LEGISLATIVE BILL 1222

Approved by the Governor April 15, 1994

Introduced by Wesely, 26; Beutler, 28; Byars, 30; Coordsen, 32; Day, 19; Hall, 7; Landis, 46; Lindsay, 9; Rasmussen, 20; Robak, 22; Vrtiska, 1, at the request of the Governor

AN ACT relating to insurance; to amend sections 48-144.03 and 71-2049, Reissue Revised Statutes of Nebraska, 1943, sections 44-210, 44-220, 44-221, 44-513, and 44-4228, Revised Statutes Supplement, 1992, and sections 44-760 and 44-1525, Revised Statutes Supplement, 1993; to adopt the Small Employer Health Insurance Availability Act; to adopt the Standardized Health Claim Form Act; to provide a penalty; to change a definition of group sickness and accident insurance; to require coverage for childhood immunizations; to provide for reimbursement for mental health practitioners; to provide additional Comprehensive Health Insurance Pool Act coverage; to change provisions relating to the organization of insurance companies, to unfair trade practices in the business of insurance, and to workers' compensation insurance cancellation; to eliminate the Hospital Consumer Information Act and the Small Employer Health Insurance Act; to harmonize provisions; to provide operative dates; to provide severability; and to repeal the original sections, and also sections 71-2062 to 71-2066, 71-2068 to 71-2072, 71-2074, and 71-2077, Reissue Revised Statutes of Nebraska, 1943, sections 44-5201 to 44-5213 and 44-5215 to 44-5222, Revised Statutes Supplement, 1992, and sections 44-5214, 71-2067, and 71-2073, Revised Statutes Supplement, 1993; and to declare an emergency.

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

Section 1. Sections 1 to 45 of this act shall be known and may be cited as the Small Employer Health Insurance Availability Act.

Sec. 2. The purposes of the Small Employer Health Insurance Availability Act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of basic and standard health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market. The act is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

Sec. 3. For purposes of the Small Employer Health Insurance Availability Act, the definitions found in sections 4 to 33 of this act shall be used.

Sec. 4. Actuarial certification shall mean a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 36 of this act based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

Sec. 5. Affiliate or affiliated shall mean any entity or person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

Sec. 6. Agent shall have the same meaning as in section 44-103.

Sec. 7. Base premium rate shall mean for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

Sec. 8. Basic health benefit plan shall mean a lower cost health benefit plan developed pursuant to section 40 of this act.

Sec. 9. Board shall mean the board of directors of the Nebraska Small Employer Health Reinsurance Program.

Sec. 10. Broker shall have the same meaning as in section 44-103.

Sec. 11. Carrier shall mean any entity that provides health insurance in this state. Carrier shall include an insurance company, a fraternal benefit society, a health maintenance organization, and any other

entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Sec. 12. Case characteristics shall mean demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage shall not be case characteristics for purposes of the Small Employer Health Insurance Availability Act.

Sec. 13. Class of business shall mean all or a separate grouping of small employers established pursuant to section 35 of this act.

Sec. 14. Committee shall mean the Health Benefit Plan Committee established pursuant to section 40 of this act.

Sec. 15. Control shall have the same meaning as in section 44-2121.

Sec. 16. Dependent shall mean a spouse, an unmarried child under the age of nineteen years, an unmarried child who is a full-time student under the age of twenty-three years and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Sec. 17. Director shall mean the Director of Insurance.

Sec. 18. Eligible employee shall mean an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term shall include a sole proprietor, a partner of a partnership, a member of a limited liability company, and an independent contractor, if the sole proprietor, partner, member, or independent contractor is included as an employee under a health benefit plan of a small employer, but shall not include an employee who works on a part-time, temporary, or substitute basis.

Sec. 19. Established geographic service area shall mean a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance business in this state, within which the carrier is authorized to provide coverage.

Sec. 20. (1) Health benefit plan shall mean any hospital or medical policy or certificate, major medical expense insurance, or health maintenance organization subscriber contract.

(2) Health benefit plan shall not include accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, specified disease insurance, hospital confinement indemnity insurance, or limited benefit health insurance.

Sec. 21. Index rate shall mean, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Sec. 22. Late enrollee shall mean an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan if the initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

(1) The individual meets the following:

(a) The individual was covered under qualifying previous coverage at the time of the initial enrollment;

(b) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(c) The individual requests enrollment within thirty days after termination of the qualifying previous coverage;

(2) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(3) A court has ordered coverage be provided for a spouse or a minor or dependent child under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of the court order.

