2026 South Dakota Legislature

House Bill 1199

Introduced by: ***Representative*** *Rehfeldt*

An Act to address preauthorization requirements for certain health care services and utilization review requirements for certain health benefit plans.

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

Section 1. That § 58-17H-1 be AMENDED:

58-17H-1. Terms used in this chapter mean:

(1) "Adverse determination," any of the following:

(a) A determination by a health carrier, or the carrier's designee utilization review organization, that, based upon the information provided, a request by a covered person for a benefit under the health carrier's health benefit plan, upon application of any utilization review technique, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is, therefore, denied, reduced, or terminated, or payment is not provided or made, in whole or in part, for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit, based on a determination by a health carrier, or the carrier's designee utilization review organization, of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit; or

(d) A rescission of coverage determination;

(2) "Ambulatory review," utilization review of health care services performed or provided in an outpatient setting;

(3) "Authorized representative," ~~a~~ one of the following:

(a) A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter~~, a~~;

(b) A person authorized by law to provide substituted consent for a covered person~~, a~~;

(c) A family member of the covered person or the covered person's treating health care professional, if the covered person is unable to provide consent~~, or a~~;

(d) A health care professional, if the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional~~.~~; and

(e) For ~~any~~ an urgent care request, ~~the term includes~~ a health care professional with knowledge of the covered person's medical condition;

(4) "Case management," a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(5) "Certification," a determination by a health carrier or the carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(6) "Clinical practice guidelines," a systematically developed statement to assist decision making by health care professionals and patient decisions about appropriate health care for specific clinical circumstances and conditions;

(7) "Clinical peer," a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review;

(8) "Clinical review criteria," the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services;

(9) "Concurrent review," utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting;

(10) "Covered benefits" or "benefits," those health care services to which a covered person is entitled under the terms of a health benefit plan;

(11) "Covered person," a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

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

(13) "Discharge planning," the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(14) "Emergency medical condition," a medical condition ~~manifesting itself~~ manifested by acute symptoms of sufficient severity~~, including severe pain, such~~ that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention, would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(15) "Emergency services," with respect to an emergency medical condition:

(a) A medical screening examination that is within the capability of the emergency department of a hospital~~, including~~ and ancillary services routinely available to the emergency department to evaluate ~~such~~ the emergency condition; and

(b) ~~Such further~~ Further medical examination and treatment~~, to the extent they are~~ that is within the capability of the staff and facilities at a hospital to stabilize a patient;

(16) "Facility," an institution providing health care services, or a health care setting, including ~~hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings;~~:

(a) Ambulatory surgical or treatment centers;

(b) Diagnostic, laboratory, and imaging centers;

(c) Hospitals and other licensed inpatient centers;

(d) Rehabilitation and other therapeutic health settings;

(e) Residential treatment centers; and

(f) Skilled nursing centers;

(17) "Health care professional," a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law;

(18) "Health care provider" or "provider," a health care professional or a facility;

(19) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

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

(a) A health maintenance organization;

(b) A nonprofit hospital and health service corporation;

(c) A sickness and accident insurance company; and

(d) Any other entity providing a plan of health insurance, health benefits, or health services;

(21) "Managed care contractor," a person who establishes, operates, or maintains a network of participating providers; or contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan or health carrier;

(22) "Managed care entity," a licensed insurance company, hospital or medical service plan, health maintenance organization, or an employer or employee organization, that operates a managed care plan or a managed care contractor. The term does not include a licensed insurance company unless ~~it~~ the company contracts with other entities to provide a network of participating providers;

(23) "Managed care plan," a plan operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through ~~any of the following~~:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; or

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(24) "Network," the group of participating providers providing services to a health carrier;

(25) "Participating provider," a provider who, under a contract with ~~the~~ a health carrier or with ~~its~~ the health carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the health carrier;

(26) "Pharmaceutical sample," a unit of a prescription drug that is not intended to be sold and is intended to promote the sale of the drug;

(27) "Preauthorization," a determination by a health carrier that the health care services proposed to be provided to a patient are medically necessary and appropriate;

(28) "Prospective review," a utilization review conducted prior to an admission, or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision;

~~(28)~~(29) "Rescission," a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. The term does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

~~(29)~~(30) "Retrospective review," ~~any~~ a review of a request for a benefit that is not a prospective review request, ~~which~~ and does not include the review of a claim that is limited to ~~veracity of documentation, or accuracy of coding, or adjudication for payment~~ the:

(a) Accuracy of coding;

(b) Adjudication for payment; or

(c) Veracity of documentation;

~~(30)~~(31) "Second opinion," an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service;

~~(31)~~(32) "Secretary," the secretary of the Department of Health;

~~(32)~~(33) "Stabilized," with respect to an emergency medical condition, that no material deterioration of the condition is likely, with reasonable medical probability, to result

from, or occur during, the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta;

