

[Nebraska State Statutes](#)

**Small Employer Health Insurance Availability Act**

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**44-5223. Act, how cited.**

Sections [44-5223](#) to [44-5267](#) shall be known and may be cited as the Small Employer Health Insurance Availability Act.

**Source:** Laws 1994, LB 1222, § 1; Laws 1997, LB 862, § 30; Laws 2000, LB 1253, § 33; Laws 2002, LB 1139, § 29; Laws 2009, LB192, § 5.

**44-5224. Purposes of act.**

The purposes of the Small Employer Health Insurance Availability Act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of basic and standard health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market. The act is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

**Source:** Laws 1994, LB 1222, § 2.

**44-5225. Definitions, where found.**

For purposes of the Small Employer Health Insurance Availability Act, the definitions found in sections [44-5226](#) to [44-5255.01](#) shall be used.

**Source:** Laws 1994, LB 1222, § 3; Laws 1997, LB 862, § 31; Laws 2000, LB 1253, § 34; Laws 2002, LB 1139, § 30; Laws 2009, LB192, § 6.

**44-5226. Actuarial certification, defined.**

Actuarial certification shall mean a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section [44-5258](#) based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

**Source:** Laws 1994, LB 1222, § 4.

#### **44-5227. Affiliate or affiliated, defined.**

Affiliate or affiliated shall mean any entity or person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

**Source:** Laws 1994, LB 1222, § 5.

#### **44-5227.01. Affiliation period, defined.**

Affiliation period means a period of time that must expire before health insurance coverage provided by a carrier becomes effective and during which the carrier is not required to provide benefits.

**Source:** Laws 2002, LB 1139, § 31.

#### **44-5228. Agent, defined.**

Agent shall have the same meaning as insurance producer in section [44-103](#).

**Source:** Laws 1994, LB 1222, § 6; Laws 2001, LB 51, § 36.

#### **44-5229. Base premium rate, defined.**

Base premium rate shall mean for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers

with similar case characteristics for health benefit plans with the same or similar coverage.

**Source:** Laws 1994, LB 1222, § 7.

#### **44-5230. Basic health benefit plan, defined.**

Basic health benefit plan shall mean a lower cost health benefit plan regulated by the board.

**Source:** Laws 1994, LB 1222, § 8; Laws 2009, LB154, § 9.

#### **44-5231. Board, defined.**

Board shall mean the board of directors of the Nebraska Small Employer Health Reinsurance Program.

**Source:** Laws 1994, LB 1222, § 9.

#### **44-5231.01. Bona fide association, defined.**

Bona fide association means, with respect to health insurance coverage offered in this state, an association that meets the following conditions:

- (1) Has been actively in existence for at least five years;
- (2) Has been formed and maintained in good faith for purposes other than obtaining insurance;
- (3) Does not condition membership in the association on a health-status-related factor of an individual, including an employee or a dependent of any employee;
- (4) Makes health insurance coverage offered through the association available to any member regardless of a health-status-related factor of the member or individual eligible for coverage through a member; and
- (5) Does not make available health insurance coverage offered through the association other than in connection with a member of the association.

**Source:** Laws 2009, LB192, § 7.

**44-5232. Broker, defined.**

Broker shall have the same meaning as insurance producer in section [44-103](#).

**Source:** Laws 1994, LB 1222, § 10; Laws 2001, LB 51, § 37.

**44-5233. Transferred to section [44-5242.01](#).**

**44-5234. Case characteristics, defined.**

Case characteristics shall mean demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage shall not be case characteristics for purposes of the Small Employer Health Insurance Availability Act.

**Source:** Laws 1994, LB 1222, § 12.

**44-5234.01. Church plan, defined.**

Church plan shall mean a plan as defined under 29 U.S.C. 1002.

**Source:** Laws 1997, LB 862, § 32.

**44-5235. Class of business, defined.**

Class of business shall mean all or a separate grouping of small employers established pursuant to section [44-5257](#).

**Source:** Laws 1994, LB 1222, § 13.

**44-5236. Repealed. Laws 2009, LB 154, § 27.**

**44-5237. Control, defined.**

Control shall have the same meaning as in section [44-2121](#).

**Source:** Laws 1994, LB 1222, § 15.

**44-5237.01. Creditable coverage, defined.**

(1) Creditable coverage shall mean, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., other than coverage consisting solely of benefits under section 1928 of the act, 42 U.S.C. 1396s;

(e) 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003;

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under 5 U.S.C. 8901 et seq.;

(i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

(j) A health benefit plan under 22 U.S.C. 2504.

