

LEGISLATIVE BILL 73

Approved by the Governor May 29, 2003

Introduced by Cunningham, 40; Byars, 30; Jensen, 20; Price, 26; Combs, 32

AN ACT relating to health; to amend section 44-1525, Revised Statutes Supplement, 2002; to adopt the Outpatient Surgical Procedures Data Act; to provide requirements for insurers; to proscribe an unfair trade practice in the business of insurance; and to repeal the original section.

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

Section 1. Sections 1 to 9 of this act shall be known and may be cited as the Outpatient Surgical Procedures Data Act.

Sec. 2. The purposes of the Outpatient Surgical Procedures Data Act are to provide for: (1) The collection and compilation of outpatient surgical procedure information from hospitals and ambulatory surgical centers; (2) the use and disclosure of such information for public health purposes; and (3) periodic reporting to the Legislature and an annual statistical report.

Sec. 3. For purposes of the Outpatient Surgical Procedures Data Act:

(1) Department means the Department of Health and Human Services Regulation and Licensure;

(2) Medicaid means the medical assistance program established in section 68-1018;

(3) Medicare means Title XVIII of the federal Social Security Act, as such title existed on January 1, 2003;

(4) Outpatient surgical procedure means a surgical procedure provided to patients who do not require inpatient hospitalization;

(5) Primary payor means the public payor or private payor which is expected to be responsible for the largest percentage of the patient's current bill;

(6) Private payor means any nongovernmental source of funding; and

(7) Public payor means medicaid, medicare, and any other governmental source of funding.

Sec. 4. (1) Every hospital or ambulatory surgical center licensed under the Health Care Facility Licensure Act shall annually report the following outpatient surgical and related information to the department no later than May 1 of each year for the preceding calendar year in a format as prescribed by the department in rule and regulation:

(a) The name of the reporting facility;

(b) The facility portion of billed charges for each patient served at such facility;

(c) The county and state of residence by zip code for each patient served at such facility;

(d) The primary outpatient surgical procedure performed for each patient at such facility;

(e) The primary payor for each patient served at such facility; and

(f) Such other outpatient surgical information as voluntarily reported by such facilities.

(2) The department may impose a late fee for failure to report such information as required by this section.

Sec. 5. All information reported to the department pursuant to section 4 of this act shall be privileged communications, shall not be discoverable or subject to subpoena, and may not be used or offered or received in evidence in any legal proceeding of any kind or character. Such information shall remain confidential with the department and shall not be disclosed except as provided in sections 6 and 7 of this act.

Sec. 6. (1) Information reported under section 4 of this act may be used by the department for statistical and public health planning purposes and for other public health purposes as identified by the department in rule and regulation.

(2) The department shall periodically review information collected under section 4 of this act for the purpose of identifying potential policies or practices of any reporting facility which may be detrimental to the public health, including, but not limited to, policies and practices which may have the effect of limiting access to needed health care services for Nebraska residents. The department shall provide recommendations to the Health and Human Services Committee of the Legislature relating to appropriate administrative and legislative responses to such policies and practices and

shall provide an annual report to the chairperson of such committee of its findings and its current or planned activities under this section, if any.

Sec. 7. The department shall publish an annual statistical report from information collected under section 4 of this act which shall include: (1) The twenty most frequently performed outpatient surgical procedures by type of procedure; (2) the total number of persons served for each listed procedure; (3) the total number of persons served by county and state of residence and region of service; and (4) the average billed charges for such procedures by county and state of residence. The department shall designate service regions for the purpose of aggregating and reporting information as required by this section. No information shall be published or disclosed by the department under this section in a manner that identifies or may be used to identify any individual hospital or ambulatory surgical center.

Sec. 8. Costs associated with implementation of the Outpatient Surgical Procedures Data Act may be considered by the department in determining variable costs for purposes of establishing licensure fees under section 71-434 and shall not require an appropriation of General Funds.

Sec. 9. The department shall adopt and promulgate rules and regulations to implement the Outpatient Surgical Procedures Data Act. Such rules and regulations shall comply with all applicable provisions of federal law and shall minimize the imposition of additional costs to reporting facilities.

Sec. 10. (1) All insurers delivering, issuing for delivery, or renewing in this state a health benefit plan which provides coverage for prescription drugs and devices and that issues, uses, or requires a card or other technology for prescription claims submission, or the insurer's agents or contractors that issue such cards or other technology, shall issue to each insured a prescription drug information card or other technology that:

(a) Conforms to the standards and format of the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide by including all of the standard information adopted by the implementation guide and required by the health benefit plan for submission and adjudication of claims for prescription drugs or devices; or

(b) Contains at a minimum the following appropriately labeled information:

(i) The card issuer name or logo on the front of the card;

(ii) The cardholder's name and identification number on the front of the card;

(iii) Complete information for electronic transaction claims routing, including:

(A) The international identification number, labeled as RxBIN;

(B) The processor control number, labeled as RxPCN, if required for proper routing of electronic claim transactions for prescription benefits; and

(C) The group number, labeled as RxGrp, if required for proper routing of electronic claim transactions for prescription benefits;

(iv) The name and address of the health benefit plan benefits administrator or the entity responsible for prescription benefits claims submission or adjudication or pharmacy provider correspondence for prescription benefits claims; and

(v) A help desk telephone number that pharmacy providers may call for prescription benefits claims assistance.

