State of South Dakota

SEVENTY-SECOND SESSION
LEGISLATIVE ASSEMBLY, 1997

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HOUSE BILL NO. 1248

Introduced by: Representatives Fischer-Clemens, Apa, Barker, Belatti, Broderick, Chicoine, Collier, Crisp, Davis, Haley, Kazmerzak, Koetzle, Lee, Lockner, Peterson (Bill), Schaunaman, Schrempp, Sperry, and Waltman and Senators Olson, Albers, Brown (Arnold), Dennert, Dunn (Rebecca), Everist, Flowers, Ham, Hunhoff, Hutmacher, Kloucek, Lange, Lawler, Morford-Burg, Reedy, Shoener, Symens, and Valandra

FOR AN ACT ENTITLED, An Act to provide for guaranteed access to health insurance.

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

Section 1. Terms used in this Act mean:

(1) "Administering insurer," the insurer selected to administer the program plan;

(2) "Board," the board of directors of the South Dakota guaranteed access program;

(3) "Dependent," a spouse, an unmarried child under the age of nineteen, an unmarried child who is a full-time student under the age of twenty-three 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;

(4) "Director," the director of the Division of Insurance of the Department of Commerce and Regulation;

(5) "Eligible person," an individual who meets the requirements of section 8 of this Act;

(6) "ERISA," the Employee Retirement Income Security Act of 1974 (Pub. L. No. 93-

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406) as amended and in effect on January 1, 1997;

(7) "Guaranteed access program" or "program," the South Dakota guaranteed access program established by this Act;

(8) "Health benefits," benefits offered on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible person, chiropractic care;

(9) "Insurer," an individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term includes nonprofit medical and surgical plans, nonprofit hospital service plans, health maintenance organizations, third-party administrators, self-insurance arrangements not subject to ERISA jurisdiction, and self-insurance reinsurance plans;

(10) "Program plan," the health insurance coverage offered through the program;

(11) "Qualified plan," a health benefit plan certified by the director as providing the minimum benefits required by this Act or the actuarial equivalent of those benefits.

Section 2. The South Dakota guaranteed access program is hereby created. As a condition of doing business, all insurers who sell health benefit plans in this state are members of the program. The program shall be available July 1, 1998.

Section 3. The program shall operate under the supervision and with the approval of a seven-member board of directors. Members of the program shall share the costs of conducting the meetings of the program and its board of directors. Members of the board may be reimbursed for expenses incurred as board members, but they may not otherwise be compensated for their services. The membership of the board shall consist of the following:

(1) The director of the Division of Insurance, who shall chair the board;

(2) The commissioner of the Bureau of Finance and Management;

(3) One senator appointed by the president pro-tem of the Senate for a term of two years;

(4) One representative appointed by the speaker of the House of Representatives for a term of two years;

(5) Two representatives of insurers who are members of the program, appointed by the director for a term of three years; and

(6) One representative of the administering insurer.

Section 4. The program may exercise powers granted to insurers under the laws of this state and may sue and be sued.

Section 5. The duties of the board are as follows:

(1) Establish administrative and accounting procedures for the operation of the program;

(2) Enter into a contract with the administering insurer of the Comprehensive Health Association of North Dakota for administration of the program;

(3) Provide for reinsuring of risks incurred as a result of issuing the coverages required by members of the program;

(4) In cooperation with the Comprehensive Health Association of North Dakota, provide for administration of policies which are reinsured pursuant to subdivision (3) of this section; and

(5) Establish procedures for reviewing grievances of applicants to and participants in the plan. The director shall adopt the procedures by rules promulgated pursuant to chapter 1-26.

