State of South Dakota

NINETY-SECOND SESSION
LEGISLATIVE ASSEMBLY, 2017

468Y0466

HOUSE BILL NO. 1148

Introduced by: Representatives Ahlers, Hawley, McCleerey, and Rasmussen and Senators Killer, Frerichs, and Nesiba

FOR AN ACT ENTITLED, An Act to reinstate certain provisions of the South Dakota risk pool, to make an appropriation therefor, and to declare an emergency.

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

Section 1. That the code be amended by adding a NEW SECTION to read:

If a person has an aggregate of at least twelve months of creditable coverage, is a resident of this state, and applies within sixty-three days of the date of losing prior creditable coverage, the person is eligible for coverage as provided for in § 58-17-68, 58-17-70, or under the provisions contained in this Act, if none of the following apply:

(1) The applicant is eligible for continuation of coverage under an employer plan;

(2) The person is eligible for an employer group plan, Part A or Part B of Medicare, or Medicaid;

(3) The person has other health insurance coverage;

(4) The person's most recent coverage was terminated because of the person's nonpayment of premium or fraud;

(5) The person loses coverage under a short-term or limited duration plan; or

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(6) The person's last coverage was creditable coverage as defined in subdivision 58-17-69(13) or a federal preexisting condition insurance plan.

Any person who has exhausted continuation rights and who is eligible for conversion or other individual or association coverage has the option of obtaining coverage pursuant to this section or the conversion plan or other coverage. If a person chooses conversion coverage, other than pursuant to § 58-17-74, in lieu of coverage pursuant to this section and the person later exhausts the lifetime maximum of the conversion coverage, the person may obtain coverage pursuant to this section as long as the person continues to satisfy the criteria of this section. A person who is otherwise eligible for the issuance of coverage pursuant to this section may not be required to show proof that coverage was denied by another carrier.

For purposes of this section, reasonable evidence that the prospective enrollee is a resident of this state shall be required. Factors that may be considered include a driver license, voter registration, and where the prospective enrollee resides.

Any person who was eligible for the risk pool and opted for coverage pursuant to § 58-17-74 may, at any time while covered under that policy or within sixty-three days of terminating that coverage, elect to enroll in the risk pool.

Section 2. That the code be amended by adding a NEW SECTION to read:

Any health carrier with any in force individual health benefit plan issued in accordance with section 1 of this Act prior to July 1, 2017, shall offer, at the option of the insured, additional deductible options of the following:

(1) One thousand dollars with a four thousand dollar out-of-pocket coinsurance maximum;

(2) Three thousand dollars with a two thousand dollar out-of-pocket coinsurance maximum;

(3) Five thousand dollars with no more than a twenty-five percent coinsurance; and

(4) Ten thousand dollars with a twelve thousand two hundred fifty dollar out-of-pocket maximum, including the deductible.

Any additional deductible option, with the exception of the five thousand dollar option, may not require that the insured be responsible for more than a fifty percent coinsurance. If the policy is a family policy, the health carrier may satisfy the options listed above by offering amounts that are twice the amounts provided in subdivisions (1) to (4), inclusive. The premium rates for these benefit plans shall be adjusted based upon the actuarial difference in benefits. A health carrier is not required to offer a deductible option if that option would decrease the insured's deductible or out-of-pocket maximum. The director may approve alternatives to those deductible options specified in this section if the alternatives are consistent with the offering of increased deductible options to insureds and at least one of the alternatives is consistent with the formation of a health savings account as provided for by 26 U.S.C. § 223.

Section 3. That the code be amended by adding a NEW SECTION to read:

Terms used in § 58-17-68, 58-17-70, or contained within the provisions of this Act, 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 includes any health benefit plan issued through an association or trust. The term 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 person 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 4. That the code be amended by adding a NEW SECTION to read:

There is established a risk pool to provide health insurance coverage, pursuant to the provisions of §§ 58-17-68, 58-17-70, and contained within the provisions of this Act, to each eligible South Dakota resident who applies for coverage after July 1, 2017.