Sec. 23. New business premium rate shall mean, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

Sec. 24. Plan of operation shall mean the plan of operation of the Nebraska Small Employer Health Reinsurance Program.

Sec. 25. Premium shall mean all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

Sec. 26. Program shall mean the Nebraska Small Employer Health Reinsurance Program established pursuant to section 39 of this act.

Sec. 27. Qualifying previous coverage and qualifying existing coverage shall mean benefits or coverage provided under:

(1) Medicare or medicaid;

(2) An employer-based group health insurance plan that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(3) An individual health insurance policy, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, and a fraternal benefit society that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan if such policy has been in effect for a period of at least one year.

Sec. 28. Rating period shall mean the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Sec. 29. Reinsuring carrier shall mean a small employer carrier.

Sec. 30. Restricted network provision shall mean any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into contractual arrangement with the carrier to provide health care services to covered individuals.

Sec. 31. Small employer shall mean any person, political subdivision, firm, corporation, limited liability company, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least three and no more than twenty-five eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

Sec. 32. Small employer carrier shall mean a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

Sec. 33. Standard health benefit plan shall mean a health benefit plan developed pursuant to section 40 of this act.

Sec. 34. (1) The Small Employer Health Insurance Availability Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(a) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code of 1986, as amended.

(2)(a) The act shall not apply to individual health benefit plans issued to employees of a small employer if the arrangements with the small employer meet any of the conditions set forth in subsection (1) of this section and were established prior to the operative date of this section.

(b) The act shall apply to individual health benefit plans issued on or after such date if any of the conditions set forth in subsection (1) of this section are met.

(3)(a) Except as provided in subdivision (b) of this subsection, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by the act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of authority pursuant to the Health Maintenance Organization Act may be considered to be a separate carrier for the purposes of the Small Employer Health Insurance Availability Act.

(c) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent of the

insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The Assumption Reinsurance Act shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

(4)(a) A Taft-Hartley trust, or a carrier with the written authorization of such a trust, may make a written request to the director for a waiver from the application of any of the provisions of subsection (1) of section 36 of this act with respect to a health benefit plan provided to the trust.

(b) The director may grant such a waiver if the director finds that application of such subsection with respect to the trust would:

(i) Have a substantial adverse effect on the participants and beneficiaries of such trust; and

(ii) Require significant modifications to one or more collective bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this section shall not apply to an individual if the person participates in such a trust as an associate member of an employee organization.

Sec. 35. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(b) The small employer carrier has acquired a class of business from another small employer carrier; or

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of section 44-760.

(2) A small employer carrier may establish up to nine separate classes of business.

(3) The director may adopt and promulgate rules and regulations to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) of this section in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that such action would enhance the efficiency and fairness of the small employer marketplace.

Sec. 36. (1) Premium rates for health benefit plans subject to the Small Employer Health Insurance Availability Act shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent;

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent of the index rate;

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate if such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business;

(d) Adjustments in rates for claim experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

(e) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to section 39 of this act;

(f) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent;

(g) In the case of health benefit plans delivered or issued for delivery prior to the operative date of this section, a premium rate for a rating period may exceed the ranges set forth in subdivisions (a) and (b) of this subsection for a period of three years following the operative date of this section. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate if such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and

(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business;

(h)(i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

(i) For the purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision if the restriction of benefits to network providers results in substantial differences in claim costs;

(j) The small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size without the prior approval of the director;

(k) The director may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of the act, including regulations that:

(i) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) Prescribe the manner in which case characteristics may be used by small employer carriers.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage since issue.

(3) The director may suspend for a specified period the application of subdivision (1)(a) of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in

claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to the renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(5)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with the act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subdivision (a) of this subsection available to the director upon request. Except in cases of violations of the act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the Department of Insurance except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Sec. 37. (1) A health benefit plan subject to the Small Employer Health Insurance Availability Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds, or their representatives;

(c) Noncompliance with the carrier's minimum participation requirements;

(d) Noncompliance with the carrier's employer contribution requirements;

(e) Repeated misuse of a restricted network provision;

(f) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

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

(ii) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected small employers; or

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

(i) Not be in the best interests of the policyholders or certificate holders; or

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

In such instance the director shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier that elects not to renew a health benefit plan shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director.

