LEGISLATURE OF NEBRASKA

ONE HUNDRED SECOND LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 838

Introduced by Pahls, 31.

Read first time January 05, 2012

Committee: Banking, Commerce and Insurance

A BILL

FOR AN ACT relating to insurance; to adopt the Nebraska Health Benefit Exchange Act.

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

Section 1. Sections 1 to 10 of this act shall be known and may be cited as the Nebraska Health Benefit Exchange Act.

Sec. 2. The purpose of the Nebraska Health Benefit Exchange Act is to provide for the establishment of a Nebraska health benefit exchange to facilitate the purchase and sale of qualified health plans in the individual market in this state and to provide for the establishment of a Small Business Health Options Program to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education, and assist individuals with access to programs, premium assistance tax credits, and cost-sharing reductions.

Sec. 3. For purposes of the Nebraska Health Benefit Exchange Act:

(1) Director means the Director of Insurance;

(2) Educated health care consumer means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters;

(3) Exchange means the Nebraska health benefit exchange established pursuant to section 4 of this act;

(4) Federal act means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law

111-152, and any amendments thereto, or regulations or guidance issued under those acts;

(5)(a) Health benefit plan means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(b) Health benefit plan does not include:

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

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for onsite medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(c) 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:

(i) Limited scope dental or vision benefits;

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

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to Public Law 104-191.

(d) 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 plan maintained by the same plan sponsor, and the 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:

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

(ii) Hospital indemnity or other fixed indemnity insurance.

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

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

(ii) Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, Civilian Health and Medical Program of the Uniformed Services; or

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

(6) Health carrier or carrier means an entity subject to the insurance laws, rules, and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services;

(7) Qualified dental plan means a limited scope dental plan that has been certified in accordance with subsection (5) of section 7 of this act;

(8) Qualified employer means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange, and at the option of the employer, some or all of its part-time employees, if the employer:

(a) Has its principal place of business in this state and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed; or

(b) Elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in this state;

(9) Qualified health plan means a health benefit plan that has in effect a certification that the plan meets the criteria

for certification described in section 1311(c) of the federal act and section 7 of this act;

(10) Qualified individual means an individual, including a minor, who:

(a) Is seeking to enroll in a qualified health plan offered to individuals through the exchange;

(b) Resides in this state;

(c) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(d) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States;

(11) Secretary means the Secretary of the federal Department of Health and Human Services;

(12) SHOP exchange means the Small Business Health Options Program established under section 6 of this act; and

(13)(a)(i) Prior to January 1, 2016, small employer means an employer that employed an average of not more than fifty employees during the preceding calendar year.

(ii) On and after January 1, 2016, small employer means an employer that employed an average of not more than one hundred employees during the preceding calendar year.

(b) For purposes of this subdivision:

(i) All persons treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code shall

be treated as a single employer;

(ii) An employer and any predecessor employer shall be treated as a single employer;

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(v) An employer that makes enrollment in qualified health plans available to its employees through the SHOP exchange and would cease to be a small employer by reason of an increase in the number of its employees shall continue to be treated as a small employer for purposes of the act as long as it continuously makes enrollment through the SHOP exchange available to its employees.

Sec. 4. (1) The director is hereby authorized to establish the Nebraska health benefit exchange.

(2) The exchange shall:

(a) Facilitate the purchase and sale of qualified health plans;

(b) Provide for the establishment of a SHOP exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and

(c) Meet the requirements of the act and any rules and regulations adopted and promulgated under the act.

(3) The exchange may contract with an eligible entity for any of its functions described in the act. An eligible entity includes, but is not limited to, the Department of Health and Human Services or an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

(4) The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under the act if such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, rules, and regulations.

Sec. 5. (1) The exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

(2)(a) The exchange shall not make available any health benefit plan that is not a qualified health plan.

(b) The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code through the exchange, either separately or in conjunction with a

qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the federal act.

(3) Neither the exchange nor a health carrier offering health benefit plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code.

Sec. 6. The exchange shall:

(1) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the secretary under section 1311(c) of the federal act and section 7 of this act, of health benefit plans as qualified health plans;

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) Provide for enrollment periods as provided under section 1311(c)(6) of the federal act;

(4) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(5) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under section 1311(c)(3) of the federal act, and determine

each qualified health plan's level of coverage in accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the federal act;

(6) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the federal Public Health Service Act;

(7) In accordance with section 1413 of the federal act, inform individuals of eligibility requirements for the medicaid program under Title XIX of the Social Security Act, the Children's Health Insurance Program under Title XXI of the Social Security Act, or any applicable state or local public program and if through screening of the application by the exchange, the exchange determines that any individual is eligible for any such program, enroll that individual in that program;

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code and any cost-sharing reduction under section 1402 of the federal act;

(9) Establish a SHOP exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage;

(10) Subject to section 1411 of the federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(a) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(b) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(11) Transfer to the federal Secretary of the Treasury the following:

(a) A list of the individuals who are issued a certification under subdivision (10) of this section, including the name and taxpayer identification number of each individual;

(b) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential coverage; or

(ii) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or

not provide the required minimum actuarial value; and

(c) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under section 1411(b)(4) of the federal act that he or she has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(12) Provide to each employer the name of each employee of the employer described in subdivision (11)(c)(ii) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(13) Perform duties required of the exchange by the secretary or the federal Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(14) Select entities qualified to serve as navigators in accordance with section 1311(i) of the federal act and standards developed by the secretary and award grants to enable navigators to:

