LEGISLATIVE BILL 862

Approved by the Governor April 2, 1997

Introduced by Banking, Commerce and Insurance Committee:
Landis, 46, Chairperson; Brashear, 4; Jensen, 20; Jones, 43; Schmitt, 41; Tyson, 19; Wesely, 26; Witek, 31; at the request of the Governor

AN ACT relating to insurance; to amend sections 44-4201, 44-4203, 44-4221, and 44-4222, Reissue Revised Statutes of Nebraska, and sections 44-760, 44-4228, 44-4233, 44-5223, 44-5225, 44-5233, 44-5242, 44-5244, 44-5253, 44-5259, 44-5260, and 44-5261, Revised Statutes Supplement, 1996; to provide, change, and eliminate definitions; to establish requirements for health coverages; to change provisions relating to the Comprehensive Health Insurance Pool and the Small Employer Health Insurance Availability Act; to harmonize provisions; to provide an operative date; to repeal the original sections; to outright repeal section 44-5249, Revised Statutes Supplement, 1996; and to declare an emergency.

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

Section 1. For purposes of sections 1 to 18 of this act, the definitions found in sections 2 to 15 of this act shall be used.

Sec. 2. Affiliation period means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.

Sec. 3. Church plan means a plan as defined under 29 U.S.C. 1002.

Sec. 4. Creditable coverage means, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

(3) Part A or Part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 of the act;

(5) 10 U.S.C. 5501 et seq.;

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under 5 U.S.C. 8901 et seq.;

(9) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

(10) A health benefit plan under 22 U.S.C. 2504.

Sec. 5. Director means the Director of Insurance.

Sec. 6. Governmental plan means a plan as defined under 29 U.S.C. 1002 and any plan maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

Sec. 7. Group health plan means an employee welfare benefit plan as defined by 29 U.S.C. 1002 to the extent that the plan provides any hospital, surgical, or medical expense benefits to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

Sec. 8. (1) Health benefit plan means any employer group hospital or medical policy or certificate or employer group health maintenance organization subscriber contract.

(2) Health benefit plan does not include one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for onsite medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) Health benefit plan does not include the following benefits if they are provided under a separate policy, certificate, or contract of

insurance or are otherwise not an integral part of the plan:

(a) Limited-scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) Health benefit plan does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) Health benefit plan does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under 10 U.S.C. 5501 et seq.; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

Sec. 9. Health carrier means any entity that provides a health benefit plan including 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. 10. Health-status-related factor means any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(8) Disability.

Sec. 11. Late enrollee means an eligible employee or dependent who requests enrollment in a health benefit plan 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 each of the following:

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

(b) The individual lost coverage under creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, divorce, or legal separation; and

(c) The individual requests enrollment within thirty days after termination of the creditable 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;

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

(4) The individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted.

Sec. 12. Medical care means amounts paid for:

(1)(a) The diagnosis, care, mitigation, treatment, or prevention of disease or (b) the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in subdivision (1) of this section; and

(3) Insurance covering medical care referred to in subdivisions (1) and (2) of this section.

Sec. 13. Network plan means health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole

or in part, through a defined set of providers under contract with the health carrier.

Sec. 14. Plan sponsor has the meaning given such term under 29 U.S.C. 1002.

Sec. 15. Preexisting condition means a condition whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six months preceding the effective date of coverage. Genetic information shall not be treated as a condition for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.

Sec. 16. (1) A health carrier shall not:

(a) Offer coverage to only certain individuals in an employer group or to only a part of the group except in the case of late enrollees;

(b) Require any individual to pay a premium which is greater than such premium for a similarly situated individual enrolled in the health benefit plan on the basis of any health-status-related factor in relation to the individual or a dependent; or

(c) Establish rules for eligibility and continued eligibility of any individual to enroll under the terms of the health benefit plan based on a health-status-related factor of the individual or a dependent.

(2) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months, or eighteen months in the case of a late enrollee, following the enrollment date of the individual's coverage due to a preexisting condition. Genetic information shall not be treated as a preexisting condition unless there is a diagnosis of the condition related to such information. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section 15 of this act. A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(3) A health benefit plan shall not impose any preexisting condition exclusion:

(a) To an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage, and the individual had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage; or

(b) To a child less than eighteen years of age who is adopted or placed for adoption and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage, and the child had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage.