(3) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

Sec. 38. (1)(a) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers at least two health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan, and one plan shall be a standard health benefit plan.

(b)(i) A small employer carrier shall issue a basic health benefit

plan or a standard health benefit plan to any eligible small employer that applies for either such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with the Small Employer Health Insurance Availability Act.

(ii) In the case of a small employer carrier that establishes more than one class of business, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if:

(A) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic health benefit plan or a standard health benefit plan;

(B) The criteria are not related to the health status or claim experience of employees or dependents of the small employer;

(C) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(D) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subdivision (ii) shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) A small employer shall be eligible under subdivision (1)(b) of this section if it employed at least three and no more than twenty-five eligible employees within this state on at least fifty percent of its working days during the preceding calendar quarter.

(d) The provisions of this subsection shall be effective one hundred eighty days after the director's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to section 40 of this act, except that if the program is not yet operative on such date, the provisions of this subsection shall be effective on the date that the program begins operation.

(2)(a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subsection may be used by a small employer carrier beginning thirty days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic health benefit plan or standard health benefit plan on the grounds that the plan does not meet the requirements of the act.

(3) Health benefit plans covering small employers shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

(i) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six months immediately preceding the effective date of coverage;

(ii) A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or

(iii) A pregnancy existing on the effective date of coverage.

(b) A small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services if the qualifying previous coverage was continuous to a date not more than ninety days prior to the effective date of new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier. This subdivision shall not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or for an eighteen-month preexisting condition exclusion, except that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the

combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan.

(d)(i) Except as provided in subdivision (3)(d)(iv) of this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii)(A) Except as provided in subdivision (3)(d)(iii)(B) of this section, in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e)(i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group except in the case of late enrollees as provided in subdivision (3)(c) of this section.

(ii) Except as permitted under subdivisions (a) and (c) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

(4)(a) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (1) of this section in the case of the following:

(i) To a small employer if the small employer is not physically located in the carrier's established geographic service area;

(ii) To an employee if the employee does not work or reside within the carrier's established geographic service area;

(iii) To an employee if previous basic health benefit plans or standard health benefit plans have, in the aggregate, paid one million dollars in benefits on behalf of the employee. Benefits paid on behalf of the employee in the immediately preceding two calendar years by prior small employer carriers under basic and standard plans shall be included when calculating the lifetime maximum benefits payable under the succeeding basic or standard plans. In any situation in which a determination of the total amount of benefits paid by prior small employer carriers is required by the succeeding carrier, prior carriers shall furnish a statement of the total benefits paid under basic and standard plans at the succeeding carrier's request; or

(iv) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier that cannot offer coverage pursuant to subdivision (4)(a)(iv) of this section may not offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

(5) A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection (1) of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of such subsection would place the small employer carrier in a financially impaired condition.

Sec. 39. (1) There is hereby created a nonprofit entity to be known as the Nebraska Small Employer Health Reinsurance Program.

(2)(a) The program shall operate subject to the supervision and control of the board. Subject to this subsection, the board shall consist of eight members appointed by the director and the director or his or her or designated representative who shall serve as an ex officio member of the board.

(b) In selecting the members of the board, the director shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the director. At least five members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the director.

(c) The initial board members shall be appointed as follows: Two of the members to serve terms of two years; three of the members to serve terms of four years; and three of the members to serve terms of six years. Subsequent board members shall serve for terms of three years. A board member's term shall continue until his or her successor is appointed.

(d) A vacancy in the board shall be filled by the director. A board member may be removed by the director for cause.

(3) Within sixty days after the operative date of this section, each small employer carrier shall make a filing with the director containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

(4) Within one hundred eighty days after the appointment of the initial board, the board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable, and equitable administration of the program and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the director.

(5) If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the director shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The director shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the director.

(6) The plan of operation shall:

(a) Establish procedures for handling and accounting of program assets and money and for an annual fiscal reporting to the director;

(b) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

(e) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers though capitation or salary; and

(f) Provide for any additional matters necessary for the implementation and administration of the program.

(7) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Small Employer Health Insurance Availability Act, including the authority, with the approval of the director, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) Take any legal action necessary to avoid the payment of improper claims against the program;

(d) Define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies, in accordance with the requirements of the act;

(e) Establish rules, conditions, and procedures for reinsuring risks under the program;

(f) Establish actuarial functions as appropriate for the operation of the program;

(g) Assess reinsuring carriers in accordance with the provisions of subsection (11) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

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

(i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(8) A reinsuring carrier may reinsure with the program as provided for in this subsection:

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic health benefit plan or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within sixty days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty days of the commencement of his or her coverage.

