, laboratory services, and medical equipment and supplies. Medical services does not include pharmacy services or ancillary services;

(12) Member means any individual who pays fees, dues, charges, or other consideration for the right to receive the benefits of a discount medical plan;

(13) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, or any similar entity or any combination of the foregoing;

(14) Provider means any health care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to provide medical or ancillary services to members; and

(15) Provider network means an entity that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider to provide medical or ancillary services to members.

Sec. 7. Control as used in the Discount Medical Plan Organization Act is presumed to exist if any person, directly or indirectly, owns, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in subsection (11) of section 44-2132 that control does not exist in fact. The director may determine,

after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Sec. 8. (1) The Discount Medical Plan Organization Act applies to all discount medical plan organizations doing business in or from this state.

(2) A discount medical plan organization that is a health carrier is not required to obtain a certificate of registration under section 9 of this act, except that any of its affiliates that operates as a discount medical plan organization in this state shall obtain a certificate of registration under section 9 of this act and comply with all other provisions of the act. The discount medical plan organization is required to comply with sections 11 to 14 of this act and report, in the form and manner as the director may require, any of the information described in subsection (2) of section 16 of this act that is not otherwise already reported.

(3) A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a certificate of registration under the act as a discount medical plan organization.

Sec. 9. (1) Before doing business in or from this state as a discount medical plan organization, a discount medical plan organization:

(a) May transact business in this state under Chapter 21;

and

(b) Shall obtain a certificate of registration from the director to operate as a discount medical plan organization.

(2) Each application for a certificate of registration to operate as a discount medical plan organization shall:

(a) Be in a form prescribed by the director and verified by an officer or authorized representative of the applicant;

(b) Be accompanied by an application fee not to exceed one thousand five hundred dollars;

(c) Include information on whether:

(i) A previous application for a certificate of registration or licensure has been denied, revoked, suspended, or terminated for cause in any jurisdiction; and

(ii) The applicant is under investigation for or the subject of any pending action or has been found in violation of a statute or regulation in any jurisdiction within the previous five years; and

(d) Include information as the director may require that permits the director, after reviewing all of the information submitted pursuant to this subsection, to make a determination that the applicant:

(i) Is financially responsible;

(ii) Has adequate expertise or experience to operate a discount medical plan organization;

(iii) Has a network that is sufficient in numbers and

types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay; and

(iv) Is of good character.

(3) After the receipt of an application filed pursuant to subsection (2) of this section, the director shall review the application and notify the applicant of any deficiencies in the application.

(4) No more than ninety days after the date of receipt of a completed application, the director shall issue a certificate of registration if the director is satisfied that the applicant has met the requirements of subsection (2) of this section or shall deny the application and state the grounds for denial.

(5) Prior to issuance of a certificate of registration by the director, each discount medical plan organization shall establish an Internet web site in order to conform to the requirements of subsection (2) of section 12 of this act.

(6)(a) A registration is effective for one year unless before its expiration it is renewed in accordance with this subsection or suspended or revoked in accordance with subsection (7) of this section.

(b) At least ninety days before a certificate of registration is set to expire, the discount medical plan organization shall submit:

(i) A renewal application form; and

(ii) The renewal fee.

(c) The director shall renew the certificate of registration of each holder that meets the requirements of the Discount Medical Plan Organization Act and pays the renewal fee of one hundred dollars.

(7)(a) The director may suspend or revoke a certificate of registration after notice and hearing held in accordance with the Administrative Procedure Act if the director finds that any of the following conditions exist:

(i) The discount medical plan organization is not operating in compliance with the act;

(ii) The discount medical plan organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising;

(iii) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

(iv) The continued operation of the discount medical plan organization would be hazardous to its members.

(b) If the director has cause to believe that grounds for the denial or nonrenewal of a certificate of registration exists, the director shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to grant or renew the certificate of registration. The applicant or

registrant has thirty days after receipt of such notification to demand a hearing. The hearing shall be held no more than thirty days after receipt of such demand by the director and shall be held in accordance with the Administrative Procedure Act.

(c)(i) The director shall, in his or her order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its certificate of registration to enroll members.

(ii) The director may rescind or modify the order of suspension prior to the expiration of the suspension period.