Section 5. That the code be amended by adding a NEW SECTION to read:

A seven-member board appointed by the Governor shall administer the risk pool. The board shall include representatives of the Governor's Office, Department of Social Services, Bureau of Human Resources, Department of Health, and Division of Insurance and two other persons appointed by the Governor. The board may contract for the performance of any of its functions.

Section 6. That the code be amended by adding a NEW SECTION to read:

The board shall request bids for an administrator of the risk pool. The contract with an administrator shall be designed to become effective no later than December 31, 2017. If the board determines that the bids are not consistent with the efficient operation of the risk pool, the board may continue to administer the risk pool and to contract for services. Regardless, the board shall perform all appropriate oversight functions.

Section 7. That the code be amended by adding a NEW SECTION to read:

There is established an advisory panel to the board consisting of two lay members, one of which shall be an employee, and at least one representative of each of the following: individual health insurance carriers, group health insurance carriers, health care providers, insurance producers, health care facilities, self-insurers, and employers as well as one state senator appointed by the president pro tempore of the Senate and one state representative appointed by the speaker of the House of Representatives. The Governor shall appoint the nonlegislative representatives of the advisory panel for a specific term not less than two years and not more than three years. The terms of service shall overlap. The advisory panel may make recommendations to the board regarding benefits and exclusions in the risk pool coverage, eligibility for the risk pool, assessments of carriers, and operation of the risk pool. The board shall consider any input from the advisory panel in making any decisions relative to rule-making, benefits, exclusions, eligibility, assessments, and risk pool operation, and shall sponsor and attend such meetings as may be necessary between the board and the advisory panel to provide the input as required by this section.

Section 8. That the code be amended by adding a NEW SECTION to read:

The board shall perform its functions in such a manner as to assure the fair and reasonable administration of the risk pool and to provide for the sharing of risk pool losses, if any, on an equitable and proportionate basis among the carriers. In addition to other requirements, the

board is responsible for all of the following:

(1) The handling and accounting of assets and moneys of the risk pool;

(2) Procedures for assessing the carriers in proportion to the number of persons they cover through primary, excess, and stop loss insurance in this state;

(3) Methods for ensuring that all risk pool enrollees are and continue to be eligible for the risk pool; and

(4) Additional provisions necessary or proper for the execution of the powers and duties of the risk pool.

The board shall file a report with the Legislature each year on or before January first, which shall include information regarding the operation of the risk pool, such as assessments, numbers of enrollees, claims, expenses, and premiums.

Section 9. That the code be amended by adding a NEW SECTION to read:

There is hereby established a South Dakota risk pool fund within the Bureau of Human Resources to receive premiums, assessments, federal funds, and any claims and make payments either directly or indirectly to health care providers and others to carry out the functions of the risk pool.

Section 10. That the code be amended by adding a NEW SECTION to read:

The board has the general powers and authority enumerated by §§ 58-17-68, 58-17-70, and this Act, may:

(1) Enter into any contract as necessary or proper to carry out §§ 58-17-68, 58-17-70, or the sections of this Act;

(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 the provisions of this Act;

(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;

(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 a person 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; and

(9) Allow an applicant who is not otherwise eligible for coverage pursuant to section 1 of this Act to enroll in the risk pool if all of the following are met:

(a) The applicant is covered by an individual health benefit plan that is no longer

being marketed in this state and has a premium rate that exceeds two hundred percent of the applicable rate, based upon that person's rating characteristics, charged to risk pool enrollees;

(b) The risk pool's financial solvency would not be impaired by enrolling the applicants under this subdivision;

(c) Sufficient federal funding exists to cover expected losses for those enrolled pursuant to this subdivision; and

(d) The number of applicants enrolled into the risk pool pursuant to this subdivision in any given calendar year does not exceed three percent of the total number of covered persons in individual health benefit plans that are no longer being marketed in this state.

Nothing in § 58-17-68, 58-17-70, or this Act, constitutes a waiver of immunity.