~~(33) "Utilization review," a set of formal techniques used by a managed care plan or utilization review organization to monitor and evaluate the medical necessity, appropriateness, and efficiency of health care services and procedures including techniques such as ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and retrospective review;~~

(34) "Step therapy override exception," a step therapy protocol should be overridden in favor of coverage of the prescription drug selected by a health care professional within the applicable time frames in § 58-17H-55 and in compliance with chapter 58-17H. This determination is based on a review of the covered person's or health care professional's request for an override, along with supporting rationale and documentation;

(35) "Step therapy protocol," a protocol or program that establishes a specific sequence in which prescription drugs, either self-administered or administered by a health care provider, are covered under a pharmacy or medical benefit by a health carrier, a health benefit plan, or a utilization review organization for a specified medical condition and medically appropriate for a health carrier, a health benefit plan, or utilization review organization~~, including self-administered drugs and drugs administered by a health care professional; and~~;

(36) "Utilization review," a set of formal techniques used by a managed care plan or utilization review organization to monitor and evaluate the medical necessity, appropriateness, and efficiency of health care services and procedures, which includes techniques such as ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and retrospective review; and

(37) "Utilization review organization," an entity that conducts utilization review other than a health carrier performing utilization review for its own health benefit plans.

Section 2. That a NEW SECTION be added to chapter 58-17H:

Before an adverse determination is issued, by a utilization review organization that questions the medical necessity, appropriateness, or experimental or investigational nature of a health care service, the organization shall provide to the health care professional who ordered, requested, provided, or is to provide the service, a reasonable

opportunity to discuss the covered person's treatment plan and the clinical basis for the organization's determination with a health care professional employed by the organization. If the service was ordered, requested, provided, or is to be provided by a physician, the opportunity to discuss the treatment plan and the clinical basis must be with another physician who is licensed to practice medicine in this state and has the same or a similar specialty.

This section applies only to a utilization review requested on or after July 1, 2026.

Section 3. That a NEW SECTION be added to chapter 58-17H:

A preauthorization process used by a health benefit plan, pursuant to sections 3 to 17, inclusive, of this Act, is subject to the same limitations and requirements provided by this title for a preauthorization used by an insurer.

Section 4. That a NEW SECTION be added to chapter 58-17H:

Sections 3 to 17, inclusive, of this Act, apply only to:

(1) A health benefit plan offered by a health carrier;

(2) A person who contracts with a health carrier to issue preauthorizations; and

(3) A preferred provider benefit plan or an exclusive benefit plan offered by a health carrier licensed pursuant to chapter 58-6.

Sections 2 to 17, inclusive, of this Act do not apply to the state medicaid program, as provided for in chapter 28-6.

Section 5. That a NEW SECTION be added to chapter 58-17H:

Except as otherwise provided, once every twelve months, a health carrier shall evaluate whether a health care provider qualifies for an exemption from preauthorization.

A health carrier that uses a preauthorization process for a health care service may not require a health care provider to obtain preauthorization for a particular health care service if, in the most recent twelve-month evaluation period, the health carrier approved or would have approved at least ninety percent of the preauthorization requests submitted by the health care provider for the particular health care service.

If compliance with a health benefit plan subject to this chapter is an additional coverage requirement, the compliance may not be considered in determining whether the preauthorization exemption is met.

A health carrier may continue an exemption under this section without evaluating whether the health care provider qualifies for the exemption for a particular evaluation period.

A health care provider is not required to request an exemption under this section to qualify for the exemption.

Section 6. That a NEW SECTION be added to chapter 58-17H:

An exemption from preauthorization requirements given to a health care provider under section 5 of this Act remains in effect until:

(1) The thirtieth day after the date the health carrier notifies the health care provider of the determination to withdraw the exemption under section 7 of this Act, if the health care provider does not appeal the determination; or

(2) The fifth day after the date the independent review organization affirms the health carrier's determination to withdraw the exemption, if the health care provider appeals the determination.

If a health carrier does not finalize an exemption withdrawal determination as provided for in this section, the health care provider is considered to have met the criteria of section 5 of this Act to continue to qualify for the exemption.

Section 7. That a NEW SECTION be added to chapter 58-17H:

A health carrier may only withdraw an exemption from the preauthorization requirement under section 5 of this Act if the health carrier:

(1) Makes a determination, on the basis of a historical review of a random sample consisting of no fewer than five nor more than twenty claims submitted by the health care provider during the most recent evaluation period described in section 5 of this Act, that less than ninety percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the health carrier when conducting preauthorization review for the particular health care service during the relevant evaluation period; and

(2) Notifies the health care provider at least thirty days before the proposed exemption withdrawal is to take effect and provides notice containing:

(a) The sample information used to make the determination under subdivision (1) of this section; and

(b) A plain language explanation of how the health care provider may appeal and seek an independent review of the determination.