(iii) The certificate of registration of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The director shall not grant the request for reinstatement if the director finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(8) In lieu of suspending or revoking a discount medical plan organization's certificate of registration under subsection (7) of this section, if the discount medical plan organization has violated any provision of the act, the director may:

(a) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the

act or practice that constitutes the violation; and

(b) Impose a monetary penalty of not more than one thousand dollars for each violation.

(9) Each registered discount medical plan organization shall notify the director immediately whenever the discount medical plan organization's certificate of registration or other form of authority to operate as a discount medical plan organization in another state is suspended, revoked, or not renewed in that state.

Sec. 10. (1) The director may examine or investigate the business and affairs of any discount medical plan organization to protect the interests of the residents of this state based on the following reasons, including, but not limited to, complaint indices, recent complaints, information from other states, or as the director deems necessary.

(2) An examination or investigation conducted as provided in subsection (1) of this section shall be performed in accordance with the provisions of the Insurers Examination Act.

(3) The director may:

(a) Order any discount medical plan organization or applicant that operates a discount medical plan organization to produce any records, books, files, advertising and solicitation materials, or other information; and

(b) Take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest.

(4) The discount medical plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount medical plan organization or applicant to pay such expenses is grounds for denial of a certificate of registration to operate as a discount medical plan organization or revocation of a certificate of registration to operate as a discount medical plan organization.

Sec. 11. (1) A discount medical plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount medical plan.

(2)(a)(i) If a member cancels his or her membership in the discount medical plan organization within thirty days after the date of receipt of the written document for the discount medical plan described in subsection (4) of section 14 of this act, the member shall receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds thirty dollars upon return of the discount medical plan card to the discount medical plan organization.

(ii)(A) Cancellation occurs when notice of cancellation is given to the discount medical plan organization.

(B) Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed, and postage prepaid to the mailing address of the discount medical plan organization or emailed to the email address of the discount

medical plan organization.

(iii) A discount medical plan organization shall return any periodic charge charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

(b) If the discount medical plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

(3) When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the marketer or discount medical plan organization shall:

(a) Provide the charges for each discount medical plan in writing to the member; or

(b) Reimburse the member for all periodic charges for the discount medical plan if the member cancels his or her membership in accordance with subdivision (2)(a) of this section.

(4) Any discount medical plan organization that is a health carrier that provides a discount medical plan product that is incidental to the insured product is not subject to this section.

(5) A fee or charge charged by a discount medical plan organization shall bear a reasonable relationship to the benefits to be received by the member. The discount medical plan organization has the burden of proof that a fee or charge bears

such a reasonable relationship.

Sec. 12. (1)(a) A discount medical plan organization shall have a written provider agreement with all providers offering medical or ancillary services to its members. The written provider agreement may be entered into directly with the provider or indirectly with a provider network to which the provider belongs.

(b) A provider agreement between a discount medical plan organization and a provider shall provide the following:

(i) A list of the medical or ancillary services and products to be provided at a discount;

(ii) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

(iii) That the provider will not charge members more than the discounted rates.

(c) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers that:

(i) Contain the provisions described in subdivision (1)(b) of this section;

(ii) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and

(iii) Require the provider network to maintain an up-to-date list of its contracted providers and to provide the list on a monthly basis to the discount medical plan organization.

(d) A provider agreement between a discount medical plan organization and an entity that contracts with a provider network shall require that the entity, in its contract with the provider network, require the provider network to have written agreements with its providers that comply with subdivision (1)(c) of this section.

(e) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.

(2) Each discount medical plan organization shall maintain on an Internet web site an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The web site address shall be prominently displayed on all of its advertisements, marketing materials, brochures, and discount medical plan cards. This subsection applies to those providers with which the discount medical plan organization has contracted directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

(3) Each discount medical plan organization shall maintain a toll-free telephone number for members to obtain additional information about and assistance on the discount medical plan and an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The toll-free telephone number shall be prominently displayed on all of its advertisements, marketing

materials, brochures, and discount medical plan cards. Capable and competent personnel shall staff the toll-free telephone number on a twenty-four-hour basis.

