LEGISLATIVE BILL 419

Approved by the Governor June 5, 1991

Introduced by Wesely, 26; Schellpeper, 18

AN ACT relating to insurance; to amend sections 44-4001, 44-4225, and 44-4234, Reissue Revised Statutes of Nebraska, 1943, and sections 44-4227 and 44-4228, Revised Statutes Supplement, 1990; to require and provide for the use of records on agents and brokers; to change provisions relating to the Comprehensive Health Insurance Pool; to require studies and a report; to adopt the Small Employer Health Insurance Act and the Health Insurance Access Act; to require the payment of interest on proceeds due under a life insurance policy; to harmonize provisions; to provide duties for the Revisor of Statutes; to appropriate funds; to provide operative dates; to repeal the original sections; and to declare an emergency.

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

Section 1. (1) The director shall keep a record on each agent and broker licensed pursuant to the Insurance Producers Licensing Act which contains at least the following information:

(a) The name and address of the employing insurance agency and any license number;

(b) The number of written complaints submitted to the director within the preceding five years, if submitted on or after the operative date of this section, involving the agent or broker; and

(c) Any disposition or other resolution of the written complaints, including any fine or other disciplinary action taken by the director in response to a complaint, or a notation that disposition is pending.

(2) A copy of the record on an agent or broker shall be available upon request to any insurer as defined in section 44-103 which holds a certificate of authority to transact the business of insurance in this state and which is considering appointing the subject agent or contracting with the subject broker pursuant to the Insurance Producers Licensing Act. Information contained in a record shall not be used by an insurer, agent, broker, or insurance agency for purposes of

obtaining a competitive advantage. Use of such information for purposes of obtaining a competitive advantage shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act. Any insurer requesting a record shall provide an employment application or other evidence that the subject agent is seeking appointment by or the subject broker is seeking to contract with the requesting insurer and a written authorization signed by the subject agent or broker and shall pay the director a fee sufficient to cover the cost of providing the report. The director and any employee of the department shall not be liable to an agent or broker for releasing any information required by this section.

(3) An agent or broker shall have access to his or her record for purposes of review. The agent or broker may include a statement of rebuttal to any written complaint included in the record. The agent or broker shall have access to the record only during normal business hours observed by the director.

Sec. 2. That section 44-4001, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

44-4001. Sections 44-4001 to 44-4044 and section 1 of this act shall be known and may be cited as the Insurance Producers Licensing Act.

Sec. 3. That section 44-4225, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

44-4225. (1) Following the close of each calendar year, the board shall determine the paid and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Each member's proportion of participation in the pool shall be determined annually by the board on the basis of annual statements and other reports deemed necessary by the board and filed with the department or with the board by the member.

(3) Each ~~insurer's~~ member's assessment shall be determined by multiplying the total net loss from operation of the pool by a fraction. The ~~,~~ ~~the~~ numerator ~~of which equals~~ shall equal that ~~insurer's~~ member's premium and subscriber contract charges for health insurance written and renewed in the state during the preceding calendar year. The ~~and the~~ denominator ~~of which equals~~ shall equal the total of all premiums and subscriber contract charges of insurers for health insurance written or renewed in the state during the

preceding calendar year. Health insurance premiums and subscriber contract charges producing assessments ~~that are~~ less than ~~an~~ the amount determined by the board to justify the cost of collection shall not be considered for the purpose of determining assessments.

(4) Any deficit incurred by the pool shall be recouped by assessments apportioned among the members in the manner specified in subsection (3) of this section by the board. ~~among the members.~~

(5) If assessments exceed the net loss of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums.

(6) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred, in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments ~~set forth~~ specified in subsection (3) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for four years. In the event an assessment which was previously abated or deferred is later recovered by the pool, the board shall credit such recovery against future assessments made against the other members of the pool who paid the assessment as a result of such abatement or deferral.

(7) If any member fails to pay an assessment when due as required by subdivision (5) of section 44-4220, the director may, after notice and hearing, take either or both of the following actions unless such payment is deferred by the board as provided for in subsection (6) of this section: (a) Suspend or revoke the member's certificate of authority to transact insurance business in this state; or (b) impose a monetary penalty of one hundred dollars per day, not to exceed an aggregate of ten thousand dollars, accruing from the date the assessment is due.

Sec. 4. That section 44-4227, Revised Statutes Supplement, 1990, be amended to read as follows:

44-4227. Premium rates charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Rates shall directly relate to the coverage provided, risk

experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age, sex, and area variation in claim costs in accordance with established actuarial and underwriting practices.