(d)(i) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent of the next fifty thousand dollars of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subdivision shall not exceed a maximum limit of ten thousand dollars in any one calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the reinsuring carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers of the United States Department of Labor, Bureau of Labor Statistics, unless the board proposes and the director approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in subdivision (d) of this subsection, shall be reduced to reflect that portion of the risk above the amount set forth in subdivision (d) of this subsection that may not be ceded to the program, if any.

(g) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, restricted network provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(9)(a) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set

forth in this subsection to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan adjusted to reflect retention levels required under the act.

(b) Premiums for the program shall be as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection; and

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection.

(c) The board periodically shall review the methodology established under subdivision (a) of this subsection, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(10) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 36 of this act.

(11)(a) Prior to March 1 of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(i) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(A) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(B) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(ii) The formula established pursuant to this subsection shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of (A) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (B) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(iii) The board may, with approval of the director, change the assessment formula established pursuant to this subsection from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.

(iv) Subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. 300 et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(c)(i) Prior to March 1 of each year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(ii) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subdivision (c)(iii) of this subsection, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program, and

the costs of coverage for small employers. If the board fails to file a report with the director within ninety days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement such amendments to the plan of operation the director deems necessary to reduce future losses and assessments.

(iii) For any calendar year, the amount specified in this subdivision is one percent of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) If the assessment in any calendar year exceeds the amount specified in subdivision (c)(iii) of this subsection, the board shall notify the director who shall, within ten days of receipt of such notice, suspend the guarantee-issue requirement of subdivision (1)(b)(i) of section 38 of this act until such time as the board has implemented changes to the reinsurance program which the board, with the director's approval, determines will be sufficient to fully fund future program liabilities and administrative expenses.

(e) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. Future losses shall include reserves for incurred but not reported claims.

(f) Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

(g) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(h) A reinsuring carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a reinsuring carrier if the director determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessment.

(12) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by the act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

(13) The board, as part of the plan of operation, shall develop standards setting forth the manner and level of compensation to be paid to agents and brokers for the sale of basic health benefit plans and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(14) The program shall be exempt from any and all taxes.

Sec. 40. (1) The director shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers, employees, health care providers, agents, and brokers.

(2) The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to section 38 of this act.

(3)(a) The committee shall recommend benefit levels, cost sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(b) The plans recommended by the committee may include cost-containment features such as:

(i) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(ii) Case management;

(iii) Selective contracting with hospitals, physicians and other

health care providers;

(iv) Reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(v) Other managed care provisions.

(c) The committee shall submit the health benefit plans to the director for approval within one hundred eighty days after the appointment of the committee.

Sec. 41. The board, in consultation with members of the committee, shall study and report at least every three years to the director on the effectiveness of the Small Employer Health Insurance Availability Act. The report shall analyze the effectiveness of the act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report shall address whether carriers, agents, and brokers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the act. The report may contain recommendations for market conduct or other regulatory standards or action.

Sec. 42. Except for specified childhood immunizations of children from birth to six years of age, a statute requiring coverage of a health care service or benefit or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner shall not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to the Small Employer Health Insurance Availability Act.

Sec. 43. The director shall adopt and promulgate rules and regulations to carry out the Small Employer Health Insurance Availability Act.

Sec. 44. (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic health benefit plans and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

(2)(a) Except as provided in subdivision (b) of this subsection, no small employer carrier, agent, or broker shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer; or

(ii) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subdivision (a) of this subsection shall not apply with respect to information provided by a small employer carrier, an agent, or a broker to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3)(a) Except as provided in subdivision (b) of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subdivision (a) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium except that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent or broker, if any, for the sale of a basic health benefit plan or a standard health benefit plan.

(5) No small employer carrier, agent, or broker may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(6) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(7) The director may establish rules and regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(8)(a) A violation of this section by a small employer carrier, an agent, or a broker shall be an unfair trade practice in the business of insurance under the Unfair Insurance Trade Practices Act.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Sec. 45. The director may adopt and promulgate rules and regulations to require small employer carriers, as a condition of transacting business with small employers in this state after the operative date of this section, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after six months prior to the operative date of this section. The director may prescribe such terms for the reissuance of coverage as the director finds are reasonable and necessary to provide continuity of coverage to small employers.

