LEGISLATIVE BILL 473

Approved by the Governor May 23, 1995

Introduced by Landis, 46

AN ACT relating to insurance; to amend sections 44-749, 44-4101, and 44-4110, Reissue Revised Statutes of Nebraska, and sections 44-513 and 44-1525, Revised Statutes Supplement, 1994; to provide requirements for preferred provider policies and contracts; to harmonize provisions; and to repeal the original sections.

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

Section 1. Section 44-513, Revised Statutes Supplement, 1994, is amended to read:

44-513. Whenever any insurer 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, 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, 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 and section 4 of this act.

Sec. 2. Section 44-749, Reissue Revised Statutes of Nebraska, is amended to read:

44-749. No sickness and accident insurer shall make or permit any unfair discrimination between individuals of substantially the same hazard in the amount of premium rates charged for any policy or contract of such insurance or in the benefits payable thereunder. This section shall not prohibit different premium rates, different benefits, or different underwriting procedure for individuals insured under group, family expense, franchise, or blanket plans of insurance. This section shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113 and section 4 of this act.

Sec. 3. Section 44-1525, Revised Statutes Supplement, 1994, is amended to read:

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

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

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

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

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

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

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

(f) Misrepresents for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion, or surrender of any policy, including intentionally 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 and section 4 of this act;

(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, 44-2132 to 44-2134, 44-3606, 44-4809, 44-4812, 44-4817, or 44-5266.

Sec. 4. Policies or contracts authorized by sections 44-4109 and 44-4110 are subject to the following requirements:

(1) A prospective insured shall be provided information about the terms and conditions of the insurance arrangement to enable him or her to make an informed decision about accepting a system of health care delivery. If the insurance arrangement is described orally to a prospective insured, the description shall use easily understood, truthful, and objective terms. All written descriptions shall be in a readable and understandable format. Specific items that shall be included are:

(a) Coverage provisions, benefits, and any exclusions by category of service, provider, or physician and, if applicable, by specific service;

(b) Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, and postpayment review, the manner in which an insured may obtain review of a denial of coverage, and the nature of any liability an insured may incur if the insured does not comply with the authorization requirements of the policy, contract, certificate, or other materials; and

(c) Information on the insured's financial responsibility for payment for deductibles, coinsurance, or other noncovered services;

(2) If an insurer conducts customer satisfaction surveys concerning an insurance arrangement, the results of such surveys shall be made available upon request to existing and prospective participants in insurance arrangements;

(3) The policy, contract, certificate, or other materials shall establish a mechanism by which a committee of preferred providers will be involved in reviewing and advising the insurance arrangement about medical policy, including coverage of new technology and procedures, quality and credentialing criteria, and medical management procedures;

(4) All policies or contracts shall have a system for credentialing participating preferred providers and shall allow all providers within the insurance arrangement's geographic service area to apply for such credentials periodically and not less than annually. The credentialing process:

(a) Shall begin upon application of a provider for inclusion in the policy or contract; and

(b) Shall be based solely on quality, accessibility, or economic considerations and shall be applied in accordance with reasonable business judgment.

Credentialing standards or criteria shall be made available, upon request, to providers and insureds;

(5) If the policy or contract is with an organized delivery system formed by insurers, hospitals, physicians, or allied health professionals, or a combination of such entities, participation by a provider may be limited to a participant in the organized delivery system or to providers having staff privileges at a particular health care facility;

(6) If an insurer or a participant in an insurance arrangement refuses to contract with a provider, the provider shall be permitted to appeal the adverse decision. A person conducting the provider-appeal procedure may be employed by the insurer or participant in an insurance arrangement if the person does not initially participate in the decision to take adverse action against the provider. The provider-appeal procedure shall include, but not be limited to, notice of the date and time of the hearing, a statement of the criteria or standards on which the decision was based, an opportunity for the provider to review information upon which the adverse decision was based, an opportunity for the provider to appear personally at the hearing and present any additional information, and a timely decision on the appeal;

(7) If the insurer or participant in an insurance arrangement excludes or fails to retain a provider previously contracted with to provide health care services, the provider shall be permitted to appeal the adverse decision in the same manner as set forth in subdivision (6) of this section. If the provider disagrees with the decision, the provider shall be permitted to appeal to an appeals committee consisting of one person selected by each party to the appeal and one person mutually agreeable to both parties. The parties to the appeal shall pay to the appeal committee any costs associated with the person they select and shall share the costs of the person mutually agreeable to both parties, which costs shall not be recoverable by the other party;

(8) Prior to initiation of a proceeding to terminate a provider's participation, the provider shall be given an opportunity to enter into and complete a corrective action plan, except in cases of fraud or imminent harm to patient health or when the provider's ability to provide services has been restricted by an action, including probation or any compliance agreements, by the Department of Health or other governmental agency; and

(9) Policies and contracts shall not exclude providers with practices containing a substantial number of patients having severe or expensive medical conditions, except that this section shall not prohibit plans from excluding providers who fail to meet the insurance arrangement's criteria for quality, accessibility, or economic considerations.

Sec. 5. Section 44-4101, Reissue Revised Statutes of Nebraska, is amended to read:

44-4101. For the purposes of sections 44-4101 to 44-4113 and section 4 of this act, unless the context otherwise requires, the definitions found in sections 44-4102 to 44-4107 shall be used.

Sec. 6. Section 44-4110, Reissue Revised Statutes of Nebraska, is amended to read:

44-4110. All providers of health services in Nebraska may develop preferred provider organizations and contract with insurers and participants in insurance arrangements if such providers have met all licensure and certification requirements necessary to practice a specific profession or to operate a specific health care facility pursuant to Chapter 71. An organization of preferred providers may limit itself to one or more specific professions or specialties within a profession, as defined in Chapter 71, and

may limit the number of participating providers to that required to adequately meet the need for its particular program and the purpose of sections 44-4101 to 44-4113 and section 4 of this act to furnish health services in a manner reasonably expected to contain or lower costs.

Sec. 7. Original sections 44-749, 44-4101, and 44-4110, Reissue Revised Statutes of Nebraska, and sections 44-513 and 44-1525, Revised Statutes Supplement, 1994, are repealed.