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

Sec. 5. That section 44-4228, Revised Statutes Supplement, 1990, be amended to read as follows:

44-4228. Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition (1) which had manifested itself during the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment or (2) for which medical advice, care, or treatment was recommended or received during the six-month period immediately preceding the effective date of coverage. This section shall not apply to a person who has received medical assistance pursuant to 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. 6. That section 44-4234, Reissue Revised Statutes of Nebraska, 1943, be amended to read as follows:

44-4234. The pool shall be operational and shall provide health insurance to eligible persons no later than January 1, 1987.

After two years of operation of the pool, the board shall conduct a study of the claims loss experience of the pool and adjust the plan of operation and the benefits plan to reflect the findings of the study with the approval of the director. The board may also recommend amendments to the Comprehensive Health Insurance Pool Act to the Legislature to address the claims loss experience of the pool.

The department shall conduct studies of the feasibility of a needs-based premium rate structure, alternative funding sources for the pool, the composition of and the procedure for appointing the board, how the annual premium rate is established and implemented, provider reimbursement methodology, cost containment strategies, strategies to address the practice of intentional separation of employees from their employers group health coverage in order to place employees in the pool, and other relevant matters and shall submit a report of its recommendations to the Governor and the Legislature not later than December 1, 1991.

Sec. 7. Sections 7 to 28 of this act shall be known and may be cited as the Small Employer Health Insurance Act.

Sec. 8. It is the intent of the Small Employer Health Insurance Act to promote the availability of health insurance to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for small employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

Sec. 9. For purposes of the Small Employer Health Insurance Act, the definitions found in sections 10 to 21 of this act shall be used.

Sec. 10. Actuarial certification shall mean a written statement by a member of the American Academy of Actuaries or any other person acceptable to the director that a small employer carrier is in compliance with section 23 of this act based upon an examination which includes a review of the appropriate records and of the actuarial assumptions and methods utilized by the

carrier in establishing premium rates for the applicable health benefit plans.

Sec. 11. Base premium rate shall mean, for each class of business as to a rating period, the lowest premium rate charged or which could be 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. 12. Carrier shall mean any person who provides health insurance in this state. Carrier shall include a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple-employer welfare arrangement, or any other person providing a plan of health insurance subject to state insurance regulation.

Sec. 13. Case characteristics shall mean demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue shall not be case characteristics for the purposes of the Small Employer Health Insurance Act.

Sec. 14. Class of business shall mean all or a distinct grouping of small employers as shown on the records of the small employer carrier. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(1) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(2) Have been acquired from another small employer carrier as a distinct grouping of plans;

(3) Are provided through an association with membership of not less than five small employers which has been formed for purposes other than obtaining insurance; or

(4) Are for a class of business that meets the requirements for exception to the restrictions related to premium rates provided in subdivision (1)(a) of section 23 of this act.

A carrier may establish no more than two additional groupings under each of subdivisions (1) through (4) of this section on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs. The director may

approve the establishment of additional groupings upon application and a finding that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

Sec. 15. Director shall mean the Director of Insurance.

Sec. 16. Health benefit plan or plan shall mean any hospital or medical expense-incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan shall not include accident-only, credit, dental, or disability income insurance coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

Sec. 17. Index rate shall mean, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Sec. 18. New business premium rate shall mean, for each class of business as to a rating period, the premium rate 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. 19. Rating period shall mean the calendar period for which premium rates established by a small employer carrier are assumed to be in effect as determined by the small employer carrier.

Sec. 20. Small employer shall mean any person, firm, corporation, partnership, or association actively engaged in business which, on at least fifty percent of its working days during the preceding year, employed no more than twenty-five eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of taxation shall be considered one employer.

Sec. 21. Small employer carrier shall mean any carrier which offers health benefit plans covering the employees of a small employer.

Sec. 22. The Small Employer Health Insurance Act shall apply to each health benefit plan for a small employer that is delivered, issued for delivery, renewed, or continued in this state after the operative date of this section. For purposes of this section, the date a plan is continued shall be the first rating period which commences after the operative date of this

section.

The act shall apply to any such health benefit plan which provides coverage to one or more employees of a small employer, except that the act shall not apply to individual health insurance policies which are subject to approval of policy form and premium rate by the director.

Sec. 23. Premium rates for health benefit plans shall be subject to the following requirements:

(1) 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. This requirement shall not apply to a class of business if:

(a) The class of business is one for which the small employer carrier does not reject and never has rejected small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis based upon their claim experience or health status;

(b) The carrier does not involuntarily transfer and never has involuntarily transferred a health benefit plan into or out of the class of business; and

(c) The class of business is currently available for purchase;

(2) 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 which 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;

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

(a) 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 a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(b) An 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 carrier's rate manual for the class

of business; and

(c) 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; and

(4) In health benefit plans issued prior to the operative date of this section, a premium rate for a rating period may exceed the ranges described in subdivision (1) or (2) of this section for a period of five years following such date and the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period shall not exceed the sum of:

(a) 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 a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) 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.