Sec. 46. Notwithstanding section 44-3,131, any expense-incurred group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed after the operative date of this section or any expense-incurred individual sickness and accident insurance policy or subscriber contract delivered or issued for delivery after such date that provides coverage for a dependent child under six years of age shall provide coverage for childhood immunizations. Benefits for childhood immunizations shall be exempt from any deductible provision contained in the applicable policy. Copayment, coinsurance, and dollar-limit provisions applicable to other medical services may be applied to the childhood immunization benefits. This section shall not apply to any individual or group policies that provide coverage for a specified disease, accident-only coverage, hospital indemnity coverage, medicare supplement coverage, long-term care coverage, or other limited benefit coverage.

For purposes of this section, childhood immunizations shall mean the complete set of vaccinations for children from birth to six years of age for immunization against measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, and haemophilus influenzae type B.

Sec. 47. That section 44-210, Revised Statutes Supplement, 1992, be amended to read as follows:

44-210. Every domestic stock and mutual company and assessment association shall hold an annual meeting of its shareholders, if a stock company, or of its members, if a mutual company or an assessment association, on or before the 30th day of June in each and every calendar year, for the purpose of receiving the report of its officers and directors, to elect directors whose terms expire, and to transact such other business as may be lawful for it to do. Special meetings of the shareholders or members may be held as may be provided in the articles of incorporation or the bylaws and as otherwise provided by law. Each outstanding share of stock in a stock company and each member in a mutual company or assessment association shall be entitled to one vote on each matter submitted to a vote at an annual or special meeting of the shareholders or members, except as otherwise provided by law and except that any such stock company in its articles of incorporation may provide that the holders of preferred shares of stock shall have no right to vote and, in such event, such shares of stock shall not be entitled to vote. A shareholder or member may vote either in person or by proxy executed in writing by the shareholder or member or by his or her duly authorized attorney in fact appointing any director, officer, shareholder, or member for such purpose. In the case of a mutual company or an assessment association, such proxy may be incorporated into a member's application for insurance or policy. All such proxies shall be filed or on file with the stock or mutual company or assessment association at least five days prior to the day of the meeting, and they shall expire eleven months from their effective date, unless otherwise provided in such proxy, application, or policy. Nothing in this section shall be construed to prohibit or limit the right of a shareholder or member to vote in person or otherwise revoke any such proxy at any time prior to any exercise thereof. In the case of a mutual company or an assessment association, there shall be no quorum requirements for any meeting of members except as set forth in the articles of incorporation or the bylaws of such mutual company or assessment association.

Sec. 48. That section 44-220, Revised Statutes Supplement, 1992, be amended to read as follows:

44-220. In addition to the general power and authority to borrow

money for its regular business purposes, any domestic insurance company may borrow money: ~~without discount or the payment of commission.~~ (1) To defray the reasonable expenses of its organization; (2) to provide special contingency loss funds; (3) to provide additional surplus funds; (4) to make good any deficiency; and (5) to provide the amount of minimum surplus required by Chapter 44 and may issue its notes therefor, to be known as surplus notes, which shall fully recite the purpose for which the money was borrowed, if application has been made to the Department of Insurance and approval in writing is obtained from the Director of Insurance for the issuance of such surplus notes in a stated maximum amount. The amount thereof outstanding with the unpaid interest shall be stated in each annual report.

Sec. 49. That section 44-221, Revised Statutes Supplement, 1992, be amended to read as follows:

44-221. Except as provided in this section, surplus notes and the indebtedness which they represent shall not be a liability or claim against any of the assets of the company. The principal of such notes may be paid from time to time, either in full or in part, from available surplus funds of the company only when the amount of the surplus of the company over all liabilities is double that of the principal amount then being paid. The ~~corporation~~ company shall have the right to make such repayments whenever it is able to do so, except that the ~~corporation~~ company shall first receive the prior approval of the Director of Insurance for any such repayments. The director shall use the standards set forth in section 44-2136 relating to adequacy of surplus in determining whether or not to approve such repayments. The interest on such notes shall only be payable from the surplus and shall not exceed such sum as may be fixed. ~~nor in any case six percent per annum.~~ Upon a dissolution of the company, the principal and accrued and unpaid interest shall be payable from the surplus.