(2) Creditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage.

(3) Creditable coverage shall not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on April 19, 1998.

**Source:** Laws 1997, LB 862, § 33; Laws 1998, LB 1035, § 11; Laws 2003, LB 6, § 2.

**44-5238. Dependent, defined.**

Dependent shall mean a spouse, an unmarried child under the age of nineteen years, an unmarried child who is a full-time student under the age of twenty-three years and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

**Source:** Laws 1994, LB 1222, § 16.

**44-5239. Director, defined.**

Director shall mean the Director of Insurance.

**Source:** Laws 1994, LB 1222, § 17.

**44-5240. Eligible employee, defined.**

Eligible employee shall mean an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term shall include a sole proprietor, a partner of a partnership, a member of a limited liability company, and an independent contractor, if the sole proprietor, partner, member, or independent contractor is included as an employee under a health benefit plan of a small employer, but shall not include an employee who works on a part-time, temporary, or substitute basis.

**Source:** Laws 1994, LB 1222, § 18.

**44-5240.01. Enrollment date, defined.**

Enrollment date means the first day of coverage in the health benefit plan or, if earlier, the first day of the waiting period.

**Source:** Laws 2000, LB 1253, § 35.

#### **44-5241. Established geographic service area, defined.**

Established geographic service area shall mean a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance business in this state, within which the carrier is authorized to provide coverage.

**Source:** Laws 1994, LB 1222, § 19.

#### **44-5241.01. Governmental plan, defined.**

Governmental plan shall mean a plan as defined under 29 U.S.C. 1002 and any plan maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

**Source:** Laws 1997, LB 862, § 34.

#### **44-5241.02. Group health plan, defined.**

Group health plan shall mean an employee welfare benefit plan as defined by 29 U.S.C. 1002 to the extent that the plan provides any hospital, surgical, or medical expense benefits to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

**Source:** Laws 1997, LB 862, § 35.

#### **44-5242. Health benefit plan, defined.**

(1) Health benefit plan shall mean any hospital or medical policy or certificate, major medical expense insurance, or health maintenance organization subscriber contract.

(2) Health benefit plan shall 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.

(3) Health benefit plan shall 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.

(4) Health benefit plan shall 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 only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) Health benefit plan shall 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;

(b) Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

**Source:** Laws 1994, LB 1222, § 20; Laws 1997, LB 862, § 36; Laws 2003, LB 6, § 3.

#### **44-5242.01. Health carrier or carrier, defined.**

Health carrier or carrier shall mean any entity that provides health insurance in this state. Health carrier or carrier shall include an insurance company, a fraternal benefit society, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

**Source:** Laws 1994, LB 1222, § 11; R.S.Supp.,1996, § 44-5233; Laws 1997, LB 862, § 37.

#### **44-5242.02. Health-status-related factor, defined.**

Health-status-related factor shall mean any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(8) Disability.

**Source:** Laws 1997, LB 862, § 38.

#### **44-5242.03. Health maintenance organization, defined.**

Health maintenance organization means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

**Source:** Laws 2002, LB 1139, § 32.

#### **44-5243. Index rate, defined.**

Index rate shall mean, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

**Source:** Laws 1994, LB 1222, § 21.

#### **44-5244. Late enrollee, defined.**

Late enrollee shall mean an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan if the initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

(1) The individual meets the following:

(a) The individual was covered under creditable coverage at the time of the initial enrollment;

(b) The individual lost coverage under creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, the death of a spouse, divorce, or legal separation; and

(c) The individual requests enrollment within thirty days after termination of the creditable coverage;

(2) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

(3) A court has ordered coverage be provided for a spouse or a minor or dependent child under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of the court order; or

(4) The individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted.

**Source:** Laws 1994, LB 1222, § 22; Laws 1997, LB 862, § 39.

#### **44-5244.01. Medical care, defined.**

Medical care shall mean amounts paid for:

(1)(a) The diagnosis, care, mitigation, treatment, or prevention of disease or (b) the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in subdivision (1) of this section; and

(3) Insurance covering medical care referred to in subdivisions (1) and (2) of this section.

