AN ACT

ENTITLED, An Act to repeal certain provisions regarding the South Dakota Risk Pool.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That § 58-17-30.3 be amended to read as follows:

58-17-30.3. The coverage for a newly born child from the moment of birth or for a newly adopted child, from the beginning of the six-month adoption bonding period, shall consist of coverage of injury or sickness including the necessary care and treatment of premature birth and medically diagnosed congenital defects and birth abnormalities. The provisions of §§ 58-17-30.2 to 58-17-30.4, inclusive, apply to any individually written health benefit plan issued or renewed by any health insurer, health carrier, health maintenance organization, fraternal benefit society, nonprofit medical and surgical plan, nonprofit hospital service plan, or other entity providing coverage through a health benefit plan subject to the provisions of this title.

Section 2. That § 58-17-85 be repealed.

Section 3. That § 58-17-85.1 be repealed.

Section 4. That § 58-17-114 be amended to read as follows:

58-17-114. Terms used in §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive, mean:

(1) "Carrier," any person that provides health insurance in the state, including an insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement, a carrier providing excess or stop loss coverage to a self-funded employer, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. The term, carrier, includes any health benefit plan issued through an association or trust. The term, carrier, does not include excess or stop loss covering a risk of insurance as defined in §§ 58-9-5 to 58-9-33, inclusive, and does not include health insurance for coverages that are not health benefit

plans issued by insurance companies, prepaid hospital or medical service plans, or health maintenance organizations;

(2) "Director," the director of the Division of Insurance;

(3) "Enrollee," any individual who is provided qualified comprehensive health coverage under the risk pool;

(4) "Health benefit plan," as defined in subdivision 58-17-66(9);

(5) "Health care facility," any health care facility licensed pursuant to chapter 34-12;

(6) "Health insurance," as defined in § 58-9-3;

(7) "Medicaid," the federal-state assistance program established under Title XIX of the Social Security Act;

(8) "Medicare," the federal government health insurance program established under Title XVIII of the Social Security Act;

(9) "Policy," any contract, policy, or plan of health insurance;

(10) "Policy year," any consecutive twelve-month period during which a policy provides or obligates the carrier to provide health insurance.

Section 5. That § 58-17-115 be repealed.

Section 6. That § 58-17-117 be repealed.

Section 7. That § 58-17-118 be repealed.

Section 8. That § 58-17-121 be amended to read as follows:

58-17-121. The board has the general powers and authority enumerated by §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive, and, in addition to the responsibilities in § 58-17-119, may:

(1) Enter into any contract as necessary or proper to carry out §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive;

(2) Take any legal action necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers;

(3) Take any legal action necessary to avoid the payment of improper claims against the risk pool or the coverage provided by or through the risk pool;

(4) Use medical review to determine that care is clinically appropriate and cost effective for the risk pool;

(5) Establish appropriate rates, scales of rates, rate classifications, and rating adjustments, none of which may be unreasonable in relation to the coverage provided and the reasonable operational expenses of the risk pool;

(6) Issue risk pool plans on an indemnity, network, or provision of service basis and may design, utilize, contract, or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements in providing the coverage required by §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive;

(7) Create appropriate legal, actuarial, and other committees necessary to provide technical assistance in the operation of the risk pool, plan and other contract design, and any other functions within the authority of the risk pool; and

(8) Provide, by including a provision in its plans, for subrogation rights by the risk pool for situations in which the risk pool pays expenses on behalf of an individual who is injured or suffers a disease under circumstances creating a liability upon another person to pay damages to the extent of the expenses paid by the risk pool, but only to the extent the damages exceed the plan deductible and coinsurance amounts paid by the enrollee.

Nothing in §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive, constitutes a waiver

of immunity.

Section 9. That § 58-17-123 be amended to read as follows:

58-17-123. An enrollee shall notify any health care provider or any provider of pharmacy goods or services prior to receiving goods or services or as soon as reasonably possible that the enrollee is qualified to receive comprehensive coverage under the risk pool. Any health care provider or provider of pharmacy goods or services who provides goods or services to an enrollee and requests payment is deemed to have agreed to the reimbursement system as provided for in §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive. Each health care provider shall be reimbursed using medicare reimbursement methodologies at a rate that is designed to achieve a payment that is equivalent to one hundred thirty-five percent of South Dakota's medicaid reimbursement for the goods or services delivered. Each provider of pharmacy goods or services shall be reimbursed at one hundred fifteen percent of South Dakota's medicaid reimbursement for any goods or services provided. Any reimbursement rate to a provider is limited to the lesser of billed charges or the rates as provided by this section. In no event may a provider collect or attempt to collect from an enrollee any money owed to the provider by the risk pool nor may the provider have any recourse against an enrollee for any covered charges in excess of the copayment, coinsurance, or deductible amounts specified in the coverage. However, the provider may bill the enrollee for noncovered services.

Section 10. That § 58-17-125 be repealed.