(4) A health 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 aggregate period of time an individual was previously covered by creditable coverage that provided benefits with respect to such services if the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment 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 plan sponsor or the health carrier. This subsection shall not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(5)(a) A health carrier shall permit an eligible employee or dependent, who requests enrollment following the open enrollment opportunity, to enroll, and the eligible employee or dependent shall not be considered a late enrollee if the eligible employee or dependent:

(i) Was covered under another health benefit plan at the time the eligible employee or dependent was eligible to enroll;

(ii) Stated in writing at the time of the open enrollment period that coverage under another health benefit plan was the reason for declining enrollment but only if the health benefit plan or health carrier required such a written statement and provided a notice of the consequences of such written statement;

(iii) Has lost coverage under another health benefit plan as a result of the termination of employment, the termination of the other health benefit plan's coverage, death of a spouse, legal separation, or divorce or was under a continuation-of-coverage policy or contract available under federal law and the coverage was exhausted; and

(iv) Requests enrollment within thirty days after the termination of coverage under the other health benefit plan.

(b)(i) If a health carrier issues a health benefit plan and makes coverage available to a dependent of an eligible employee and such dependent becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption, then such health benefit plan shall provide for a dependent special enrollment period during which the dependent may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of an eligible employee may be enrolled if otherwise eligible for coverage.

(ii) A dependent special enrollment period shall be a period of not less than thirty days and shall begin on the later of (A) the date such dependent coverage is available or (B) the date of the marriage, birth, adoption, or placement for adoption.

(iii) If an eligible employee seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(A) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(B) In the case of the birth of a dependent, as of the date of birth; and

(C) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(6)(a) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion with respect to any particular coverage option may impose an affiliation period for such coverage option but only if:

(i) Such period is applied uniformly without regard to any health-status-related factors; and

(ii) Such period does not exceed two months or, in the case of a late enrollee, three months.

(b) An affiliation period under a group health plan shall run concurrently with any waiting period under the group health plan.

(c) A health maintenance organization may use alternative methods, from those described in subdivision (6)(a) of this section, to address adverse selection, as approved by the director.

Sec. 17. (1) A health benefit plan shall be renewable with respect to all eligible employees or dependents, at the option of the plan sponsor, except in any of the following cases:

(a) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(b) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

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

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

(e) A health carrier decides to discontinue offering a particular type of group health benefit plan in this state. A health carrier discontinuing such plan shall:

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

(ii) Provide notice of the decision not to renew coverage to all affected plan sponsors, participants, and beneficiaries, and to the commissioner of insurance in each state in which an affected insured individual is known to reside, at least ninety days prior to the nonrenewal of any health benefit plans by the health carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected plan sponsors, participants, and beneficiaries;

(iii) Offer to each plan sponsor provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the health carrier to plan sponsors in this state; and

(iv) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under subdivision (1)(e)(iii) of this section, act uniformly without regard to the claims experience of those plan sponsors or any health-status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

(f) A health carrier decides to discontinue offering and nonrenews all its health benefit plans delivered or issued for delivery to plan sponsors

in this state. A health carrier that discontinues such plans shall:

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

(ii) Provide notice of the decision not to renew coverage to all affected plan sponsors, participants, and beneficiaries, and to the commissioner of insurance 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 health carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected plan sponsors, participants, and beneficiaries; and

(iii) Discontinue all health insurance issued or delivered for issuance in the state's employer market and not renew coverage under any health benefit plan issued to an employer; and

(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 health carrier's ability to meet its contractual obligations.

(2) A health carrier that elects not to renew all of its health benefit plans in the state under subdivision (1)(f) of this section shall be prohibited from writing new business in the large employer market in this state for a period of five years after the date of notice to the director.

(3) A health carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (1) or (2) of this section in the case of the following:

(a) To an eligible person who no longer resides, lives, or works in the service area of the health carrier or in an area for which the health carrier is authorized to do business, but only if coverage is terminated under this section uniformly without regard to any health-status-related factor of covered individuals; or

(b) To a plan sponsor that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the health carrier or in an area for which the health carrier is authorized to do business.

Sec. 18. The director may adopt and promulgate rules and regulations to carry out sections 1 to 18 of this act.

Sec. 19. Section 44-760, Revised Statutes Supplement, 1996, is amended to read:

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 ~~three~~ two 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; ~~or~~

(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; ~~or~~

(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; ~~or~~

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

(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. 20. Section 44-4201, Reissue Revised Statutes of Nebraska, is amended to read:

44-4201. Sections 44-4201 to 44-4235 and sections 22 to 25 of this act shall be known and may be cited as the Comprehensive Health Insurance Pool Act.