**Source:** Laws 1997, LB 862, § 40.

#### **44-5244.02. Network plan, defined.**

Network plan shall mean health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

**Source:** Laws 1997, LB 862, § 41.

#### **44-5245. New business premium rate, defined.**

New business premium rate shall mean, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

**Source:** Laws 1994, LB 1222, § 23.

#### **44-5246. Plan of operation, defined.**

Plan of operation shall mean the plan of operation of the Nebraska Small Employer Health Reinsurance Program.

**Source:** Laws 1994, LB 1222, § 24.

#### **44-5246.01. Plan sponsor, defined.**

Plan sponsor shall have the meaning given such term under 29 U.S.C. 1002.

**Source:** Laws 1997, LB 862, § 42.

#### **44-5246.02. Preexisting condition, defined.**

Preexisting condition means a condition whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. Genetic information shall not be treated as a condition for which a

preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.

**Source:** Laws 1997, LB 862, § 43; Laws 2000, LB 1253, § 36.

**44-5247. Premium, defined.**

Premium shall mean all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

**Source:** Laws 1994, LB 1222, § 25.

**44-5248. Program, defined.**

Program shall mean the Nebraska Small Employer Health Reinsurance Program established pursuant to section [44-5261](#).

**Source:** Laws 1994, LB 1222, § 26.

**44-5249. Repealed. Laws 1997, LB 862, § 50.**

**44-5250. Rating period, defined.**

Rating period shall mean the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

**Source:** Laws 1994, LB 1222, § 28.

**44-5251. Reinsuring carrier, defined.**

Reinsuring carrier shall mean a small employer carrier.

**Source:** Laws 1994, LB 1222, § 29.

**44-5252. Restricted network provision, defined.**

Restricted network provision shall mean any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into contractual arrangement with the carrier to provide health care services to covered individuals.

**Source:** Laws 1994, LB 1222, § 30.

#### **44-5253. Small employer, defined.**

Small employer shall mean any person, political subdivision, firm, corporation, limited liability company, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two and no more than fifty eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

**Source:** Laws 1994, LB 1222, § 31; Laws 1995, LB 837, § 2; Laws 1997, LB 862, § 44.

#### **44-5254. Small employer carrier, defined.**

Small employer carrier shall mean a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

**Source:** Laws 1994, LB 1222, § 32.

#### **44-5255. Standard health benefit plan, defined.**

Standard health benefit plan shall mean a health benefit plan regulated by the board.

**Source:** Laws 1994, LB 1222, § 33; Laws 2009, LB154, § 10.

#### **44-5255.01. Waiting period, defined.**

Waiting period means the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the health benefit plan. If an individual enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period.

**Source:** Laws 2000, LB 1253, § 37.

**44-5256. Act; applicability; conditions; waiver.**

(1) The Small Employer Health Insurance Availability Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(a) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

(2) The act shall not apply to individual health benefit plans issued:

(a) To eligible employees of a small employer if the arrangement with the small employer was established prior to January 1, 1995, and met any of the conditions set forth in subsection (1) of this section;

(b) On or after January 1, 1995, to eligible employees of a small employer if the small employer had fewer than three eligible employees when the arrangement was established regardless of whether the small employer subsequently employs three or more employees; or

(c) To eligible employees of a small employer if the full cost of the premium is paid by a salary reduction plan or payroll deduction.

(3)(a) Except as provided in subdivision (b) of this subsection, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by the act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of authority pursuant to the Health Maintenance Organization Act may be considered to be a separate carrier for the purposes of the Small Employer Health Insurance Availability Act.

(c) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The Assumption Reinsurance Act shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

(4)(a) A Taft-Hartley trust, or a carrier with the written authorization of such a trust, may make a written request to the director for a waiver from the application of any of the provisions of subsection (1) of section [44-5258](#) with respect to a health benefit plan provided to the trust.

(b) The director may grant such a waiver if the director finds that application of such subsection with respect to the trust would:

(i) Have a substantial adverse effect on the participants and beneficiaries of such trust; and

(ii) Require significant modifications to one or more collective-bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this section shall not apply to an individual if the person participates in such a trust as an associate member of an employee organization.

**Source:** Laws 1994, LB 1222, § 34; Laws 1995, LB 574, § 48; Laws 1995, LB 837, § 3; Laws 2002, LB 719, § 1.

## Cross References

**Assumption Reinsurance Act,** see section [44-6201](#).  
**Health Maintenance Organization Act,** see section [44-3292](#).