Section 6. The program shall offer a basic health benefit plan to eligible persons which meets or exceeds the following minimum standards:

(1) The minimum benefits for covered individuals shall be equal to at least eighty percent of the cost of covered services in excess of an annual deductible. The annual deductible may not be less than five hundred dollars for each person. The coverage

shall include a limit of three thousand dollars a person on total annual out-of-pocket expenses for services covered. Coverage shall be subject to a maximum lifetime benefit of five hundred thousand dollars;

(2) Covered expenses shall include the usual and customary charges for the following services and articles when prescribed by a physician:

(a) Hospital services;

(b) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction;

(c) Use of radium or other radioactive materials;

(d) Oxygen;

(e) Anesthetics;

(f) Diagnostic X rays and laboratory tests;

(g) Services of a physical therapist; and

(h) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(3) Covered expenses shall include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor. An additional premium may be charged for the services in this subdivision;

(4) Covered expenses may not include the following:

(a) Drugs requiring a physician's prescription;

(b) Services of a nursing home;

(c) Services of a home health agency;

(d) Home and office calls;

(e) Prostheses;

(f) Rental or purchase of durable medical equipment;

(g) The first twenty dollars of diagnostic X rays and laboratory charges in each fourteen-day period;

(h) Oral surgery;

(I) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent to self-insurance, or for which benefits are payable under another accident or health insurance policy or medicare;

(j) Any charge for treatment for cosmetic purposes other than for surgery for the repair of an injury or birth defect;

(k) Any charge for travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(l) Any charge for confinement in a private room to the extent that it exceeds the facility's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(m) That part of a charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care provider which exceeds the prevailing charge in the locality where the service is provided;

(n) Any charge for services or articles the provision of which is not within the scope of authorized practice of the facility or individual rendering the services or articles;

(o) Care which is primarily for custodial or domiciliary purposes and which would

not qualify as eligible services under medicare; and

(p) Any charge for organ transplants unless prior approval is received from the board of directors of the program.

Section 7. Members of the program or the administering insurer may apply to the director for certification of a health benefit plan as a qualified plan under this Act. The director shall determine within ninety days whether or not a plan is qualified. If the director does not respond within ninety days, the plan is considered qualified. Insurers shall label health benefits plans on the front of the policy or certificate as qualified or nonqualified under this Act.

Section 8. Except as provided in section 9 of this Act, any resident of this state is eligible for coverage by the guaranteed access program, including the insured's spouse and any dependent unmarried child of the insured from the moment of birth. A person is eligible for coverage by the program if the person can document the inability to obtain coverage substantially similar to the program without material underwriting restriction at a rate equal to or less than the program rate. The coverage of a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

Section 9. The following persons are not eligible for coverage in the guaranteed access program:

(1) A person who has equivalent coverage under another contract or policy on the date of issue of coverage from the program;

(2) A person who is currently receiving health benefits under any federal or state program providing financial assistance or preventive or rehabilitative social services;

(3) A person whose coverage by the program was terminated less than seven months previously;

(4) A person in whose behalf the program has paid out five hundred thousand dollars in covered benefits;

(5) An inmate incarcerated in a state penal institution or confined to a narcotic detention, treatment, and rehabilitation facility; and

(6) A person who voluntarily terminated or declined conversion from a group health plan or an ERISA plan within the preceding twelve months.

Section 10. Each insurance carrier which rejects an applicant or applies underwriting restrictions to an applicant for health insurance coverage shall notify the applicant of the existence of the program plan, the requirements for being accepted in it, and the procedure for applying to it.

Section 11. The administering insurer shall pay an agent's referral fee of twenty-five dollars to each agent who refers an applicant to the guaranteed access program if the applicant is accepted. The selling or marketing of the program plan is not limited to the administering insurer or its agents. The administering insurer shall pay the referral fees from moneys received as premiums for the program plan.

Section 12. The schedule of premiums to be charged eligible persons for coverage under the program's health benefit plan may not exceed one hundred thirty-five percent of the average of the premium rates charged by the five largest insurers in this state, as determined by the director from information provided by all insurers annually. The director shall prescribe the information required and the procedure for reporting it by rules promulgated pursuant to chapter 1-26.