Nothing in this section shall be construed to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

A small employer carrier shall not involuntarily transfer a small employer 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 since issue.

Sec. 24. (1) Except as provided in subsection (2) of this section, a health benefit plan shall be renewable to all eligible employees and dependents at the option of the small employer except for the following reasons:

(a) Nonpayment of required premiums;

(b) Fraud or misrepresentation of the small employer or, with respect to coverage of an insured individual, fraud or misrepresentation by the insured individual or such individual's representative;

(c) Noncompliance with plan provisions;

(d) The number of individuals covered under the plan is less than the number or percentage of eligible individuals required by percentage requirements under the plan; or

(e) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

(2) A small employer carrier may cease to renew all health benefit plans under a class of business. The carrier shall provide notice to all affected plans and to the director or commissioner of insurance in each state in which an affected insured individual is known to reside at least ninety days prior to termination of coverage. A carrier which exercises its right to cease to renew all plans in a class of business shall not:

(a) Establish a new class of business for a period of five years after the nonrenewal of the plans without prior approval of the director; or

(b) Transfer or otherwise provide coverage to any of the small employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status, or duration of coverage.

Sec. 25. Each small employer carrier shall make reasonable disclosure in solicitation and sales materials provided to small employers of:

(1) The extent to which premium rates for a specific small employer are established or adjusted due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer;

(2) The provisions concerning the carrier's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates;

(3) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

(4) The provisions relating to renewability of coverage.

Sec. 26. 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 which demonstrate that its rating

methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. A small employer carrier shall make the information and documentation described in this section available to the director upon request. 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 carrier or as ordered by a court of competent jurisdiction. Each small employer carrier shall file each March 1 with the director an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the certification shall be retained by the carrier at its principal place of business.

Sec. 27. The director may suspend all or any part of section 23 of this act as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the director that either the suspension is reasonable in light of the financial condition of the carrier or the suspension would enhance the efficiency and fairness of the small employer health insurance marketplace.

Sec. 28. The director may adopt and promulgate rules and regulations to carry out the Small Employer Health Insurance Act.

Sec. 29. Sections 29 to 39 of this act shall be known and may be cited as the Health Insurance Access Act.

Sec. 30. The Legislature finds and declares that there is an increasing number of Nebraskans who lack health insurance and that these uninsured people include many individuals who cannot afford the rising cost of medical care but do not qualify for the various income-based assistance programs. The lack of financial means of uninsured people to pay for their medical care leaves health care providers with uncollectible debts which are transferred to other patients and to insurers. It is the purpose and intent of the Legislature to provide a mechanism to allow insurers to provide basic levels of health insurance to those people who are uninsured, are below certain income levels, and are not qualified for income-based assistance programs.

Sec. 31. For purposes of the Health Insurance Access Act:

(1) Insurer shall mean any insurance company

as defined in section 44-103 authorized to transact health insurance business in the State of Nebraska or a health maintenance organization which has obtained a valid certificate of authority;

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

(3) Provider shall mean any physician or hospital who is licensed or authorized in this state to furnish medical care or hospitalization to any individual;

(4) Spell of illness shall mean a continuous period as a hospital inpatient or successive periods as a hospital inpatient when the date of discharge and the following date of admission are less than sixty consecutive days apart; and

(5) Uninsured access coverage shall mean a policy of sickness and accident insurance or a contract for health care services covering individuals, with or without their dependents, issued by an insurer subject to the limitations and requirements in the act.

Sec. 32. Policies of sickness and accident insurance and contracts for health care services issued pursuant to the Health Insurance Access Act shall be subject to all applicable provisions of Chapter 44 except as otherwise provided in such chapter.

Sec. 33. (1) An uninsured access coverage policy or contract shall limit eligibility to individuals or families:

(a) Whose gross income does not exceed one hundred eighty-five percent of income standards prescribed by the federal Office of Management and Budget income poverty guidelines in effect on February 1, 1991, or as may be later amended; and

(b) Who are not eligible for medicare or any other medical assistance program, including, but not limited to, the program established pursuant to sections 68-1018 to 68-1025.

(2) Every uninsured access coverage policy or contract shall specify the time period, not exceeding six months, for which any applicant is required to demonstrate eligibility based upon the income standards of such policy or contract, and every such policy or contract shall specify what constitutes sufficient verification of income at the time of application and annual renewals.

