LEGISLATIVE BILL 589

Approved by the Governor June 3, 2005

Introduced by Legislative Performance Audit Committee:
Beutler, 28, Chairperson; Brashear, 4; Engel, 17; Erdman, 47; McDonald, 41; D. Pederson, 42; Price, 26

AN ACT relating to state benefit programs; to amend section 44-1540, Reissue Revised Statutes of Nebraska; to state intent; to define terms; to provide duties for insurers; to require coordination of benefits; to provide penalties; to provide severability; and to repeal the original section.

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

Section 1. The Legislature finds that (1) the Department of Health and Human Services and the Department of Health and Human Services Finance and Support rely on health insurance and claims information from private insurers to ensure accuracy in processing state benefit program payments to providers and in verifying individual recipients' eligibility, (2) delay or refusal to provide such information causes unnecessary expenditures of state funds, (3) disclosure of such information to the Department of Health and Human Services and the Department of Health and Human Services Finance and Support is permitted pursuant to the federal Health Insurance Portability and Accountability privacy rules under 45 C.F.R. part 164, and (4) for medical assistance program recipients who also have other insurance coverage, including coverage by licensed and self-funded insurers, the Department of Health and Human Services Finance and Support is required by 42 U.S.C. 1396a(a)(25) to assure that licensed and self-funded insurers coordinate benefits with the program.

Sec. 2. For purposes of sections 1 to 8 of this act:

(1) Coordinate benefits means:

(a) Provide to the Department of Health and Human Services or the Department of Health and Human Services Finance and Support information regarding the licensed insurer's or self-funded insurer's existing coverage for an individual who is eligible for a state benefit program; and

(b) Meet payment obligations;

(2) Coverage information means health information possessed by a licensed insurer or self-funded insurer that is limited to the following information about an individual:

(a) Eligibility for coverage under a health plan;

(b) Coverage of health care under the health plan; or

(c) Benefits and payments associated with the health plan;

(3) Health plan means any policy of insurance issued by a licensed insurer or any employee benefit plan offered by a self-funded insurer that provides for payment to or on behalf of an individual as a result of an illness, disability, or injury or change in a health condition;

(4) Individual means a person covered by a state benefit program, including the medical assistance program established under sections 68-1018 to 68-1025, or a person applying for such coverage;

(5) Licensed insurer means any insurer, except a self-funded insurer, including a fraternal benefit society, producer, or other person licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of the state; and

(6) Self-funded insurer means any employer or union who provides a self-funded employee benefit plan.

Sec. 3. (1) Except as provided in subsection (2) of this section, at the request of the Department of Health and Human Services or the Department of Health and Human Services Finance and Support, a licensed insurer or a self-funded insurer shall provide coverage information to the requesting department without an individual's authorization for purposes of:

(a) Determining an individual's eligibility for state benefit programs, including the medical assistance program established under sections 68-1018 to 68-1025; or

(b) Coordinating benefits with state benefit programs.

Such information shall be provided within thirty days after the date of request unless good cause is shown. Requests for coverage information shall specify individual recipients for whom information is being requested.

(2)(a) Coverage information requested pursuant to subsection (1) of this section regarding a limited benefit policy shall be limited to whether a

specified individual has coverage and, if so, a description of that coverage, and such information shall be used solely for the purposes of subdivision (1)(a) of this section.

(b) For purposes of this section, limited benefit policy means a policy of insurance issued by a licensed insurer that consists only of one or more, or any combination of the following:

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

(ii) Coverage for specified disease or illness; or

(iii) Hospital indemnity or other fixed indemnity insurance.

Sec. 4. Any violation of section 3 of this act by a licensed insurer shall be subject to the Unfair Insurance Claims Settlement Practices Act.

Sec. 5. The Department of Health and Human Services Finance and Support may impose and collect a civil penalty on a self-funded insurer who violates the requirements of section 3 of this act if the department finds that the self-funded insurer:

(1) Committed the violation flagrantly and in conscious disregard of the requirements; or

(2) Has committed violations with such frequency as to indicate a general business practice to engage in that type of conduct.

The civil penalty shall not be more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation by the self-funded insurer was committed flagrantly and in conscious disregard of section 3 of this act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars.

Sec. 6. The Department of Health and Human Services Finance and Support is authorized to recover all amounts paid or to be paid to state benefit programs as a result of failure to coordinate benefits by a licensed insurer or a self-funded insurer.

Sec. 7. The Department of Health and Human Services Finance and Support shall establish a process by rule and regulation for resolving any violation by a self-funded insurer of section 3 of this act and for assessing the financial penalties contained in section 5 of this act. Any appeal of an action by the department under such policies shall be in accordance with the Administrative Procedure Act.

Sec. 8. All money collected as a civil penalty under section 4 or 5 of this act shall be remitted to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Sec. 9. Section 44-1540, Reissue Revised Statutes of Nebraska, is amended to read:

44-1540. Any of the following acts or practices by an insurer, if committed in violation of section 44-1539, shall be an unfair claims settlement practice:

(1) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

(4) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of property and casualty claims (a) in which coverage and the amount of the loss are reasonably clear and (b) for loss of tangible personal property within real property which is insured by a policy subject to section 44-501.02 and which is wholly destroyed by fire, tornado, windstorm, lightning, or explosion;

(6) Compelling insureds or beneficiaries to institute litigation to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in litigation brought by them;

(7) Refusing to pay claims without conducting a reasonable investigation;

(8) Failing to affirm or deny coverage of a claim within a reasonable time after having completed its investigation related to such claim;

(9) Attempting to settle a claim for less than the amount to which a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

(10) Attempting to settle claims on the basis of an application which was materially altered without notice to or knowledge or consent of the insured;

(11) Making a claims payment to an insured or beneficiary without indicating the coverage under which each payment is being made;

(12) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof-of-loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof-of-loss form;

(13) Failing, in the case of the denial of a claim or the offer of a compromise settlement, to promptly provide a reasonable and accurate explanation of the basis for such action;

(14) Failing to provide forms necessary to present claims with reasonable explanations regarding their use within fifteen working days of a request;

(15) Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or affiliated with the insurer are performed in a skillful manner. For purposes of this subdivision, a repairer is affiliated with the insurer if there is a preexisting arrangement, understanding, agreement, or contract between the insurer and repairer for services in connection with claims on policies issued by the insurer; ~~and~~

(16) Requiring the insured or claimant to use a particular company or location for motor vehicle repair. Nothing in this subdivision shall prohibit an insurer from entering into discount agreements with companies and locations for motor vehicle repair or otherwise entering into any business arrangements or affiliations which reduce the cost of motor vehicle repair if the insured or claimant has the right to use a particular company or reasonably available location for motor vehicle repair. If the insured or claimant chooses to use a particular company or location other than the one providing the lowest estimate for like kind and quality motor vehicle repair, the insurer shall not be liable for any cost exceeding the lowest estimate. For purposes of this subdivision, motor vehicle repair shall include motor vehicle glass replacement and motor vehicle glass repair; and

(17) Failing to provide coverage information or coordinate benefits pursuant to section 3 of this act.

Sec. 10. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.

Sec. 11. Original section 44-1540, Reissue Revised Statutes of Nebraska, is repealed.