Section 13. An eligible person may enroll in the program plan by applying to the administering insurer and paying the program plan premium to the administering insurer. The application shall include the following information:

(1) The name, address, and age of the applicant;

(2) The name, address, and age of any dependents who are to be insured;

(3) Written evidence that the applicant was rejected for health insurance by at least one insurer within the previous six months or that restrictive riders or waiting periods for

preexisting conditions were required by the insurer that substantially reduced the coverage compared with that of a person considered to be a standard risk; and

(4) A designation of the coverage desired.

Section 14. Within thirty days after receipt of an application for enrollment, the administering insurer shall either reject the application for failing to comply with the requirements of section 8 of this Act or forward the eligible person a notice of acceptance and billing information. Coverage is effective immediately upon receipt of the first month's premium for the plan and is retroactive to the date of the application. An eligible person may not purchase more than one policy under the program.

Section 15. A person who obtains coverage under the program plan may not be covered for maternity for the first two hundred seventy days. A person may not be covered for any other preexisting condition for the first one hundred eighty days of coverage under the program plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the date of the application. The waiting periods in this section do not apply to a person being treated by nonelective procedures who has lost dependent status under a parent's or guardian's policy that was in effect for the twelve months immediately preceding the date of the application or to a person who is being treated by nonelective procedures for a congenital or genetic disease.

Section 16. Coverage under this chapter terminates under the following circumstances:

(1) At the request of the covered person;

(2) For failure to pay the required premium, subject to a thirty-one-day grace period;

(3) The lifetime maximum benefit amount has been reached;

(4) The covered person qualifies for health benefits under other plans or policies; or

(5) The covered person ceases to be a resident of this state.

Section 17. Not less than eighty-seven and one-half percent of the program plan premium

may be used to pay claims and not more than twelve and one-half percent may be used for payment of the administering insurer's direct and indirect expenses as specified in section 24 of this Act. The program shall hold at interest any income in excess of the costs incurred by the program in providing reinsurance or administrative services and shall use it to offset past and future losses due to claims or shall allocate it to reduction of premiums.

Section 18. Each member of the program shall share the losses due to claims and the expenses of conducting meetings of the program and the board. The difference between the total claims expense of the program plan and the premium payments allocated to the payment of benefits is the liability of the program members. The program members shall share in the excess costs of the program plan in an amount equal to the ratio of a member's total annual premium volume for health insurance charges received from or on behalf of state residents to the total health insurance premium contract charges received by program members, as determined by the director. Each member's liability may be determined retroactively, and payment is due to the administering insurer within thirty days after notice of the assessment is given. Failure by a member to remit to the administering insurer the full amount assessed within thirty days after notice is grounds for termination of membership.

Section 19. The administering insurer of the South Dakota guaranteed access program is the administering insurer of the Comprehensive Health Association of North Dakota. The administering insurer shall perform all administrative and claims payment functions for the program plan.

Section 20. The administering insurer shall provide an individual certificate to all eligible persons enrolled in the program plan. The certificate shall set forth a statement of the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the program.

Section 21. The administering insurer shall submit to the program and the director a semiannual report of the operation of the program plan. The board shall determine the specific information to be contained in the report before the effective date of the program plan.

Section 22. The administering insurer shall publicize the existence of the guaranteed access program in this state, the eligibility requirements for the program, and the procedures for enrollment in the program and shall maintain public awareness of the program.

Section 23. The administering insurer shall pay all claims pursuant to this Act and shall indicate that the claim was paid by the program plan. Each claim payment shall include information specifying the procedure for resolving a dispute over the amount of payment.

Section 24. The program shall reimburse the administering insurer for its direct and indirect expenses from the premiums received for the program plan. Direct and indirect expenses include a prorated reimbursement for the portion of the administering insurer's administrative, printing, claims administration, management, and building overhead expenses which are assignable to the maintenance and administration of the program plan. The board shall approve cost accounting methods consistent with generally accepted accounting principles to substantiate the administering insurer's cost reports. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the administering insurer.

Section 25. When carrying out its duties under this Act, the administering insurer is an agent of the program and the director, and it is civilly liable for its actions, subject to the laws of this state.