(3) If an individual's or a family's income exceeds the income eligibility standards of the uninsured access coverage policy or contract and such

individual or family is thereby no longer eligible for continued coverage, the uninsured access coverage policy or contract shall allow a transfer to a designated type of individual policy or contract without evidence of insurability and without interruption in coverage subject to payment of premiums. Each uninsured access coverage policy or contract shall specify the type of individual policy or contract to which an insured person may transfer.

Sec. 34. (1) An individual or a family member shall not be eligible for initial or continued coverage under an uninsured access coverage policy or contract if he or she:

(a) Is eligible as an employee or dependent for group insurance coverage sponsored or maintained by an employer;

(b) Is covered by any other type of hospital, surgical, or medical expense-incurred policy or health maintenance organization contract; or

(c) Exceeds the income eligibility standards of the uninsured access coverage policy or contract at any time or at any annual renewal.

(2) An uninsured access coverage policy or contract may require evidence of insurability but shall not use underwriting guidelines that are more strict than those normally used by the insurer for its regular individual health insurance contracts.

Sec. 35. (1) Every uninsured access coverage policy or contract shall include hospital-only and surgical-only benefits which shall mean:

(a) Inhospital benefits for not less than thirty continuous days nor more than ninety continuous days for each spell of illness; and

(b) Surgical benefits for both inpatient and outpatient surgery.

(2) An uninsured access coverage policy or contract may not:

(a) Use a definition of spell of illness more restrictive than the definition found in section 31 of this act; or

(b) Use a definition of preexisting condition more restrictive than the definition normally used by the insurer for its regular individual health insurance contracts.

(3) Every uninsured access coverage policy or contract shall provide that the benefit payment shall be accepted as payment in full by the provider and there shall be no deductible or coinsurance charged to the insured.

Sec. 36. Each uninsured access coverage policy or contract shall include:

(1) A reasonable description of the geographic area or areas to be served; and

(2) A listing of the providers who have a contract with the insurers to furnish health care services.

Sec. 37. Notwithstanding any other provision of law, every uninsured access coverage policy or contract shall be exempt from any and all mandated benefits which require coverage of any type of services or conditions.

Sec. 38. An insurer issuing an uninsured access coverage policy or contract may enter into contracts to arrange for health services by certain providers, may limit the number and types of providers with which it contracts, and shall not be required to provide benefits for services furnished by providers who do not contract with the insurer.

Sec. 39. The Director of Insurance may adopt and promulgate rules and regulations to carry out the Health Insurance Access Act.

Sec. 40. Any insurance company authorized to do business in this state shall pay interest on any proceeds due on a life insurance policy if:

(1) The insured was a resident of this state on the date of death;

(2) The date of death was on or after the operative date of this section;

(3) The beneficiary elects in writing to receive the proceeds in a lump-sum payment; and

(4) The proceeds are not paid to the beneficiary within thirty days of receipt of proof of death of the insured by the insurance company.

Interest shall accrue from the date of receipt of proof of death to the date of payment at the rate calculated pursuant to section 45-103 in effect on January 1 of the calendar year in which occurs the date of receipt of proof of death. For purposes of this section, date of payment shall include the date of the postmark stamped on an envelope, properly addressed and postage prepaid, containing the payment.

If an action is commenced to recover the proceeds, this section shall not require the payment of interest for any period of time for which interest is awarded pursuant to sections 45-103 to 45-103.04.

Sec. 41. The Revisor of Statutes shall assign section 40 of this act within Chapter 44, article 3, and any reference to Chapter 44, article 3, shall be

construed to include section 40 of this act.

Sec. 42. There is hereby appropriated (1) $187,078 from the Department of Insurance Cash Fund for FY1991-92 and (2) $101,066 from the Department of Insurance Cash Fund for FY1992-93 to the Department of Insurance, for Program 69, to aid in carrying out the provisions of this act.

Total expenditures for permanent and temporary salaries and per diems from funds appropriated in this section shall not exceed $79,884 for FY1991-92 or $67,201 for FY1992-93.

Sec. 43. Sections 1, 2, 7 to 28, and 44 of this act shall become operative October 1, 1991. The other sections of this act shall become operative on their effective date.

Sec. 44. That original section 44-4001, Reissue Revised Statutes of Nebraska, 1943, is repealed.

Sec. 45. That original sections 44-4225 and 44-4234, Reissue Revised Statutes of Nebraska, 1943, and sections 44-4227 and 44-4228, Revised Statutes Supplement, 1990, are repealed.

Sec. 46. Since an emergency exists, this act shall be in full force and take effect, from and after its passage and approval, according to law.