### **44-5257. Separate class of business; established; when; limit.**

(1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(b) The small employer carrier has acquired a class of business from another small employer carrier; or

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of section [44-760](#).

(2) A small employer carrier may establish up to nine separate classes of business.

(3) The director may adopt and promulgate rules and regulations to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) of this section in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that such action would enhance the efficiency and fairness of the small employer marketplace.

**Source:** Laws 1994, LB 1222, § 35.

### **44-5258. Premium rates; requirements; limitation on transfers; director; powers; disclosures required; small employer carrier; duties.**

(1) Premium rates for health benefit plans subject to the Small Employer Health Insurance Availability Act shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent;

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent of the index rate;

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate if such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business;

(d) Adjustments in rates for claim experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

(e) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to section [44-5261](#);

(f) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent;

(g) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1995, a premium rate for a rating period may exceed the ranges set forth in subdivisions (a) and (b) of this subsection for a period of three years following January 1, 1995. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate if such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and

(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business;

(h)(i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

(i) For the purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision if the restriction of benefits to network providers results in substantial differences in claim costs;

(j) The small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size without the prior approval of the director;

(k) The director may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of the act, including regulations that:

(i) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) Prescribe the manner in which case characteristics may be used by small employer carriers.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage since issue.

(3) The director may suspend for a specified period the application of subdivision (1)(a) of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to the renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(5)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with the act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subdivision (a) of this subsection available to the director upon request. Except in cases of violations of the act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the Department of Insurance except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

**Source:** Laws 1994, LB 1222, § 36.

**44-5259. Health benefit plan; renewable; exceptions; small employer carrier; requirements.**

(1) A health benefit plan subject to the Small Employer Health Insurance Availability Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

(a) The small employer has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(b)(i) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds, or their representatives; or

(ii) The small employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) Noncompliance with the small employer carrier's minimum participation requirements;

(d) Noncompliance with the small employer carrier's employer contribution requirements;

(e) A decision by the small employer carrier to discontinue offering a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by the small employer carrier in that market only if the small employer carrier:

(i) Provides advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provides notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner of insurance in each state in which an affected insured individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the small employer carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected small employers, participants, and beneficiaries;

(iii) Offers to each small employer provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the small employer carrier to small employers in the state; and

(iv) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under subdivision (1)(e)(iii) of this section, acts uniformly without regard to the claims experience of those small employers or any health-status-related factor relating to any participants or

beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

(f) A decision by the small employer carrier to discontinue offering and to nonrenew all its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the small employer carrier shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner of insurance in each state in which an affected insured individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the small employer carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected small employers, participants, and beneficiaries; and

(iii) Discontinue all health insurance issued or delivered for issuance in the state's small employer market and not renew coverage under any health benefit plan issued to a small employer; and

(g) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the director shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier that elects not to renew a health benefit plan shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director.

(3) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

(4) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (1) or (2) of this section in the case of the following:

(a) To an eligible person who no longer resides, lives, or works in the service area of the small employer carrier or in an area for which the small employer carrier is authorized to do business, but only if coverage is terminated under this section uniformly without regard to any health-status-related factor of covered individuals; or

(b) To a small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the small employer carrier or the area for which the small employer carrier is authorized to do business.

**Source:** Laws 1994, LB 1222, § 37; Laws 1997, LB 862, § 45.

**44-5260. Small employer, defined; group health plan; health benefit plans; requirements; filing; exceptions; preexisting condition exclusion; network plans.**

(1) For purposes of this section, small employer shall mean, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code shall be treated as one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Small Employer Health Insurance Availability Act that apply to a small employer shall continue to apply at least until the health benefit plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference

in the act to an employer shall include a reference to any predecessor of such employer.

(2)(a) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state, including at least two health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan, and one plan shall be a standard health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan by such small employer carrier. This subdivision shall not require a small employer carrier to offer to small employers a health benefit plan marketed only through a bona fide association.

(b)(i) Subject to subdivision (2)(a) of this section, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with the Small Employer Health Insurance Availability Act. However, no small employer carrier shall be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

(ii) In the case of a small employer carrier that establishes more than one class of business, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if:

(A) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic health benefit plan or a standard health benefit plan;

(B) The criteria are not related to the health status or claim experience of employees or dependents of the small employer;

(C) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(D) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of subdivision (2)(b)(ii) of this section shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(3)(a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subsection may be used by a small employer carrier beginning thirty days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic health benefit plan or standard health benefit plan on the grounds that the plan does not meet the requirements of the act.