Section 11. That § 58-17-126 be amended to read as follows:

58-17-126. Following the close of each fiscal year, the board shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the risk pool for the year. In sharing losses among the carriers, the board may abate or defer in any part the assessment of a carrier, if, in the opinion of the board, payment of the assessment would endanger the ability of the carrier to fulfill its contractual obligations. The board may also provide for an initial or interim

assessment against carriers if necessary to assure the financial capability of the risk pool to meet the incurred or estimated claims expenses or operating expenses of the risk pool. This assessment may not exceed twenty-five cents per covered life per month from the time period the risk pool becomes effective. Any assessment made after June 30, 2009, may not be in excess of thirty-five cents per covered life per month. Net gains shall be held at interest to offset future losses or allocated to reduce future assessments.

The assessment of each carrier shall be based upon the number of persons each carrier covers through primary, excess, and stop loss insurance in this state and shall be as follows:

(1) In addition to the powers enumerated in §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive, the board may assess carriers in accordance with the provisions of this section, and make advance interim assessments as may be reasonable and necessary for the risk pool's organizational and interim operating expenses;

(2) Following the close of each fiscal year, the board shall determine the expenses of administration, the net premiums (premiums less reasonable administrative expense allowances), and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. The deficit incurred by the risk pool shall be recouped by assessments apportioned under this section by the board among carriers and from other sources as may be allowed under law;

(3) Each carrier's assessment shall be determined by multiplying the total assessment of all carriers as determined in subdivision (2) by a fraction, the numerator of which equals the number of individuals in this state covered under health benefit plans and certificates, including by way of excess or stop loss coverage, by that carrier, and the denominator of which equals the total number of all individuals in this state covered under health insurance policies and certificates, including by way of excess or stop loss coverage, by

all carriers, all determined as of the end of the prior calendar year;

(4) The board shall make reasonable efforts designed to ensure that each insured individual is counted only once with respect to any assessment. For that purpose, the board shall require each carrier that obtains excess or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured, including by way of excess or stop loss coverage, in whole or part. The board shall allow a carrier who is an excess or stop loss carrier to exclude from its number of insured individuals those who have been counted by the primary carrier, the primary reinsurer, or the primary excess or stop loss carrier for the purpose of determining its assessment under this section;

(5) Each carrier shall file with the board annual statements and other reports deemed to be necessary by the board. The board shall determine each carrier's assessment based on these annual statements and reports. The board may use any reasonable method of estimating the number of insureds of a carrier if the specific number is unknown. With respect to carriers that are excess or stop loss carriers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer or excess or stop loss carrier;

(6) Each carrier may petition the board for an abatement or deferment of all or part of an assessment imposed by the board. The board may abate or defer, in whole or in part, the assessment if, in the opinion of the board, payment of the assessment would endanger the ability of the carrier to fulfill the carrier's contractual obligations. If an assessment against a carrier is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other carriers in a manner consistent with the basis for assessments set forth in this section. The carrier receiving the deferment is liable to the risk pool and remains liable for the deficiency.

Any assessment of the carrier is due and payable on any covered person who is a resident in this state regardless of the state of issuance of the policy or master policy.

Section 12. That § 58-17-127 be repealed.

Section 13. That § 58-17-128 be repealed.

Section 14. That § 58-17-129 be repealed.

Section 15. That § 58-17-130 be repealed.

Section 16. That § 58-17-131 be repealed.

Section 17. That § 58-17-132 be repealed.

Section 18. That § 58-17-133 be repealed.

Section 19. That § 58-17-134 be repealed.

Section 20. That § 58-17-135 be repealed.

Section 21. That § 58-17-136 be repealed.

Section 22. That § 58-17-137 be repealed.

Section 23. That § 58-17-138 be amended to read as follows:

58-17-138. None of the following may be the basis of any civil action or criminal liability against the board or any individual member of the board, or the risk pool, either jointly or separately: the establishment of rates, forms, or procedures for coverage provided pursuant to §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive; serving as a member or carrying out the functions of the board; or any joint or collective action required by §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive. Any person aggrieved by a determination or administrative action made pursuant to §§ 58-17-68, 58-17-70, and 58-17-113 to 58-17-142, inclusive, may request a contested case hearing pursuant to chapter 1-26, which constitutes the person's sole remedy.

Section 24. That § 58-17-139 be repealed.

Section 25. That § 58-17-140 be repealed.

Section 26. That § 58-17-141 be repealed.

Section 27. That § 58-17-142 be amended to read as follows:

58-17-142. Any carrier of any in force individual health benefit plan issued guarantee issued policies prior to August 1, 2003, for which rates are established pursuant to § 58-17-75, may set and charge a maximum premium rate of not more than two and two-tenths times the base premium rate until January 1, 2005, and may set and charge a maximum premium rate of not more than two and one-half times the base premium rate for each year thereafter, if the carrier actively markets individual major medical policies in this state during the entire year of 2003 and each year thereafter. If, in any year after 2003, the carrier discontinues actively marketing individual health benefit plans in this state, the premium rate provisions of § 58-17-75 apply to those policies in force issued guarantee issued policies from the date of the carrier's discontinuance of active marketing.