Sec. 50. That section 44-513, Revised Statutes Supplement, 1992, be amended to read as follows:

44-513. Whenever any insurer ~~shall provide~~ provides by contract, policy, certificate, or any other means whatsoever for a service, or for the partial or total reimbursement, payment, or cost of a service, to or on behalf of any of its policyholders, group policyholders, subscribers, or group subscribers or any person or group of persons, which service may be legally performed by a person licensed in this state for the practice of osteopathic medicine and surgery, chiropractic, optometry, psychology, dentistry, ~~or~~ podiatry, or mental health practice, the person rendering such service or such policyholder, subscriber, or other person shall be entitled to such partial or total reimbursement, payment, or cost of such service, whether the service is performed by a duly licensed medical doctor or by a duly licensed osteopathic physician, chiropractor, optometrist, psychologist, dentist, ~~or~~ podiatrist, or mental health practitioner. This section shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113.

Sec. 51. That section 44-760, Revised Statutes Supplement, 1993, be amended to read as follows:

44-760. Group sickness and accident insurance is hereby declared to be that form of sickness and accident insurance covering groups of persons, with or without their dependents, and issued upon the following basis:

(1) Under a policy issued to an employer, who shall be deemed the policyholder, insuring at least ~~five~~ three employees of such employer, for the benefit of persons other than the employer. The term employees as used herein shall be deemed to include the officers, managers, and employees of the employer, the partners if the employer is a partnership, the members if the employer is a limited liability company, the officers, managers, and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners, and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The policy may provide that the term employees shall include retired employees. The term employer as used herein may be deemed to include any municipal or governmental corporation, unit, agency, or department thereof and the proper officers, as such, of any unincorporated municipality or department thereof, as well as private individuals, partnerships, limited liability companies, and corporations.

(2) Under a policy issued to an association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least twenty-five members of the association for the benefit of persons other than the association or its officers or trustees, as such.

(3) Under a policy issued to any other substantially similar group which, in the discretion of the director, may be subject to the issuance of a group sickness and accident policy or contract.

(4) Under a policy issued to any other group as authorized by Chapter 44, article 16.

(5) Under a health benefit policy issued to an association consisting solely of Nebraska residents which has a constitution and bylaws and which insures at least twenty-five or more of the members of the association. For purposes of this subdivision, policy shall not include accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, specified disease insurance, hospital confinement indemnity insurance, or limited benefit health insurance.

Sec. 52. Sections 52 to 58 of this act shall be known and may be cited as the Standardized Health Claim Form Act.

Sec. 53. The purposes of the Standardized Health Claim Form Act are to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized and increase efficiency in the reimbursement of health care through standardization, and encourage the use of electronic data interchange of health care expenses and reimbursement.

Sec. 54. For purposes of the Standardized Health Claim Form Act:

(1) Ambulatory surgical facility shall mean a facility, not a part of a hospital, which provides surgical treatment to patients not requiring hospitalization and which is licensed as a health clinic as defined by section 71-2017.01 but shall not include the offices of private physicians or dentists whether for individual or group practice;

(2) Health care shall mean any treatment, procedure, or intervention to diagnose, cure, care for, or treat the effects of disease or injury or congenital or degenerative condition;

(3) Health care practitioner shall mean an individual or group of individuals in the form of a partnership, limited liability company, or corporation licensed, certified, or otherwise authorized or permitted by law to administer health care in the course of professional practice and shall include the health care professions and occupations which are regulated in Chapter 71;

(4) Hospital shall mean a hospital as defined by section 71-2017.01 except state hospitals administered by the Department of Public Institutions;

(5) Institutional care providers shall mean all facilities licensed or otherwise authorized or permitted by law to administer health care in the ordinary course of business and shall include all facilities defined in section 71-2017.01;

(6) Issuer shall mean an insurance company, fraternal benefit society, health maintenance organization, third-party administrator, or other entity reimbursing the costs of health care expenses;

(7) Medicaid shall mean the medical assistance program pursuant to sections 68-1018 to 68-1025;

(8) Medicare shall mean Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended; and

(9) Uniform claim form shall mean the claim forms and electronic transfer procedures developed pursuant to section 55 of this act.

Sec. 55. The Director of Insurance shall develop uniform claim forms and uniform electronic transfer procedures for issuers, institutional care providers, and health care practitioners. The director shall consult with interested individuals and associations who have expertise in the development and maintenance of uniform claim forms and procedures. The director shall utilize forms available from state and federal sources and may modify such forms to meet the specific needs for health care in this state.