Section 11. That the code be amended by adding a NEW SECTION to read:

If a claim to the risk pool for which benefits are payable under the risk pool exists under circumstances creating in some other person a legal liability to pay damages in respect thereto, the enrollee may either make claim to the risk pool or proceed at law against such other person to recover damages or proceed against both the risk pool and such other person. However, if the injured enrollee recovers any like damages from such other person, the recovered damages shall be an offset against any risk pool benefits which the enrollee would otherwise have been entitled to receive. If claims have been paid by the risk pool and the enrollee has recovered damages from another person, the risk pool may recover from the enrollee an amount equal to the amount of the claim paid to the enrollee by the other person, less the necessary and reasonable expense of collecting the same. However, the risk pool may waive its subrogation rights if the risk pool determines that the exercise of the rights would be impractical, uneconomical, or would create

a hardship on the enrollee.

Section 12. That the code be amended by adding a NEW SECTION to read:

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 this Act. 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 fifteen 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 13. That the code be amended by adding a NEW SECTION to read:

The board may promulgate rules, pursuant to chapter 1-26, necessary for the operation of the risk pool. Any rule promulgated pursuant to this section shall be designed to assure the fair, equitable, and efficient operation of the risk pool. The board shall consult with and consider any recommendations of the advisory panel. The rules may address the following:

(1) Definition of terms;

(2) Provider reimbursement and participation;

(3) Rating;

(4) Assessments;

(5) Eligibility;

(6) Notices, forms, and disclosures;

(7) Plan benefits, exclusions, and requirements;

(8) Reports and audits; and

(9) Cost containment and intervention mechanisms.

Section 14. That the code be amended by adding a NEW SECTION to read:

The premium rates for coverages provided by the risk pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing coverage. Case characteristics as allowed pursuant to § 58-17-74 may be used in establishing rates for those covered by the risk pool. The rates shall take into consideration the extra morbidity and administrative expenses, if any, for enrollees in the risk pool. The rates for a given classification for those that qualify for coverage pursuant to section 1 of this Act shall be one hundred fifty percent of the average actively marketed premium or payment rate for that classification charged by the carriers with the largest number of individual health benefit plans in the state during the preceding calendar year. For purposes of this section, only individual health benefit plans that are being actively marketed to the general public may be utilized in determining the largest carriers. The board shall select a sufficient number of carriers from which to calculate the average so that at least ninety percent of the market is represented and the carriers selected sequentially have the largest number of actively marketed health benefit plans. The number of carriers selected may not be less than three. In determining the average rate of the largest individual health carriers, the rates or payments charged by the carriers shall be actuarially adjusted to determine the rate or payment that would have been charged for benefits

similar to those provided by the risk pool.

Section 15. That the code be amended by adding a NEW SECTION to read:

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, 2017, 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 contained within the provisions of this Act, 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 persons 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 persons 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 person 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 persons all persons 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 persons 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 16. That the code be amended by adding a NEW SECTION to read:

The board may conduct periodic audits to assure the general accuracy of the financial data submitted to the board and may require the plan administrator or any contractor to provide the board with an annual audit of its operations to be made by an independent certified public accountant.

Section 17. That the code be amended by adding a NEW SECTION to read:

Any plan provided pursuant to § 58-17-68, 58-17-70, or in accordance with the provisions of this Act shall be filed with and approved by the director before its use.

Section 18. That the code be amended by adding a NEW SECTION to read:

No fee or tax levied by this state or any of its political subdivisions applies to the risk pool or any function of the risk pool performed pursuant to § 58-17-68, 58-17-70, or this Act.