(a) Conduct public education activities to raise awareness of the availability of qualified health plans;

(b) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code and cost-sharing reductions under section 1402 of the federal act;

(c) Facilitate enrollment in qualified health plans;

(d) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the federal Public Health Service Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health benefit plan or coverage or a determination under that plan or coverage; and

(e) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(15) Review the rate of premium growth within the exchange and outside the exchange and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(16) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the federal act, and collect the amount credited from the offering employer;

(17) Consult with stakeholders relevant to carrying out the activities required under the act, including, but not limited to:

(i) Educated health care consumers who are enrollees in qualified health plans;

(ii) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(iii) Representatives of small businesses and self-employed individuals;

(iv) The Department of Health and Human Services; and

(v) Advocates for enrolling hard-to-reach populations; and

(18) Meet the following financial integrity requirements:

(a) Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the secretary, the Governor, the director, and the Legislature a report concerning such accountings;

(b) Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the federal act and allow the secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(c) In carrying out its activities under the act, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

Sec. 7. (1) The exchange may certify a health benefit plan as a qualified health plan if:

(a) The plan provides the essential health benefits package described in section 1302(a) of the federal act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection (5) of this section, if:

(i) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(ii) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

(b) The premium rates and contract language have been approved by the director;

(c) The plan provides at least a bronze level of coverage, as determined pursuant to subdivision (5) of section 6 of this act unless the plan (i) is certified as a qualified catastrophic plan, (ii) meets the requirements of the federal act for catastrophic plans, and (iii) will only be offered to individuals eligible for catastrophic coverage;

(d) The plan's cost-sharing requirements do not exceed

the limits established under section 1302(c)(1) of the federal act, and if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the federal act;

(e) The health carrier offering the plan:

(i) Is licensed and in good standing to offer health insurance coverage in this state;

(ii) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the exchange in which the health carrier participates. For purposes of this subdivision, component refers to the SHOP exchange and the exchange for individual coverage;

(iii) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;

(iv) Does not charge any cancellation fees or penalties in violation of subsection (3) of section 5 of this act; and

(v) Complies with the regulations developed by the secretary under section 1311(d) of the federal act and such other requirements as the exchange may establish;

(f) The plan meets the requirements of certification as adopted and promulgated by rule and regulation of the director and by the secretary under section 1311(c) of the federal act, which include, but are not limited to, minimum standards in the areas of

marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance; and

(g) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

(2) The exchange shall not exclude a health benefit plan:

(a) On the basis that the plan is a fee-for-service plan;

(b) Through the imposition of premium price controls by the exchange; or

(c) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

(3) The exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(a) Submit a justification for any premium increase before implementation of that increase. The health carrier shall prominently post the information on its Internet web site. The exchange shall take this information, along with the information and the recommendations provided to the exchange by the director under section 2794(b) of the federal Public Health Service Act into consideration when determining whether to allow the health carrier to make plans available through the exchange;

(b)(i) Make available to the public, in the format

described in subdivision (3)(b)(ii) of this section, and submit to the exchange, the secretary, and the director, accurate and timely disclosure of the following:

(A) Claims payment policies and practices;

(B) Periodic financial disclosures;

(C) Data on enrollment;

(D) Data on disenrollment;

(E) Data on the number of claims that are denied;

(F) Data on rating practices;

(G) Information on cost-sharing and payments with respect to any out-of-network coverage;

(H) Information on enrollee and participant rights under Title I of the federal act; and

(I) Other information as determined appropriate by the secretary; and

(ii) The information required in subdivision (3)(a) of this section shall be provided in plain language as that term is defined in section 1311(e)(3)(B) of the federal act; and

(c) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet web site and through

other means for individuals without access to the Internet.

(4) The exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the health carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

(5)(a) The provisions of the Nebraska Health Benefit Exchange Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with subdivisions (5)(b), (c), and (d) of this section or by rules and regulations adopted and promulgated by the director;

(b) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(c) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the federal act and such other dental benefits as the exchange or the secretary may specify by regulation; and

(d) Health carriers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a health carrier through a qualified dental plan and the other

benefits are provided by a health carrier through a qualified health plan if the plans are priced separately and are also made available for purchase separately at the same price.

Sec. 8. (1) The exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under the Nebraska Health Benefit Exchange Act.

(2) The exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the exchange, and the administrative costs of the exchange on an Internet web site to educate consumers on such costs. This information shall include information on money lost to waste, fraud, and abuse.

(3) Money collected pursuant to the act shall be remitted to the State Treasurer and shall be credited to the Health Benefit Exchange Act Cash Fund, which is hereby created. The fund shall be used for the operation of the exchange. Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

Sec. 9. The director may adopt and promulgate rules and regulations to carry out the Nebraska Health Benefit Exchange Act. Such rules and regulations shall not conflict with or prevent the application of regulations promulgated by the secretary under the federal act.

Sec. 10. Nothing in the Nebraska Health Benefit Exchange

Act, and no action taken by the exchange pursuant to the act, shall be construed to preempt or supersede the authority of the director to regulate the business of insurance within this state. Except as expressly provided to the contrary in the act, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules and regulations adopted and promulgated and orders issued by the director.