Sec. 21. Section 44-4203, Reissue Revised Statutes of Nebraska, is amended to read:

44-4203. For the purposes of the Comprehensive Health Insurance Pool Act, unless the context otherwise requires, the definitions found in sections 44-4204 to 44-4215 and sections 22 to 25 of this act shall be used.

Sec. 22. Church plan shall mean a plan as defined under 29 U.S.C. 1002.

Sec. 23. Creditable coverage shall mean, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

(3) Part A or Part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 of the act;

(5) 10 U.S.C. 5501 et seq.;

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under 5 U.S.C. 8901 et seq.;

(9) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

(10) A health benefit plan under 22 U.S.C. 2504.

Sec. 24. Governmental plan shall mean a plan as defined under 29 U.S.C. 1002 and any plan maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

Sec. 25. Group health plan shall mean an employee welfare benefit plan as defined by 29 U.S.C. 1002 to the extent that the plan provides any hospital, surgical, or medical expense benefits to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

Sec. 26. Section 44-4221, Reissue Revised Statutes of Nebraska, is amended to read:

44-4221. (1) To be eligible to purchase health insurance from the pool, a person shall:

(a) Be ~~be~~ a resident of the state for a period of at least six months and shall:

~~(a)~~ (i) Have received, within six months prior to application to the pool, a rejection in writing, for reasons of health, from an insurer;

~~(b)~~ (ii) Currently have, or have been offered within six months prior to application to the pool, health insurance coverage by an insurer which includes a restrictive rider which limits insurance coverage for a preexisting medical condition for a period of time exceeding twelve months; or

~~(c)~~ (iii) Have been refused health insurance coverage comparable to the pool, or have been offered such coverage at a rate exceeding the premium rate for pool coverage, within six months prior to application to the pool; or

(b) Be a resident of the state for any length of time and be an individual:

(i) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(ii) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;

(iii) With respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(iv) Who had been offered the option of continuation coverage under COBRA or under a similar program, who elected such continuation coverage, and who has exhausted such continuation coverage.

(2) The board may adopt and promulgate a list of medical or health conditions for which a person would be eligible for pool coverage without applying for health insurance pursuant to this section. Persons who can

demonstrate the existence or history of any medical or health conditions on the list adopted and promulgated by the board shall be eligible to apply directly to the pool for insurance coverage.

Sec. 27. Section 44-4222, Reissue Revised Statutes of Nebraska, is amended to read:

44-4222. (1) A person shall not be eligible for initial or continued coverage under the pool if:

(a) He or she is eligible for medicare benefits by reason of age or medical assistance established pursuant to sections 68-1018 to 68-1025;

(b) He or she is a resident or inmate of a correctional facility, except that this subdivision shall not apply if such person is eligible for coverage under subdivision (1)(b) of section 44-4221; ~~or is a resident or inmate of a correctional facility~~;

~~(b)~~ (c) He or she has terminated coverage in the pool unless twelve months have elapsed since such termination, except that this subdivision shall not apply if such person has received and become ineligible for medical assistance pursuant to sections 68-1018 to 68-1025 during the immediately preceding twelve months or if such person is eligible for coverage under subdivision (1)(b) of section 44-4221;

~~(c)~~ (d) The pool has paid out ~~five hundred thousand~~ one million dollars in claims for the person; or

~~(d)~~ (e) He or she is no longer a resident of Nebraska.

(2) Coverage under the Comprehensive Health Insurance Pool Act shall terminate for any person on the date the person becomes ineligible under subsection (1) of this section.

Sec. 28. Section 44-4228, Revised Statutes Supplement, 1996, is amended to read:

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 subdivision (1)(a) of 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 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)(a) 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.

(b) Subsection (1) of this section shall not apply to a person

eligible for pool coverage under subdivision (1)(b) of section 44-4221 as long as application to the pool is made not later than sixty-three days following termination of the person's most recent prior creditable coverage and as long as proof of eligibility under subdivision (1)(b) of section 44-4221 is submitted.

Sec. 29. Section 44-4233, Revised Statutes Supplement, 1996, 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, ~~1998~~ 2000, 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, ~~1998~~ 2000, 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. 30. Section 44-5223, Revised Statutes Supplement, 1996, is amended to read:

44-5223. Sections 44-5223 to 44-5267 and sections 32 to 35, 37, 38, and 40 to 43 of this act shall be known and may be cited as the Small Employer Health Insurance Availability Act.