(4)(a) A discount medical plan organization shall maintain contracts with sufficient numbers and types of providers to ensure that all health care services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the discount medical plan organization, including, but not limited to: Provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. The discount medical plan organization shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a discount medical plan organization has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under consideration.

(b) A discount medical plan organization shall maintain an access plan meeting the requirements of the Discount Medical Plan Organization Act for each of the discount medical plans that the discount medical plan organization offers in this state. The discount medical plan organization may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For purposes of this section, information is proprietary or competitive if revealing the information would cause the discount medical plan organization's competitors to obtain valuable business information. The discount medical plan organization shall make the access plans, absent proprietary information, available on its business premises and shall provide them to the director or any interested party upon request. The discount medical plan organization shall prepare an access plan prior to offering a new discount medical plan and shall update an existing access plan whenever it makes any material change to an existing access plan. The access plan shall describe or contain at least the following:

(i) The discount medical plan organization's network;

(ii) The discount medical plan organization's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in plans;

(iii) The health carrier's method of informing covered persons of the plan's services and features; and

(iv) Any other information required by the director to determine compliance with the provisions of the act.

(c) A health carrier that offers discount medical plans shall file with the director such information as the director may require to ensure compliance with this section.

Sec. 13. (1) A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.

(2)(a) The discount medical plan organization shall have an executed written agreement with each marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan.

(b) The agreement between the discount medical plan organization and the marketer shall prohibit the marketer from using advertising, marketing materials, brochures, and discount medical plan cards without the discount medical plan organizations's approval in writing.

(c) The discount medical plan organization shall be bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization.

(3) A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures, and discount cards used by marketers to market, promote, sell, or distribute the discount medical plan prior to their use.

(4) Upon request, a discount medical plan organization shall submit to the director all advertising, marketing materials, and brochures regarding a discount medical plan.

Sec. 14. (1)(a) All advertisements, marketing materials, brochures, discount medical plan cards, and any other communications of a discount medical plan organization provided to prospective members and members shall be truthful and not misleading in fact or in implication.

(b) Any advertisement, marketing material, brochure, discount medical plan card, or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.

(2)(a) Except as otherwise provided in the Discount Medical Plan Organization Act, as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, a discount medical plan organization shall not use in its advertisements, marketing material, brochures, or discount medical plan cards the term insurance;

(b) Except as otherwise provided in state law, a discount medical plan organization shall not describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insured product and the insurance

benefits are incidental to the discount medical plan benefits; and

(c) A discount medical plan organization shall not:

(i) Use in its advertisements, marketing material, brochures, or discount medical plan cards the terms health plan, coverage, copay, copayment, deductible, preexisting condition, guaranteed issue, premium, PPO, preferred provider organization, or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;

(ii) Use language in its advertisements, marketing material, brochures, or discount medical plan cards with respect to being licensed or registered by a state insurance department in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by a state;

(iii) Make misleading, deceptive, or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;

(iv) Have restrictions on access to discount medical plan providers, including waiting periods and notification periods, except for hospital services; or

(v) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan unless the discount medical plan organization

has an active certificate of authority to act as a third-party administrator in accordance with the Third-Party Administrator Act.

(3)(a) Each discount medical plan organization shall make the following general disclosures in writing in not less than twelve-point font on the first content page of any advertisement, marketing material, or brochure made available to the public relating to a discount medical plan together with any enrollment forms given to a prospective member:

(i) That the plan is a discount plan and is not insurance coverage;

(ii) That the range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;

(iii) Unless the discount medical plan organization has an active certificate of authority to act as a third-party administrator as described in subdivision (2)(c)(v) of this section, that the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

(iv) That the plan member is obligated to pay for all medical or ancillary services but will receive a discount from those providers that have contracted with the discount medical plan organization; and

(v) The toll-free telephone number and Internet web site address for the registered discount medical plan organization for

prospective members and members to obtain additional information about and assistance on the discount medical plan and an up-to-date list of providers participating in the discount medical plan.

(b) If the initial contact with a prospective member is by telephone, the disclosures required under subdivision (a) of this subsection shall be made orally and included in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

(4)(a) In addition to the general disclosures required under subsection (3) of this section, each discount medical plan organization shall provide to:

(i) Each prospective member, at the time of enrollment, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan; and

(ii) Each new member a written document that contains the terms and conditions of the discount medical plan.