Section 19. That the code be amended by adding a NEW SECTION to read:

The risk pool shall offer at least three plan designs that provide comprehensive coverage benefits consistent with major medical coverage currently being offered in the individual health insurance market. The coverage and benefits for plans provided pursuant to § 58-17-68, 58-17-70, or any section of this Act, may be established by the board, consistent with the requirements of §§ 58-17-68, 58-17-70, and the provisions of this Act, and may not be altered by any other state law without specific reference to §§ 58-17-68, 58-17-70, and any other applicable section under this Act, indicating a legislative intent to add or delete from the coverage provided pursuant to § 58-17-68, 58-17-70, or any section contained within this Act. Each plan shall cover biologically-based mental illnesses on the same basis as other covered illnesses. The board may create plan designs to meet federal requirements for qualifying high deductible health plans for health savings accounts.

Section 20. That the code be amended by adding a NEW SECTION to read:

Each plan shall include disease management programs that contain cost containment mechanisms. If the enrollee does not enroll and participate in the applicable cost containment activities, the enrollee is responsible for fifty percent of the eligible expenses for related services after the deductible is met, and there is no maximum out-of-pocket coinsurance amount.

Section 21. That the code be amended by adding a NEW SECTION to read:

Each plan shall provide pharmacy benefits. The cost sharing provisions for the pharmacy benefit shall be established by the board and outlined in the plan document.

Section 22. That the code be amended by adding a NEW SECTION to read:

Each plan shall offer the following plan-year benefit maximums:

(1) Thirty days coverage for inpatient alcoholism and substance abuse treatment;

(2) Two thousand dollars for outpatient alcoholism and substance abuse treatment; and

(3) Nine hundred dollars for up to thirty outpatient mental health visits for qualified

conditions that are not biologically-based.

Section 23. That the code be amended by adding a NEW SECTION to read:

Each plan shall provide the following lifetime benefit maximums:

(1) Two million dollars in paid expenses; and

(2) Ninety days coverage for inpatient alcoholism and substance abuse treatment.

Section 24. That the code be amended by adding a NEW SECTION to read:

Any plan provided pursuant to §§ 58-17-68, 58-17-70, or this Act, shall extend newborn coverage pursuant to §§ 58-17-30.2 to 58-17-30.4, inclusive, and shall provide that the newborn is eligible for an individual risk pool plan unless deemed ineligible pursuant to section 25 of this Act.

Section 25. That the code be amended by adding a NEW SECTION to read:

Except as otherwise provided in §§ 58-17-68, 58-17-70, or any section of this Act, no person is eligible for a plan created by §§ 58-17-68, 58-17-70, or this Act, if the person, on the effective date of coverage, has or will have coverage as an insured or covered dependent under any insurance plan that has creditable coverage as defined in § 58-17-69; is eligible for benefits under chapter 28-6 at the time of application; is an inmate of any public institution or is eligible for public programs for which medical care is provided; or has his or her premiums paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider. Coverage under a plan provided pursuant to § 58-17-68, 58-17-70, or any section of this Act, is in excess of, and may not duplicate, coverage under any other form of health insurance, employee/employer welfare plan, medical coverage under any homeowner's or motorized vehicle insurance, no-fault automobile coverage, service or payment received under the laws of any national, state, or local government, or TRICARE.

This section does not apply to those persons meeting the provisions of chapter 28-13. An enrollee of the risk pool who has met the lifetime maximum under the risk pool plan is ineligible for further benefits as an enrollee in the risk pool.

Coverage provided pursuant to § 58-17-68, 58-17-70, or any section of this Act, terminates for any person on the date that, if such circumstance had been present at the time of application, the person would have been ineligible for coverage provided by §§ 58-17-68, 58-17-70, or any section of this Act. Coverage may also be terminated for nonpayment of premiums.

For purposes of this section, if any premium is paid to the risk pool by an employer, other than an employer with only one employee, the enrollee is deemed to have equivalent coverage and is ineligible for the risk pool.

Section 26. That the code be amended by adding a NEW SECTION to read:

The rates for any plan created by § 58-17-68, 58-17-70, or pursuant to this Act, may not change except on a class basis with a clear disclosure in the plan.

Section 27. That the code be amended by adding a NEW SECTION to read:

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, or under this Act; 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, or under any of the provisions contained within this Act. Any person aggrieved by a determination or administrative action made pursuant to § 58-17-68, 58-17-70, or under any section of this Act, may request a contested case hearing pursuant to chapter 1-26, which constitutes the person's sole remedy.