(4) Health benefit plans covering small employers shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months, or eighteen months in the case of a late enrollee, following the enrollment date of the individual's coverage due to a preexisting condition or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section [44-5246.02](#). A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(b) A health benefit plan shall not impose any preexisting condition exclusion:

(i) To an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage, and the individual had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage; or

(ii) To a child less than eighteen years of age who is adopted or placed for adoption and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage, and the child had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage;

(c)(i) A small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the aggregate period of time an individual was previously covered by creditable coverage that provided benefits with respect to such services if the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage. The period of continuous coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier. This subdivision shall not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(ii) A small employer carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period:

(A) That does not exceed sixty days for new entrants and does not exceed ninety days for late enrollees;

(B) During which the carrier charges no premiums and the coverage issued is not effective; and

(C) That is applied uniformly, without regard to any health-status-related factor.

(iii) This subdivision does not preclude application of any waiting period applicable to all enrollees under the health benefit plan if any carrier waiting period is no longer than sixty days.

(iv)(A) In lieu of the requirements of subdivision (4)(c)(i) of this section, a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations.

(B) A small employer electing to reduce the period of any preexisting condition exclusion using the alternative method described in subdivision (4)(c)(iv)(A) of this section shall make the election on a uniform basis for all enrollees and count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(C) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described in subdivision (4)(c)(iv)(A) of this section shall prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to

each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage and include in the disclosure statements the effect of the election;

(d)(i) A small employer carrier shall permit an eligible employee or dependent, who requests enrollment following the open enrollment opportunity, to enroll, and the eligible employee or dependent shall not be considered a late enrollee if the eligible employee or dependent:

(A) Was covered under another health benefit plan at the time the eligible employee or dependent was eligible to enroll;

(B) Stated in writing at the time of the open enrollment period that coverage under another health benefit plan was the reason for declining enrollment but only if the health benefit plan or health carrier required such a written statement and provided a notice of the consequences of such written statement;

(C) Has lost coverage under another health benefit plan as a result of the termination of employment, the termination of the other health benefit plan's coverage, death of a spouse, legal separation, or divorce or was under a continuation-of-coverage policy or contract available under federal law and the coverage was exhausted; and

(D) Requests enrollment within thirty days after the termination of coverage under the other health benefit plan.

(ii)(A) If a small employer carrier issues a health benefit plan and makes coverage available to a dependent of an eligible employee and such dependent becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption, then such health benefit plan shall provide for a dependent special enrollment period during which the dependent may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of an eligible employee may be enrolled if otherwise eligible for coverage.

(B) A dependent special enrollment period shall be a period of not less than thirty days and shall begin on the later of (I) the date such dependent coverage is available or (II) the date of the marriage, birth, adoption, or placement for adoption.

(C) If an eligible employee seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(I) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(II) In the case of the birth of a dependent, as of the date of birth; and

(III) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;

(e)(i) Except as provided in subdivision (4)(e)(iv) of this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii)(A) Except as provided in subdivision (4)(e)(iii)(B) of this section, in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage; and

(f)(i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small

employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group except in the case of late enrollees as provided in subdivision (4)(a) of this section.

(ii) Except as permitted under subdivisions (a) and (d) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

(iii) A small employer carrier shall not place any restriction in regard to any health-status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.

(5) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (2) of this section in the case of the following:

(a) To an employee if previous basic health benefit plans or standard health benefit plans have, in the aggregate, paid one million dollars in benefits on behalf of the employee. Benefits paid on behalf of the employee in the immediately preceding two calendar years by prior small employer carriers under basic and standard plans shall be included when calculating the lifetime maximum benefits payable under the succeeding basic or standard plans. In any situation in which a determination of the total amount of benefits paid by prior small employer carriers is required by the succeeding carrier, prior carriers shall furnish a statement of the total benefits paid under basic and standard plans at the succeeding carrier's request; or

(b) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(6)(a) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (2) of this section to or from a small employer as defined in subsection (1) of this section:

(i) If the small employer does not have eligible employees who live, work, or reside in the service area for such network plan; or

(ii) If the small employer does have eligible employees who live, work, or reside in the service area for such network plan, the carrier has demonstrated, if required, to the director that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying subdivision (6)(a)(ii) of this section uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health-status-related factor relating to such employees and dependents.