Sec. 56. No issuer, institutional care provider, or health care practitioner shall contract with any person or employer, union, or other organization under which health care services or benefits are provided unless such person or organization accepts and utilizes or agrees to accept and utilize the uniform claim form for claims for health care services and benefits provided to employees or members.

Sec. 57. Each hospital and ambulatory surgical facility shall issue and complete a billing invoice on the uniform claim form for outpatient and inpatient services provided by the hospital or ambulatory surgical facility as a condition of reimbursement by medicaid, medicare, and issuers.

Sec. 58. Any person who knowingly violates or knowingly aids or abets in the violation of the Standardized Health Claim Form Act or who fails to perform any duty under such act shall be guilty of a Class III misdemeanor. Any issuer who violates the act shall be subject to license revocation by the Department of Insurance.

Sec. 59. That section 44-1525, Revised Statutes Supplement, 1993, be amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any sickness and accident insurance policy or in the benefits payable thereunder, in any of the terms or conditions of such policy, or in any other manner, except that this subdivision shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113;

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

location of the risk unless:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) Making false or fraudulent statements or representations on or relative to an application for a policy for the purpose of obtaining a fee,

commission, money, or other benefit from any insurer, agent, broker, or individual person;

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

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

Sec. 60. That section 44-4228, Revised Statutes Supplement, 1992, be amended to read as follows:

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

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

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

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

Sec. 61. That section 48-144.03, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

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

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

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

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

Sec. 62. That section 71-2049, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

71-2049. Except for state hospitals administered by the Department of Public Institutions, each hospital, as defined in section 71-2017.01, and each ambulatory surgical facility, as defined in section ~~71-2065~~ 54 of this act, shall, upon written request of a patient or third-party payor on behalf of a patient, include in such patient's or payor's bill an itemized list of all expenses such patient incurred during his or her stay at such hospital or ambulatory surgical facility. Such expenses shall include, but not be limited to, the cost of (1) X-rays, (2) laboratory fees, (3) respiratory therapy services, (4) oxygen, (5) pharmaceuticals, (6) take-home drugs, (7) chargeable medical supplies, (8) central service supplies, (9) medical equipment, (10) room and board, and (11) all additional charges incurred by the patient. The right to request such information shall be clearly and conspicuously stated in each patient's or payor's bill. The patient or payor shall receive a copy of the itemized bill within fourteen days after the hospital receives the request. Such request shall be made by the patient or payor within twenty-eight days after the date of discharge.

Upon receipt of an itemized list, a patient or payor may request and the hospital or ambulatory surgical facility shall provide an explanation of any or all expenses or services included on the itemized list. The patient or payor shall make a request for such explanation within twenty-eight days of receipt of an itemized list. The patient or payor shall receive the explanation within fourteen days after the hospital or ambulatory surgical facility receives the request.

Any person who violates this section shall be guilty of a Class IV misdemeanor.

Sec. 63. Sections 1 to 46, 52 to 59, 62, and 65 of this act shall become operative on January 1, 1995. Sections 47 to 51, 61, and 66 of this act shall become operative three calendar months after the adjournment of this legislative session. The other sections of this act shall become operative on their effective date.

Sec. 64. If any section in this act or any part of any section shall be declared invalid or unconstitutional, such declaration shall not affect the validity or constitutionality of the remaining portions thereof.

Sec. 65. That original section 71-2049, Reissue Revised Statutes of Nebraska, 1943, and section 44-1525, Revised Statutes Supplement, 1993, and also sections 71-2062 to 71-2066, 71-2068 to 71-2072, 71-2074, and 71-2077, Reissue Revised Statutes of Nebraska, 1943, and sections 71-2067 and 71-2073, Revised Statutes Supplement, 1993, are repealed.

Sec. 66. That original section 48-144.03, Reissue Revised Statutes of Nebraska, 1943, sections 44-210, 44-220, 44-221, and 44-513, Revised Statutes Supplement, 1992, and section 44-760, Revised Statutes Supplement, 1993, and also sections 44-5201 to 44-5213 and 44-5215 to 44-5222, Revised Statutes Supplement, 1992, and section 44-5214, Revised Statutes Supplement, 1993, are repealed.

Sec. 67. That original section 44-4228, Revised Statutes Supplement, 1992, is repealed.

Sec. 68. Since an emergency exists, this act shall be in full force

and take effect, from and after its passage and approval, according to law.