LEGISLATIVE BILL 837

Approved by the Governor May 3, 1995

Introduced by Wesely, 26

AN ACT relating to health care; to amend section 44-4233, Reissue Revised Statutes of Nebraska, and sections 44-5253, 44-5256, and 44-5260, Revised Statutes Supplement, 1994; to change provisions relating to Comprehensive Health Insurance Pool assessments and small employer health insurance; to adopt the Health Care Purchasing Pool Act; to repeal the original sections; and to declare an emergency.

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

Section 1. Section 44-4233, Reissue Revised Statutes of Nebraska, is amended to read:

44-4233. (1) Any member subject to premium and related retaliatory tax liability imposed by section 44-150 or 77-908 may offset assessments paid to the pool by such member against its tax liability in the year of payment or subsequent years. For tax years commencing on or after January 1, 1992, the member may offset such paid assessments against (a) subsequent premium tax prepayments imposed by section 77-918, (b) subsequent premium tax payments imposed by section 77-908, and (c) related retaliatory tax liability imposed by section 44-150. Prior to January 1, ~~1996~~ 1998, no individual member shall be subject to any liability of the pool in excess of its premium and related retaliatory tax liability which may be offset under this section.

(2) Commencing with assessments imposed or paid in 1991 and for all subsequent years prior to January 1, ~~1996~~ 1998, whenever it reasonably appears to the satisfaction of the board that a member has during a calendar year paid assessments that exceed that member's premium and related retaliatory tax liability for that calendar year, the board shall, upon request from such member, order the refund to that member of the amount of the assessment that exceeded that member's premium and related retaliatory tax liability. A member's request for a refund shall be filed with the board not later than thirty days after the due date of the member's premium tax return filed with the department. If the refund is not made by the board within thirty days after receipt of the refund request, the member may within thirty days thereafter initiate a suit in district court for the amount claimed. The suit shall be heard by the district court de novo. In the event that an assessment against a member is limited by reason of that member's premium and related retaliatory tax liability, the amount by which the assessment is limited may be assessed against the other members in a manner consistent with the basis for assessments specified in subsection (3) of section 44-4225.

Sec. 2. Section 44-5253, Revised Statutes Supplement, 1994, is amended to read:

44-5253. 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~~ fifty 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. 3. Section 44-5256, Revised Statutes Supplement, 1994, is amended to read:

44-5256. (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~~

(a) To eligible employees of a small employer if the ~~arrangements~~ arrangement with the small employer ~~meet~~ was established prior to January 1,

1995, and met any of the conditions set forth in subsection (1) of this section; or ~~and were established prior to January 1, 1995~~

(b) On or after January 1, 1995, to eligible employees of a small employer if the small employer had fewer than three eligible employees when the arrangement was established regardless of whether the small employer subsequently employs three or more employees.

~~(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 44-5258 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. 4. Section 44-5260, Revised Statutes Supplement, 1994, is amended to read:

44-5260. (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~~ fifty 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 44-5262, 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~~ fifty 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. 5. Sections 5 to 8 of this act shall be known and may be cited as the Health Care Purchasing Pool Act.

Sec. 6. The Legislature recognizes that a pooling mechanism offers the potential to purchase health care at more affordable prices. The Legislature further recognizes that health care purchasing pools do not require that all groups have the same type of health care coverage or benefits and that many options are available.

It is the intent of the Legislature to establish a process to determine whether there should be a coordinated purchasing process for some or all publicly sponsored health care coverage in order to reduce costs and to promote the most efficient methods of financing and coordinating health care services. It is also the intent of the Legislature that the process established also determine whether a health care purchasing pool if established should be made available to individuals, small employer groups, and other associations.

Sec. 7. The Director of Health shall report to the Legislature and the Governor by December 1, 1995, as to whether a health care purchasing pool should be established and recommendations concerning who should be included in such a pool. The report should include recommendations for a governing structure for the pool and recommendations concerning the operation and management of the pool.

Sec. 8. The report of the Director of Health under section 7 of this act shall also include:

(1) The benefits of consolidating administrative functions on behalf

of participants in the health care purchasing pool, including claims processing, utilization review, management reports, and benefit management;

(2) Evaluation of potential cost savings;

(3) A recommendation as to whether to place the medical and acute care components of the medical assistance program established under sections 68-1018 to 68-1025 or persons currently participating in the Comprehensive Health Insurance Pool into a health care purchasing pool. The recommendations shall include whether the health care purchasing pool should be available to individuals, small employers, or associations who or which may choose to participate in the pool;

(4) Other recommendations regarding purchasing strategies and techniques for efficient administration that have potential application to all state-purchased health services; and

(5) Recommendations to insure access to quality care, including assuring reasonable access to local providers, especially for persons residing in rural areas.

Sec. 9. Original section 44-4233, Reissue Revised Statutes of Nebraska, and sections 44-5253, 44-5256, and 44-5260, Revised Statutes Supplement, 1994, are repealed.

Sec. 10. Since an emergency exists, this act takes effect when passed and approved according to law.