(b) A small employer carrier, upon denying health insurance coverage in any service area in accordance with subdivision (6)(a)(ii) of this section, shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the date such coverage is denied.

(7) A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection (2) of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of such subsection would place the small employer carrier in a financially impaired condition.

**Source:** Laws 1994, LB 1222, § 38; Laws 1995, LB 837, § 4; Laws 1997, LB 862, § 46; Laws 2002, LB 1139, § 33; Laws 2009, LB192, § 8.

#### **44-5260.01. Certification of creditable coverage.**

(1) Small employer carriers shall provide written certification of creditable coverage to individuals in accordance with subsection (2) of this section.

(2) The certification of creditable coverage shall be provided:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(b) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(c) At the time a request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage described in subdivision (2)(a) or (b) of this section, whichever is later.

(3) Small employer carriers may provide the certification of creditable coverage required under subdivision (2)(a) of this section at a time consistent with notices required under any applicable COBRA continuation provision.

(4) The certificate of creditable coverage required to be provided pursuant to subsection (1) of this section shall contain:

(a) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(b) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(5) To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under subsection (1) of this section if the small employer carrier offering the coverage provides for certification in accordance with subsection (2) of this section.

(6)(a) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to subdivision (4)(c)(iv) of section [44-5260](#) and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (3) of this section, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.

(b) The entity providing the information pursuant to subdivision (6)(a) of this section may charge the requesting group health plan the reasonable cost of disclosing the information.

**Source:** Laws 2002, LB 1139, § 34.

**44-5261. Nebraska Small Employer Health Reinsurance Program; created; powers; board; members; terms; vacancy; powers and duties; small employer**

**carrier; filing required; plan of operation; reinsuring carrier; reinsure with program; when; requirements; premium rates; assessment to fund losses; limitation on liability; exemption from taxation.**

(1) There is hereby created a nonprofit entity to be known as the Nebraska Small Employer Health Reinsurance Program.

(2)(a) The program shall operate subject to the supervision and control of the board. Subject to this subsection, the board shall consist of eight members appointed by the director and the director or his or her designated representative who shall serve as an ex officio member of the board.

(b) In selecting the members of the board, the director shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the director. At least five members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the director.

(c) The initial board members shall be appointed as follows: Two of the members to serve terms of two years; three of the members to serve terms of four years; and three of the members to serve terms of six years. Subsequent board members shall serve for terms of three years. A board member's term shall continue until his or her successor is appointed.

(d) A vacancy in the board shall be filled by the director. A board member may be removed by the director for cause.

(3) Within sixty days after January 1, 1995, each small employer carrier shall make a filing with the director containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

(4) Within one hundred eighty days after the appointment of the initial board, the board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable, and equitable administration of the program and to provide for the sharing of program gains or losses on an equitable and

proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the director.

(5) If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the director shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The director shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the director.

(6) The plan of operation shall:

(a) Establish procedures for handling and accounting of program assets and money and for an annual fiscal reporting to the director;

(b) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

(e) Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; and

(f) Provide for any additional matters necessary for the implementation and administration of the program.

(7) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Small Employer Health Insurance Availability Act, including the authority, with the approval of the director, to enter into contracts with similar

programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) Take any legal action necessary to avoid the payment of improper claims against the program;

(d) Define the health benefit plans for which reinsurance will be provided and issue reinsurance policies, in accordance with the requirements of the act;

(e) Establish rules, conditions, and procedures for reinsuring risks under the program;

(f) Establish actuarial functions as appropriate for the operation of the program;

(g) Assess reinsuring carriers in accordance with the provisions of subsection (11) of this section, and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(h) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and

(i) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(8) A reinsuring carrier may reinsure with the program as provided for in this subsection:

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic health benefit plan or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within sixty days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty days of the commencement of his or her coverage.

(d)(i) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent of the next fifty thousand dollars of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subdivision shall not exceed a maximum limit of ten thousand dollars in any one calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the reinsuring carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers of the United States Department of Labor, Bureau of Labor Statistics, unless the board proposes and the director approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. 300e(c)(2)(A), as such section existed on January 1, 2002, and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in subdivision (d) of this subsection, shall be reduced to reflect that portion of the risk above the amount set forth in subdivision (d) of this subsection that may not be ceded to the program, if any.