(b) The written document required under subdivision (a)(ii) of this subsection shall be clear and include the following information:

(i) The name of the member;

(ii) The benefits to be provided under the discount medical plan;

(iii) Any processing fees and periodic charges associated

with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

(iv) The frequency of payment of any processing fees and periodic charges and procedures for changing the frequency of payment;

(v) Any limitations, exclusions, or exceptions regarding the receipt of discount medical plan benefits;

(vi) Any waiting periods for certain medical or ancillary services under the discount medical plan;

(vii) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;

(viii) Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;

(ix) Renewal, termination, and cancellation terms and conditions;

(x) Procedures for adding new members to a family discount medical plan, if applicable;

(xi) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact his or

her state insurance department, including contact information for the Department of Insurance; and

(xii) The name, email address, and mailing address of the discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices, and file complaints.

Sec. 15. Each discount medical plan organization shall provide the director notice of any change in the discount medical plan organization's name, address, telephone number, principal business address or mailing address, or Internet web site address no less than thirty days before such change is to occur.

Sec. 16. (1) If the information required in subsection (2) of this section is not provided at the time of renewal of a certificate of registration under section 9 of this act, a discount medical plan organization shall file an annual report with the director in the form prescribed by the director within three months after the end of each fiscal year.

(2) The report shall include:

(a) If different from the initial application for a certificate of registration or at the time of renewal of a certificate of registration, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with such persons and the discount medical plan organization, including any possible

conflicts of interest;

(b) The number of discount medical plan members in the state;

(c) Information allowing the director to determine whether the discount medical plan organization maintains an adequate provider network as required by subdivision (4)(a) of section 12 of this act; and

(d) Any other information relating to the performance of the discount medical plan organization that may be required by the director.

(3)(a) Any discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall forfeit:

(i) Up to five hundred dollars each day for the first ten days during which the violation continues; and

(ii) Up to one thousand dollars each day after the first ten days during which the violation continues.

(b) Upon notice by the director, the discount medical plan organization described in subdivision (a) of this subsection shall lose its authority to enroll new members or to do business in this state if the violation continues.

Sec. 17. (1) A violation of the Discount Medical Plan Organization Act shall be an unfair trade practice under the Unfair Insurance Trade Practices Act.

(2) In addition to the penalties and other enforcement

provisions of the Discount Medical Plan Organization Act, any person who willfully violates the act is subject to administrative penalties of up to one thousand dollars per violation.

(3) A person that willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 9 of this act commits a fraudulent insurance act under section 28-631.

(4) A person that collects fees for purported membership in a discount medical plan but purposefully fails to provide the promised benefits commits a fraudulent insurance act under section 28-631. In addition, upon conviction, such person shall be ordered to pay restitution to persons aggrieved by the violation of the act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of such fine or imprisonment.

Sec. 18. (1) The director may issue an order directing a discount medical plan organization to cease and desist from engaging in any action or practice in violation of the Discount Medical Plan Organization Act. Within ten days after service of the cease and desist order, the organization may request a hearing on the question of whether an action or practice in violation of the act has occurred. Such hearing shall be conducted as provided by the Administrative Procedure Act. The organization may appeal the decision of the director. Such appeal shall be in accordance with the Administrative Procedure Act.

(2)(a) In addition to the penalties and other enforcement

provisions of the act, the director may seek both temporary and permanent injunctive relief when:

(i) A discount medical plan is being operated by a person or entity that is not registered pursuant to the Discount Medical Plan Organization Act; or

(ii) Any person, entity, or discount medical plan organization has engaged in any activity prohibited by the act or any rules or regulations adopted and promulgated pursuant to the act.

(b) The district court of Lancaster County shall have exclusive jurisdiction over any proceeding brought pursuant to this section.

(3) The director's authority to seek relief under this section is not conditioned upon having conducted any proceeding pursuant to the provisions of the Administrative Procedure Act.

Sec. 19. The director may adopt and promulgate rules and regulations to carry out the provisions of the Discount Medical Plan Organization Act.

Sec. 20. Original sections 44-6603 and 44-6604, Reissue Revised Statutes of Nebraska, and section 28-631, Revised Statutes Cumulative Supplement, 2006, are repealed.