Sec. 31. Section 44-5225, Revised Statutes Supplement, 1996, is amended to read:

44-5225. For purposes of the Small Employer Health Insurance Availability Act, the definitions found in sections 44-5226 to 44-5255 and sections 32 to 35, 37, 38, and 40 to 43 of this act shall be used.

Sec. 32. Church plan shall mean a plan as defined under 29 U.S.C. 1002.

Sec. 33. Creditable coverage shall mean, with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

(3) Part A or Part B of Title XVIII of the Social Security Act;

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 of the act;

(5) 10 U.S.C. 5501 et seq.;

(6) A medical care program of the Indian Health Service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under 5 U.S.C. 8901 et seq.;

(9) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

(10) A health benefit plan under 22 U.S.C. 2504.

Sec. 34. Governmental plan shall mean a plan as defined under 29 U.S.C. 1002 and any plan maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

Sec. 35. Group health plan shall mean an employee welfare benefit plan as defined by 29 U.S.C. 1002 to the extent that the plan provides any hospital, surgical, or medical expense benefits to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

Sec. 36. Section 44-5242, Revised Statutes Supplement, 1996, is amended to read:

44-5242. (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 one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for onsite medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) Health benefit plan shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited-scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) Health benefit plan shall not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) Health benefit plan shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under 10 U.S.C. 5501 et seq.; and

(c) Similar supplemental coverage provided to coverage under a group health plan. ~~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. 37. Section 44-5233, Revised Statutes Supplement, 1996, is amended to read:

~~44-5233.~~ ~~Carrier~~ Health carrier or carrier shall mean any entity that provides health insurance in this state. ~~Carrier~~ Health carrier or 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. 38. Health-status-related factor shall mean any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(8) Disability.

Sec. 39. Section 44-5244, Revised Statutes Supplement, 1996, is amended to read:

44-5244. 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~~ creditable coverage at the time of the initial enrollment;

(b) The individual lost coverage under ~~qualifying previous~~ creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the ~~qualifying previous~~ creditable coverage, the death of a spouse, ~~or~~ divorce, or legal separation; and

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

(4) The individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted.

Sec. 40. Medical care shall mean amounts paid for:

(1)(a) The diagnosis, care, mitigation, treatment, or prevention of disease or (b) the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in subdivision (1) of this section; and

(3) Insurance covering medical care referred to in subdivisions (1) and (2) of this section.

Sec. 41. Network plan shall mean health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

Sec. 42. Plan sponsor shall have the meaning given such term under 29 U.S.C. 1002.

Sec. 43. Preexisting condition shall mean a condition whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six months preceding the effective date of coverage. Genetic information shall not be treated as a condition for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.

Sec. 44. Section 44-5253, Revised Statutes Supplement, 1996, 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~~ two and no more than 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. 45. Section 44-5259, Revised Statutes Supplement, 1996, is amended to read:

44-5259. (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~~ The small employer has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

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

(ii) The small employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

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

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

(e) A decision by the small employer carrier to discontinue offering

a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by the small employer carrier in that market only if the small employer carrier:

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

(ii) Provides notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner of insurance 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 small employer carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected small employers, participants, and beneficiaries;

(iii) Offers to each small employer provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the small employer carrier to small employers in the state; and

(iv) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under subdivision (1)(e)(iii) of this section, acts uniformly without regard to the claims experience of those small employers or any health-status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

(f) A decision by the small employer carrier to discontinue offering and to nonrenew all its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the small employer carrier shall:

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

(ii) Provide notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner of insurance 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 small employer carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected small employers, participants, and beneficiaries; and

(iii) Discontinue all health insurance issued or delivered for issuance in the state's small employer market and not renew coverage under any health benefit plan issued to a small employer; and

~~(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.

(4) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (1) or (2) of this section in the case of the following:

(a) To an eligible person who no longer resides, lives, or works in the service area of the small employer carrier or in an area for which the small employer carrier is authorized to do business, but only if coverage is terminated under this section uniformly without regard to any health-status-related factor of covered individuals; or

(b) To a small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the small employer carrier or the area for which the small employer carrier is authorized to do business.

Sec. 46. Section 44-5260, Revised Statutes Supplement, 1996, is amended to read:

44-5260. (1) For purposes of this section, small employer shall mean, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code shall be treated as one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Small Employer Health Insurance Availability Act that apply to a small employer shall continue to apply at least until the health benefit plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in the act to an employer shall include a reference to any predecessor of such employer.