The provisions of this section apply only to grandfathered plans pursuant to 75 Fed. Reg. 116 (2010) to be codified at 26 C.F.R. §§ 54 and 602, as of January 1, 2015, and 29 C.F.R. § 2590, as of January 1, 2015, and 45 C.F.R. § 147, as of January 1, 2015.

Section 28. That § 58-17-144 be repealed.

Section 29. That § 58-17-145 be repealed.

Section 30. That chapter 58-17 be amended by adding thereto a NEW SECTION to read as follows:

Any person covered under a risk pool established pursuant to the provisions of § 58-17-113 in the state of South Dakota may submit a health claim within six months from June 30, 2015. Each claim shall be submitted in writing to the Bureau of Human Resources. A claim shall be paid in accordance with the South Dakota risk pool plan document in effect July 1, 2014, through June 30, 2015, inclusive.

Section 31. That § 58-18-7.11 be amended to read as follows:

58-18-7.11. No insurer may be required to offer or renew a continuation or conversion policy covering any person if:

(1) The person is covered for similar benefits by another individual or group policy;

(2) Similar benefits are provided for or available to such person, by reason of any state or federal law, except any person who becomes entitled to Medicare on or before continuation is elected or who is covered under another group plan on or before continuation is elected;

(3) The benefits under sources of the kind referred to in subdivision (1) for such person or benefits provided or available under sources of the kind referred to in subdivision (2) for such person, together with the continued or converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance;

(4) There has been fraud or material misrepresentation in applying for any benefits under continued or converted policy;

(5) The person failed to pay any required contribution;

(6) There has been cancellation of all similar insurance policies in the entire state;

(7) For cause on the same basis, the plan could terminate the coverage of a similarly situated active employee;

(8) The person was terminated from employment for gross misconduct; or

(9) The group health insurance policy is terminated by an insurer as a result of the group not meeting an insurer's participation or eligibility requirements.

Section 32. That ARSD 20:06:48:01 be repealed.

Section 33. That ARSD 20:06:48:02 to 20:06:48:08, inclusive, and 20:06:48:10 to 20:06:48:20, inclusive, and 20:06:48:22 be repealed.

Section 34. That ARSD 20:06:48:09 be amended to read as follows:

20:06:48:09. Appeals. If a claim is denied, the aggrieved party may appeal in writing to the claims administrator within 90 days of the date of the denial at the address listed on the explanation of benefits (EOB) or in the written utilization review denial. If the claims administrator again denies the claim, the aggrieved party may appeal in writing to the administrator of the risk pool, c/o the Bureau of Human Resources, 500 East Capitol Avenue, Pierre, SD 57501, within 30 days of receiving notification of the denial. The administrator of the risk pool shall issue a written decision within 15 days from the date that the appeal is received. If the administrator of the risk pool denies the claim, the aggrieved party may appeal in writing to the risk pool board within 30 days of receiving notification of the denial and the board shall issue a written decision on the appeal within 15 days from the date the appeal is received. If the risk pool board denies the claim, the aggrieved party may request a hearing before the Office of Hearing Examiners within 30 days of receiving notification of the denial.

If the subject matter of the appeal is not a claim, the aggrieved party shall file an appeal directly to the administrator of the risk pool within 90 days of the date of the decision, and if not satisfied with the decision of the administrator of the risk pool, may appeal to the board within 30 days of the date of that decision. If the aggrieved party is not satisfied with the decision of the board, the aggrieved party may request a hearing before the Office of Hearing Examiners within 30 days of receiving notification of the board's decision.

Prior to the board hearing an appeal the chair of the risk pool board shall appoint a member of the board to serve as the final decision maker. The final decision maker may not participate in the appeal or in any discussions related to the appeal. The final decision maker may accept, reject, or modify the findings, conclusions, and decisions of the hearing examiner pursuant to SDCL 1-26D-6. The aggrieved party may appeal any final decision to the circuit court in accordance with SDCL chapter 1-26.

If an aggrieved party fails to appeal within the time limits provided in this section, no further action is required.

Section 35. That ARSD 20:06:48:09 and 20:06:48:21 be repealed on January 1, 2017.

Section 36. That §§ 58-17-113, 58-17-114, 58-17-116, 58-17-119, 58-17-120, 58-17-121, 58-17-122, 58-17-123, 58-17-124, 58-17-126, 58-17-138, and 58-17-143 be repealed on January 1, 2017.

An Act to repeal certain provisions regarding the South Dakota Risk Pool.

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I certify that the attached Act originated in the

HOUSE as Bill No. 1015

_____
Chief Clerk

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_____
Speaker of the House

Attest:

_____
Chief Clerk

_____
President of the Senate

Attest:

_____
Secretary of the Senate

House Bill No. 1015
File No. ____
Chapter No. _____

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Received at this Executive Office this _____ day of _____ ,

20____ at _____ M.

By _____
for the Governor

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The attached Act is hereby approved this _____ day of _____ , A.D., 20___

_____
Governor

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STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____ , 20___
at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State