LEGISLATURE OF NEBRASKA

ONE HUNDRED FIRST LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 637

Introduced by Mello, 5.

Read first time January 21, 2009

Committee: Banking, Commerce and Insurance

A BILL

FOR AN ACT relating to insurance; to require disclosure of information by health carriers providing group health benefit plan coverages as prescribed; and to provide a duty for the Revisor of Statutes.

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

Section 1. (1)(a) A health carrier issuing a policy or contract providing group health benefit plan coverages to a group of fifty-one or more covered employees shall provide to the group policyholder, contract holder, or sponsor of the group health benefit plan or to an insurance producer authorized by and acting on behalf of the group policyholder, contract holder, or sponsor of the group health benefit plan, upon request by the group policyholder, contract holder, or sponsor of the group health benefit plan or the insurance producer, annually, but not more than three months prior to the policy or contract renewal date, the total amount of actual claims identified as paid or incurred and paid by month, including claims experience for medical, dental, and pharmacy benefits, as applicable, the total number of covered employees on a monthly basis by coverage tier, the total number of covered employees that have reached deductible by tier, the major categories of expenses, and the total premium paid by month.

(b) The information required by this section shall be provided for the immediately preceding thirty-six months or for the entire period of coverage, whichever is shorter. In the case of a request made as of termination of coverage, the report shall contain all such information from the health carrier preceding the date of termination of coverage or for the entire policy period, whichever is shorter.

(c) The information required by this section shall not disclose any confidential information or otherwise disclose the

identity of an individual insured, subscriber, or enrollee who has submitted a claim within the time period covered by the information provided.

(d) The information required by this section shall be given to the employer in the case of a single employer group, to the association in the case of an association group, or to the trustees of the trust in the case of a union group or a multiple employer welfare arrangement.

(2) For purposes of this section:

(a) Group policyholder, contract holder, or sponsor means the employer, association, union, or other entity specified in section 44-760 to whom the policy or contract is issued.

(b)(i) Health benefit plan means any hospital or medical policy, group major medical expense insurance policy, or health maintenance organization group contract.

(ii) 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.

(iii) 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.

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

(B) Hospital indemnity or other fixed indemnity

insurance.

(v) 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, as such section existed on January 1, 2009;

(B) Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, as such chapter existed on January 1, 2009; and

(C) Similar supplemental coverage provided to coverage under a group health plan; and

(c) Health carrier means an insurance company, fraternal benefit society, or health maintenance organization licensed in this state.

(3) Any violation of this section or of any rules and regulations adopted and promulgated thereunder by a health carrier shall be subject to the Unfair Insurance Trade Practices Act.

(4) The Director of Insurance may adopt and promulgate rules and regulations to carry out this section.

Sec. 2. The Revisor of Statutes shall assign section 1 of this act to Chapter 44, article 3.