(2)(a) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state, including 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. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan by such small employer carrier.

(b)(i) Subject to subdivision (2)(a) of this section, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the 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. However, no small employer carrier shall be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer. ~~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 (2)(b)(ii) of this section 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 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)~~ (3)(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)~~ (4) 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, or eighteen months in the case of a late enrollee, following the enrollment ~~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 as defined in section 43 of this act. A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition; ~~:~~

~~(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 health benefit plan shall not impose any preexisting condition exclusion:

(i) To an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage, and the individual had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage; or

(ii) To a child less than eighteen years of age who is adopted or placed for adoption and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage, and the child had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage;

(c) ~~(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 aggregate period of time an individual was previously covered by ~~qualifying previous~~ creditable coverage that provided benefits with respect to such services if the ~~qualifying previous~~ creditable coverage was continuous to a date not more than ~~ninety~~ sixty-three days prior to the ~~effective~~ enrollment 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) A small employer carrier shall permit an eligible employee or dependent, who requests enrollment following the open enrollment opportunity, to enroll, and the eligible employee or dependent shall not be considered a late enrollee if the eligible employee or dependent:

(A) Was covered under another health benefit plan at the time the eligible employee or dependent was eligible to enroll;

(B) Stated in writing at the time of the open enrollment period that coverage under another health benefit plan was the reason for declining enrollment but only if the health benefit plan or health carrier required such a written statement and provided a notice of the consequences of such written statement;

(C) Has lost coverage under another health benefit plan as a result of the termination of employment, the termination of the other health benefit plan's coverage, death of a spouse, legal separation, or divorce or was under a continuation-of-coverage policy or contract available under federal law and the coverage was exhausted; and

(D) Requests enrollment within thirty days after the termination of coverage under the other health benefit plan.

(ii)(A) If a small employer carrier issues a health benefit plan and makes coverage available to a dependent of an eligible employee and such dependent becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption, then such health benefit plan shall provide for a dependent special enrollment period during which the dependent may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of an eligible employee may be enrolled if otherwise eligible for coverage.

(B) A dependent special enrollment period shall be a period of not less than thirty days and shall begin on the later of (I) the date such dependent coverage is available or (II) the date of the marriage, birth, adoption, or placement for adoption.

(C) If an eligible employee seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(I) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(II) In the case of the birth of a dependent, as of the date of birth; and

(III) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;

~~(d)(i)~~ (e)(i) Except as provided in subdivision ~~(3)(d)(iv)~~ (4)(e)(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)~~ (4)(e)(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~~ creditable 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; and ~~.~~

~~(e)(i)~~ (f)(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)~~ (4)(a) of this section.

(ii) Except as permitted under subdivisions (a) and ~~(c)~~ (d) 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)~~ (5) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection ~~(1)~~ (2) 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)~~ (a) 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)~~ (b) 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 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)~~ (6)(a) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (2) of this section to or from a small employer as defined in subsection (1) of this section:

(i) If the small employer does not have eligible employees who live, work, or reside in the service area for such network plan; or

(ii) If the small employer does have eligible employees who live, work, or reside in the service area for such network plan, the carrier has demonstrated, if required, to the director that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying subdivision (6)(a)(ii) of this section uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health-status-related factor relating to such employees and dependents.

(b) A small employer carrier, upon denying health insurance coverage in any service area in accordance with subdivision (6)(a)(ii) of this section, shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the date such coverage is denied.

(7) A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection ~~(1)~~ (2) 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. 47. Section 44-5261, Revised Statutes Supplement, 1996, is amended to read:

44-5261. (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 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 January 1, 1995, 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 44-5258.

(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)~~ (2)(b)(i) of section 44-5260 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. 48. This act becomes operative on July 1, 1997.

Sec. 49. Original sections 44-4201, 44-4203, 44-4221, and 44-4222, Reissue Revised Statutes of Nebraska, and sections 44-760, 44-4228, 44-4233, 44-5223, 44-5225, 44-5233, 44-5242, 44-5244, 44-5253, 44-5259, 44-5260, and 44-5261, Revised Statutes Supplement, 1996, are repealed.

Sec. 50. The following section is outright repealed: Section 44-5249, Revised Statutes Supplement, 1996.

Sec. 51. Since an emergency exists, this act takes effect when passed and approved according to law.