A determination under subdivision (1) must be made by an individual licensed to practice medicine in this state. If the determination under subdivision (1) pertains to claims submitted by a physician, the determination must be made by an individual who is licensed to practice medicine in this state and has the same or a similar specialty as that of the physician.

A health carrier may only rescind an exemption from the preauthorization requirement under section 5 of this Act during January or July of each year.

Section 8. That a NEW SECTION be added to chapter 58-17H:

A health carrier may deny an exemption from the preauthorization requirement under section 5 of this Act only if:

(1) The health care provider does not have the exemption at the time of the relevant preauthorization request evaluation period; and

(2) The health carrier provides the health care provider with statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the health care provider does not meet the criteria for an exemption from the preauthorization requirement for the particular health care service under section 5 of this Act.

Section 9. That a NEW SECTION be added to chapter 58-17H:

A health care provider may request a review of an adverse exemption determination by an independent review organization. A health carrier may not require a health care provider to engage in an internal appeal process before requesting a review by an independent review organization.

A health carrier must pay:

(1) For any appeal or independent review of an adverse exemption determination regarding a preauthorization exemption requested under this section; and

(2) The recordholder's customary costs for any copies of medical records or other documents requested from a health care provider during an exemption withdrawal review under this section.

An independent review organization must complete an expedited review of an adverse exemption determination regarding a preauthorization exemption no later than thirty days after the date on which a health care provider files the request for a review under this section.

A health care provider may request that the independent review organization consider another random sample of at least five and no more than twenty claims submitted to the health carrier by the health care provider during the relevant evaluation period, for the relevant health care service, as part of the review. The independent review organization must base the determination on the medical necessity of the claims reviewed by the health carrier under section 7 of this Act and reviewed as provided for in this section.

Section 10. That a NEW SECTION be added to chapter 58-17H:

A health carrier is bound by an appeal or independent review determination that does not affirm the determination made by the health carrier to withdraw a preauthorization exemption.

A health carrier may not deny a health care service solely on the basis of a denial or carrier withdrawal of an exemption, even if the health carrier's determination to withdraw the preauthorization exemption is affirmed by an independent review organization.

If a determination of a preauthorization exemption made by the health carrier is overturned on review by an independent review organization, the health carrier:

(1) May not attempt to withdraw the exemption before the end of the next evaluation period that occurs; and

(2) May withdraw the exemption only after the health carrier complies with sections 7 and 9 of this Act.

Section 11. That a NEW SECTION be added to chapter 58-17H:

After a final determination or review affirming the exemption withdrawal or denial of an exemption for a specific health care service under section 5 of this Act, a health care provider is eligible for consideration of an exemption for the same health care service after the twelve-month evaluation period following the period that formed the basis of the carrier withdrawal or denial of an exemption.

Section 12. That a NEW SECTION be added to chapter 58-17H:

A health carrier may not deny or reduce payment to a health care provider for a health care service that the health care provider has qualified for an exemption from the

preauthorization requirement under section 5 of this Act, based on medical necessity or appropriateness of care, unless the health care provider:

(1) Knowingly and materially misrepresented the health care service in a request for payment submitted to the health carrier with the specific intent to deceive and obtain an unlawful payment from the health carrier; or

(2) Failed to substantially perform the health care service.

Section 13. That a NEW SECTION be added to chapter 58-17H:

A health carrier may not conduct a historical review of a health care service subject to an exemption except:

(1) To determine if the health care provider qualifies for an exemption; or

(2) If the health carrier has a reasonable cause to suspect a basis for denial exists under section 12 of this Act.

Section 14. That a NEW SECTION be added to chapter 58-17H:

No later than five days after qualifying for an exemption from the preauthorization requirements under section 5 of this Act, a health carrier must provide to the health care provider notice that:

(1) States the health care provider qualifies for an exemption from the preauthorization requirements under section 5 of this Act;

(2) Lists the health care services and health benefit plans to which the exemption applies; and

(3) States the duration of the exemption.

Section 15. That a NEW SECTION be added to chapter 58-17H:

If a health care provider submits a preauthorization request regarding a health care service for which the health care provider qualifies for an exemption from the preauthorization requirements under section 5 of this Act, the health carrier must provide a notice to the health care provider that:

(1) Contains the information set forth in section 5 of this Act;

(2) Details the impediments to coverage, if any; and

(3) Sets forth the payment requirements of the health carrier.

Section 16. That a NEW SECTION be added to chapter 58-17H:

Nothing in sections 3 to 17, inclusive, of this Act may be construed to:

(1) Authorize the provision of a health care service that is outside the scope of the health care provider's licensure; or

(2) Require a health carrier to pay for a health care service that falls outside the scope of licensure and is performed in violation of the law.

Section 17. That a NEW SECTION be added to chapter 58-17H:

Sections 3 to 17, inclusive, of this Act apply to requests for the preauthorization of health care services and requests for utilization reviews made on or after July 1, 2026.