(2) All information required by subsection (1) of this section that is necessary for submission and adjudication of claims for prescription drug or device benefits, exclusive of information that can be derived from the prescription, shall be included in a clear, readable, and understandable manner on the card or other technology issued by the insurer or its agents or contractors. The content and format of all information required by such subsection shall be in the content and format required by the health benefit plan for electronic claims routing, submission, and adjudication.

(3) A prescription drug information card or technology required under subsection (1) of this section shall be issued by an insurer upon enrollment in a health benefit plan and reissued within a reasonable time upon any change in the insured's coverage that impacts data contained on the card or technology, except that the insurer or its agents or contractors shall not be required to issue a new prescription drug information card more than once in a calendar year and nothing in this section prevents the insurer or its agents or contractors from issuing stickers or other methodologies to the insureds to update the cards or other technology temporarily until the cards or other technology are reissued or from reissuing updated new cards or other technology on a more frequent basis. Cards or technology shall be updated with the latest coverage information and shall comply with the format as approved in subsection (1) of this section.

(4) The card or other technology may be used for any and all health insurance coverage. Nothing in this section requires any person issuing, using, or requiring the card or other technology to issue, use, or require a separate card for prescription coverage if the card or other technology can accommodate the information necessary to process the claim as required by subsection (1) of this section.

(5) For purposes of this section, health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

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

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

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

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance.

(6) This section shall apply to all health benefit plans delivered or issued for delivery on or after January 1, 2004, and to all health benefit plans renewed on or after January 1, 2005.

(7) The Department of Insurance shall enforce this section. The department may adopt and promulgate rules and regulations to carry out the purposes of this section.

Sec. 11. Section 44-1525, Revised Statutes Supplement, 2002, is amended to read:

44-1525. Any of the following acts or practices, if committed in violation of section 44-1524, shall be unfair trade practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy;

(b) Misrepresents the dividends or share of the surplus to be received on any policy;

(c) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any policy;

(d) Misleads as to or misrepresents the financial condition of any insurer or the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any policy or class of policies which misrepresents the true nature thereof;

(f) Misrepresents for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion, or surrender of any policy, including intentionally misquoting any premium rate;

(g) Misrepresents for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(h) Misrepresents any policy as being shares of stock;

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any insurer in the conduct of his or her insurance business which is untrue, deceptive, or misleading;

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or derogatory to the financial condition of any insurer and which is calculated to injure such insurer;

(4) Entering into any agreement to commit or by any concerted action committing any act of boycott, coercion, or intimidation resulting in or

tending to result in unreasonable restraint of or monopoly in the business of insurance;

(5) (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer; or

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer;

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(7) (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such policy or annuity;

(b) Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any sickness and accident insurance policy or in the benefits payable thereunder, in any of the terms or conditions of such policy, or in any other manner, except that this subdivision shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113;

(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law, rule, or regulation;

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law, rule, or regulation;

(e) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual solely because of the sex or marital status of the individual. This subdivision shall not prohibit an insurer from taking marital status into account for the purpose of defining individuals eligible for dependent benefits; or

(f) Terminating or modifying coverage or refusing to issue or refusing to renew any property or casualty insurance policy solely because the applicant or insured or any employee of the applicant or insured is mentally or physically impaired unless:

(i) The termination, modification, or refusal is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The termination, modification, or refusal is required by law, rule, or regulation.

This subdivision (f) shall not apply to any sickness and accident insurance policy sold by a casualty insurer and shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any policy;

(8) (a) Except as otherwise expressly provided by law:

(i) Knowingly permitting or offering to make or making any life insurance policy, annuity, or sickness and accident insurance policy, or agreement as to any such policy or annuity, other than as plainly expressed in the policy or annuity issued thereon, or paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such policy or annuity, any rebate of premiums payable on the policy or annuity, or any special favor or advantage in the dividends or other benefits thereon, or

any valuable consideration or inducement whatever not specified in the policy or annuity; or

(ii) Giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith any stocks, bonds, or other securities of any insurer or other corporation, association, partnership, or limited liability company, or any dividends or profits accrued thereon, or anything of value not specified in the policy or annuity.

(b) Nothing in subdivision (7) or (8)(a) of this section shall be construed as including within the definition of discrimination or rebates any of the following acts or practices:

(i) In the case of any life insurance policy or annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance if such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the insurer and its policyholders;

(ii) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or

(iii) Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(9) Failing of any insurer to maintain a complete record of all the complaints received since the date of its last examination conducted pursuant to the Insurers Examination Act. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subdivision, complaint shall mean any written communication primarily expressing a grievance;

(10) Making false or fraudulent statements or representations on or relative to an application for a policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual person;

(11) Failing of any insurer, upon receipt of a written inquiry from the department, to respond to such inquiry or request additional reasonable time to respond within fifteen working days;

(12) Accepting applications for or writing any policy of insurance sold, negotiated, or solicited by an insurance producer or business entity not licensed or appointed as required by the Insurance Producers Licensing Act; and

(13) Violating any provision of section 44-320, 44-348, 44-360, 44-361, 44-369, 44-393, 44-515 to 44-518, 44-522, 44-523, 44-2132 to 44-2134, 44-3606, 44-4809, 44-4812, 44-4817, or 44-5266, section 10 of this act, the Privacy of Insurance Consumer Information Act, or the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

Sec. 12. Original section 44-1525, Revised Statutes Supplement, 2002, is repealed.