(g) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, restricted network provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(9)(a) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in this subsection to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan adjusted to reflect retention levels required under the act.

(b) Premiums for the program shall be as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection; and

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection.

(c) The board periodically shall review the methodology established under subdivision (a) of this subsection, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(10) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any

rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section [44-5258](#).

(11)(a) Prior to April 1 of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(i) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(A) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(B) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(ii) The formula established pursuant to this subsection shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of (A) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (B) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(iii) The board may, with approval of the director, change the assessment formula established pursuant to this subsection from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.

(iv) Subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. 300e et

seq., as such section existed on January 1, 2002, to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(c)(i) Prior to April 1 of each year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(ii) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subdivision (c)(iii) of this subsection, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the director within ninety days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement such amendments to the plan of operation as the director deems necessary to reduce future losses and assessments.

(iii) For any calendar year, the amount specified in this subdivision is one percent of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) If the assessment in any calendar year exceeds the amount specified in subdivision (c)(iii) of this subsection, the board shall notify the director who shall, within ten days of receipt of such notice, suspend the guarantee-issue requirement of subdivision (2)(b)(i) of section [44-5260](#) until such time as the board has implemented changes to the reinsurance program which the board, with the director's approval, determines will be sufficient to fully fund future program liabilities and administrative expenses.

(e) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. Future losses shall include reserves for incurred but not reported claims.

(f) Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

(g) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(h) A reinsuring carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a reinsuring carrier if the director determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessment.

(12) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by the act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

(13) The board, as part of the plan of operation, shall develop standards setting forth the manner and level of compensation to be paid to agents and brokers for the sale of basic health benefit plans and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(14) The program shall be exempt from any and all taxes.

**Source:** Laws 1994, LB 1222, § 39; Laws 1997, LB 862, § 47; Laws 2002, LB 1139, § 35.

**44-5262. Repealed. Laws 2009, LB 154, § 27.**

**44-5263. Board; report required; contents.**

The board shall study and report at least every three years to the director on the effectiveness of the Small Employer Health Insurance Availability Act. The report shall analyze the effectiveness of the act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report shall address whether carriers, agents, and brokers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of the act. The report may contain recommendations for market conduct or other regulatory standards or action.

**Source:** Laws 1994, LB 1222, § 41; Laws 2009, LB154, § 11.

#### **44-5264. Basic health benefit plan; required coverage; applicability.**

Except for specified childhood immunizations of children from birth to six years of age, a statute requiring coverage of a health care service or benefit or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner shall not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to the Small Employer Health Insurance Availability Act.

**Source:** Laws 1994, LB 1222, § 42.

#### **44-5265. Rules and regulations.**

The director shall adopt and promulgate rules and regulations to carry out the Small Employer Health Insurance Availability Act.

**Source:** Laws 1994, LB 1222, § 43.

#### **44-5266. Small employer carrier; market health benefit plan coverage; carrier, agent, or broker; prohibited activities; compensation to agent or broker; denial of application; rules and regulations; unfair trade practice; when; third-party administrator.**

(1) Each small employer carrier shall actively market health benefit plan coverage, including the basic health benefit plans and standard health benefit plans,

to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

(2)(a) Except as provided in subdivision (b) of this subsection, no small employer carrier, agent, or broker shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer; or

(ii) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subdivision (a) of this subsection shall not apply with respect to information provided by a small employer carrier, an agent, or a broker to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3)(a) Except as provided in subdivision (b) of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subdivision (a) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium except that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent or broker, if any, for the sale of a basic health benefit plan or a standard health benefit plan.

(5) No small employer carrier, agent, or broker may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(6) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(7) The director may establish rules and regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(8)(a) A violation of this section by a small employer carrier, an agent, or a broker shall be an unfair trade practice in the business of insurance under the Unfair Insurance Trade Practices Act.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

**Source:** Laws 1994, LB 1222, § 44.

#### **Cross References**

**Unfair Insurance Trade Practices Act**, wsee section [44-1521](#).

#### **44-5267. Reissuance of health benefit plan; when; director; powers.**

The director may adopt and promulgate rules and regulations to require small employer carriers, as a condition of transacting business with small employers in this state after January 1, 1995, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after six months prior to January 1, 1995. The director may prescribe such terms for the reissuance of coverage as the director finds are reasonable and necessary to provide continuity of coverage to small employers.

**Source:** Laws 1994, LB 1222, § 45.