Section 28. That the code be amended by adding a NEW SECTION to read:

Any carrier authorized to provide individual health care insurance or coverage for health

care services in this state shall provide notice of the availability of the coverage provided by § 58-17-68, 58-17-70, or any section of this Act, and an application for the coverage to any person eligible pursuant to section 1 of this Act. The director shall prescribe the format for the notice, and the board shall prescribe the application forms and make the forms available to the carriers.

Section 29. That the code be amended by adding a NEW SECTION to read:

Any carrier that issued a basic or standard policy pursuant to section 1 of this Act prior to December 31, 2017, with an original effective date of December 31, 2017, or thereafter, to a person who applied for a basic or standard policy and is eligible for the risk pool may rescind that policy. The carrier shall forward all application materials of any person whose policy was rescinded pursuant to this section to the risk pool and the person shall be provided with coverage under the risk pool as provided by §§ 58-17-68, 58-17-70, and this Act.

Section 30. That the code be amended by adding a NEW SECTION to read:

No commission paid to any insurance producer for placing coverage with the risk pool may exceed three percent.

Section 31. That the code be amended by adding a NEW SECTION to read:

Any carrier of any in force individual health benefit plan issued as risk pool coverage prior to July 1, 2017, 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, 2019, 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 2017 and each year thereafter. If, in any year after 2017, 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 as risk pool coverage from the date of the carrier's discontinuance of active marketing.

Section 32. That the code be amended by adding a NEW SECTION to read:

The board may, directly or indirectly, enter into preferred provider contracts to obtain discounts on goods or services from out-of-state providers. If health care goods or services are provided pursuant to a preferred provider contract and the goods or services are either not readily available in this state or are emergency services as by § 58-17H-1, the provisions of that contract shall govern the reimbursement rate. The payment by the risk pool for any services received from out-of-network providers in other states, other than emergency treatment as defined by § 58-17H-1, is limited to one hundred fifteen percent of South Dakota's Medicaid reimbursement. Emergency treatment, as defined in § 58-17H-1, that is from an out-of-state provider that is an out-of-network provider, to the extent that the services are payable under the plan, may be reimbursed by the risk pool at an amount that does not exceed the amount determined to be reasonable by the plan administrator.

Section 33. That the code be amended by adding a NEW SECTION to read:

A person under the age of nineteen, who is not otherwise qualified for the risk pool pursuant to section 1 of this Act, may enroll in the risk pool if the following conditions are met:

(1) The person is a citizen of the United States of America and a resident of this state;

(2) The person has been rejected, or offered coverage conditioned upon exclusionary riders, by at least one carrier in the individual market for comprehensive major medical coverage in the last six months;

(3) The person has not had comprehensive major medical coverage or other creditable coverage within the six months preceding application for the risk pool; and

(4) The person is not covered or eligible to be covered by any other creditable coverage.

The risk pool board may establish open enrollment periods for persons, which qualify for enrollment pursuant to this section and which have been without creditable coverage for at least twelve months. No enrollee is subject to a preexisting waiting period as defined by § 58-17-84 during an open enrollment period. The open enrollment period shall be two months in duration.

Section 34. There is hereby appropriated from the state health care trust fund the sum of six million dollars ($6,000,000), or so much thereof as may be necessary, to the South Dakota risk pool fund.

Section 35. The commissioner of the Bureau of Human Resources shall approve vouchers and the state auditor shall draw warrants to pay expenditures authorized by this Act.

Section 36. Any amounts appropriated in this Act not lawfully expended or obligated shall revert in accordance with the procedures prescribed in chapter 4-8.

Section 37. This Act is repealed on July 1, 2022.

Section 38. Whereas, this Act is necessary for the immediate preservation of the public peace, health, or safety, an emergency is hereby declared to exist, and this Act shall be in full force and effect from and after its passage and approval.