LB278
2025

LEGISLATURE OF NEBRASKA

ONE HUNDRED NINTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 278

Introduced by von Gillern, 4.

Read first time January 15, 2025

Committee:

A BILL FOR AN ACT relating to insurance; to amend section 44-4109.01, Reissue Revised Statutes of Nebraska; to change requirements for certain insurance policies and contracts; and to repeal the original section.

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

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Section 1. Section 44-4109.01, Reissue Revised Statutes of Nebraska, is amended to read:

44-4109.01 Policies or contracts authorized by sections 44-4109 and 44-4110 are subject to the following requirements:

(1) A prospective insured shall be provided information about the terms and conditions of the insurance arrangement to enable him or her to make an informed decision about accepting a system of health care delivery. If the insurance arrangement is described orally to a prospective insured, the description shall use easily understood, truthful, and objective terms. All written descriptions shall be in a readable and understandable format. Specific items that shall be included are:

(a) Coverage provisions, benefits, and any exclusions by category of service, provider, or physician and, if applicable, by specific service;

(b) Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, and postpayment review, the manner in which an insured may obtain review of a denial of coverage, and the nature of any liability an insured may incur if the insured does not comply with the authorization requirements of the policy, contract, certificate, or other materials; and

(c) Information on the insured's financial responsibility for payment for deductibles, coinsurance, or other noncovered services;

(2) If an insurer conducts customer satisfaction surveys concerning an insurance arrangement, the results of such surveys shall be made available upon request to existing and prospective participants in insurance arrangements;

(3) The policy, contract, certificate, or other materials shall establish a mechanism by which a committee of preferred providers will be involved in reviewing and advising the insurance arrangement about medical policy, including coverage of new technology and procedures, quality and credentialing criteria, and medical management procedures;

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(4) All policies or contracts shall have a system for credentialing participating preferred providers and shall allow all providers within the insurance arrangement's geographic service area to apply for such credentials periodically and not less than annually. The credentialing process:

(a) Shall begin upon application of a provider for inclusion in the policy or contract; and

(b) Shall be based solely on quality, accessibility, or economic considerations and shall be applied in accordance with reasonable business judgment.

Credentialing standards or criteria shall be made available, upon request, to providers and insureds;

(5) If the policy or contract is with an organized delivery system formed by insurers, hospitals, physicians, or allied health professionals, or a combination of such entities, participation by a provider may be limited to a participant in the organized delivery system or to providers having staff privileges at a particular health care facility;

(6) If an insurer or a participant in an insurance arrangement refuses to contract with a provider, the provider shall be permitted to appeal the adverse decision. A person conducting the provider-appeal procedure may be employed by the insurer or participant in an insurance arrangement if the person does not initially participate in the decision to take adverse action against the provider. The provider-appeal procedure shall include, but not be limited to, notice of the date and time of the hearing, a statement of the criteria or standards on which the decision was based, an opportunity for the provider to review information upon which the adverse decision was based, an opportunity for the provider to appear personally at the hearing and present any additional information, and a timely decision on the appeal;

(7) If the insurer or participant in an insurance arrangement

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excludes or fails to retain a provider previously contracted with to provide health care services, the provider shall be permitted to appeal the adverse decision in the same manner as set forth in subdivision (6) of this section. If the provider disagrees with the decision, the provider shall be permitted to appeal to an appeals committee consisting of one person selected by each party to the appeal and one person mutually agreeable to both parties. The parties to the appeal shall pay to the appeal committee any costs associated with the person they select and shall share the costs of the person mutually agreeable to both parties, which costs shall not be recoverable by the other party;

(8) Prior to initiation of a proceeding to terminate a provider's participation, the provider shall be given an opportunity to enter into and complete a corrective action plan, except in cases of fraud or imminent harm to patient health or when the provider's ability to provide services has been restricted by an action, including probation or any compliance agreements, by the Department of Health and Human Services or other governmental agency; and

(9) Policies and contracts shall not exclude a provider (a) ~~providers~~ with a practice ~~practices~~ containing a substantial number of patients having severe or expensive medical conditions or (b) who holds a visiting faculty permit as described in section 38-2045. An insurance arrangement shall not be prohibited ~~, except that this section shall not prohibit plans~~ from excluding a provider ~~providers~~ who fails ~~fail~~ to meet the insurance arrangement's criteria for quality, accessibility, or economic considerations.

Sec. 2. Original section 44-4109.01, Reissue Revised Statutes of Nebraska, is repealed.