



# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

400S0163

SENATE COMMERCE AND ENERGY

ENGROSSED NO. **HB 1034** - 2/8/2011

**This bill has been extensively amended (hoghoused) and may no longer be consistent with the original intention of the sponsor.**

Introduced by: The Committee on Commerce at the request of the Department of Revenue and Regulation

1 FOR AN ACT ENTITLED, An Act to revise the requirement for motor vehicle liability  
2 insurance safety rating discounts for certain older motor vehicle drivers.

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

4 Section 1. That § 58-11-58 be amended to read as follows:

5 58-11-58. Any schedule of rates or rating plan for private passenger motor vehicle bodily  
6 injury and property damage liability insurance and collision insurance submitted to, or filed  
7 with, the Division of Insurance shall provide for an appropriate reduction in premium charges  
8 for persons fifty-five years of age or older who have successfully completed a motor vehicle  
9 accident prevention course ~~meeting the criteria approved by the Department of Revenue and~~  
10 ~~Regulation.~~

11 A motor vehicle accident prevention course shall include at least four hours of online or  
12 classroom instruction on the effects of aging on driving behavior; the effects of alcohol, drugs,  
13 and medications on older drivers; laws relating to the proper use of a motor vehicle and safe  
14 driving behavior; traffic crash avoidance and prevention measures; and driving hazards and risk



1 factors associated with traffic crash prevention.

2       However, insurers who offer a separate discount which is based upon the age of persons who  
3 are fifty-five years of age or older or upon their driving record, are exempt from the provisions  
4 of this section and are not required to make an additional filing with the Division of Insurance  
5 as a result of the discount required by this section.

6       Section 2. That § 58-11-59 be amended to read as follows:

7       58-11-59. Upon successfully completing the approved course, each person shall be issued  
8 a certificate by the organization offering the course which shall be used to qualify for the  
9 premium discount required by § 58-11-58.

10       Section 3. That § 58-11-60 be amended to read as follows:

11       58-11-60. A person shall take and pass the approved course every three years to continue  
12 to be eligible for the premium discount required by § 58-11-58.

13       Section 4. That § 58-11-61 be amended to read as follows:

14       58-11-61. The premium discount required by § 58-11-58 shall be effective for an insured  
15 for a three-year period after successful completion of the approved course. However, the insurer  
16 may require, as a condition of providing and maintaining the discount, that the insured:

- 17       (1) Has not been involved in an accident for which the insured is at fault;
- 18       (2) Has not been convicted, pled guilty, or nolo contendere to a moving traffic violation,  
19 or to a traffic related alcohol or narcotics offense; and
- 20       (3) Has maintained a driving record free of violations and accidents for which the  
21 insured has been found liable for a three-year period prior to course completion.

22       This section does not apply if the approved course is taken as specified by a court or other  
23 governmental entity resulting from a moving traffic violation.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

866S0331

## HOUSE ENGROSSED NO. **HB 1093** - 2/22/2011

**This bill has been extensively amended (hoghoused) and may no longer be consistent with the original intention of the sponsor.**

Introduced by: Representatives Munsterman, Hubbel, Lust, Novstrup (David), and Sly and  
Senators Kraus and Krebs

1 FOR AN ACT ENTITLED, An Act to repeal certain education mandates to allow the  
2 institutions under the control of the Board of Regents to operate more economically.

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

4 Section 1. That chapter 13-51 be amended by adding thereto a NEW SECTION to read as  
5 follows:

6 Notwithstanding any other provision of law, the Board of Regents shall have the exclusive  
7 authority to supervise the construction of any maintenance and repair projects that have a value  
8 of less than fifty thousand dollars.



# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

186S0465

## HOUSE LOCAL GOVERNMENT ENGROSSED NO. **HB 1104** - 2/15/2011

Introduced by: Representatives Hansen (Jon), Bolin, Brunner, Liss, and Nelson (Stace) and  
Senators Holien, Buhl, Garnos, Lederman, and Rave

1 FOR AN ACT ENTITLED, An Act to revise the deadline for withdrawing from a primary  
2 election.

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

4 Section 1. That § 12-6-8.1 be amended to read as follows:

5 12-6-8.1. Any person may have his or her name withdrawn from the primary election by  
6 making a written request under oath. The request shall be filed with the officer with whom the  
7 nominating petition was filed pursuant to § 12-6-4, not later than ~~the second~~ to two days after  
8 the last Tuesday in March at five p.m. If the request is mailed by registered mail ~~by the second~~  
9 ~~to~~ not later than two days after the last Tuesday in March at five p.m., the request is properly  
10 filed. No name that is withdrawn pursuant to this section may be printed on the ballots to be  
11 used at the election.



# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

481S0239

## HOUSE JUDICIARY ENGROSSED NO. **HB 1155** - 2/14/2011

Introduced by: Representatives Lust, Cronin, Feinstein, and Moser and Senators Cutler,  
Adelstein, Peters, and Vehle

1 FOR AN ACT ENTITLED, An Act to revise various trust provisions.

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

3 Section 1. That § 55-1B-2 be amended to read as follows:

4 55-1B-2. An excluded fiduciary is not liable, either individually or as a fiduciary, for any  
5 of the following:

6 (1) Any loss that results from compliance with a direction of the trust advisor, custodial  
7 account owner, or authorized designee of a custodial account owner;

8 (2) Any loss that results from a failure to take any action proposed by an excluded  
9 fiduciary that requires a prior authorization of the trust advisor if that excluded  
10 fiduciary timely sought but failed to obtain that authorization;

11 (3) Any loss that results from any action or inaction, except for gross negligence or  
12 willful misconduct, when an excluded fiduciary is required, pursuant to the trust  
13 agreement or any other reason, to assume the role of trust advisor, trust protector,  
14 investment trust advisor, or distribution trust advisor.



1 Any excluded fiduciary is also relieved from any obligation to perform investment or  
2 suitability reviews, inquiries, or investigations or to make recommendations or evaluations with  
3 respect to any investments to the extent the trust advisor, custodial account owner, or authorized  
4 designee of a custodial account owner had authority to direct the acquisition, disposition, or  
5 retention of any such investment. If the excluded fiduciary offers such communication to the  
6 trust advisor, trust protector, investment trust advisor, or distribution trust advisor or any  
7 investment person selected by the investment trust advisor, such action may not be deemed to  
8 constitute an undertaking by the excluded fiduciary to monitor or otherwise participate in  
9 actions within the scope of the advisor's authority or to constitute any duty to do so.

10 Any excluded fiduciary is also relieved of any duty to communicate with or warn or apprise  
11 any beneficiary or third party concerning instances in which the excluded fiduciary would or  
12 might have exercised the excluded fiduciary's own discretion in a manner different from the  
13 manner directed by the trust advisor, trust protector, investment trust advisor, or distribution  
14 trust advisor.

15 Absent clear and convincing evidence to the contrary, the actions of the excluded fiduciary  
16 pertaining to matters within the scope of authority of the trust advisor, trust protector,  
17 investment trust advisor, or distribution trust advisor (such as confirming that the advisor's  
18 directions have been carried out and recording and reporting actions taken at the advisor's  
19 direction) shall be presumed to be administrative actions taken by the excluded fiduciary solely  
20 to allow the excluded fiduciary to perform those duties assigned to the excluded fiduciary under  
21 the governing instrument, and such administrative actions may not be deemed to constitute an  
22 undertaking by the excluded fiduciary to monitor or otherwise participate in actions within the  
23 scope of authority of the trust advisor, trust protector, investment trust advisor, or distribution  
24 trust advisor.

1 Nothing in subdivision (2) imposes an obligation or liability with respect to a custodian of  
2 a custodial account.

3 Section 2. That § 55-5-16 be amended to read as follows:

4 55-5-16. A trustee has a duty to personally perform the responsibilities of the trusteeship  
5 except as a prudent person might delegate those responsibilities to others. In deciding whether,  
6 to whom, and in what manner to delegate fiduciary authority in the administration of a trust, and  
7 thereafter in monitoring agents, the trustee may seek the prior approval for the delegation from  
8 all known beneficiaries of the trust or from the court. If such approval is given in writing by all  
9 known beneficiaries or by the court, the trustee is not liable for the acts of the person to whom  
10 the authority is delegated except in the cases of ~~gross willful~~ misconduct or gross negligence by  
11 the delegating trustee in the selection or monitoring of the agent.

12 Section 3. That § 55-1B-1 be amended to read as follows:

13 55-1B-1. Terms used in this chapter mean:

- 14 (1) "Instrument," any revocable or irrevocable trust document created inter vivos or  
15 testamentary or any custodial account agreement;
- 16 (2) "Trust protector," any person whose appointment as protector is provided for in the  
17 instrument. Such person may not be considered to be acting in a fiduciary capacity  
18 except to the extent the governing instrument provides otherwise. However, a  
19 protector shall be considered acting in a fiduciary capacity to the extent that the  
20 person exercises the authority of an investment trust advisor or a distribution trust  
21 advisor;
- 22 (3) ~~Repealed by SL 2005, ch 260, § 2.~~ "Trust advisor," either an investment trust advisor  
23 or a distribution trust advisor;
- 24 (4) "Fiduciary," a trustee or custodian under any instrument, an executor, administrator,

1 or personal representative of a decedent's estate, or any other party, including a trust  
2 advisor, a trust protector, or a trust committee, who is acting in a fiduciary capacity  
3 for any person, trust, or estate;

4 (5) "Excluded fiduciary," any fiduciary excluded from exercising certain powers under  
5 the instrument which powers may be exercised by the grantor, custodial account  
6 owner, trust advisor, trust protector, trust committee, or other persons designated in  
7 the instrument;

8 (6) "Investment trust advisor," a fiduciary, given authority by the instrument to exercise  
9 all or any portions of the powers and discretions set forth in § 55-1B-10;

10 (7) "Distribution trust advisor," a fiduciary, given authority by the instrument to exercise  
11 all or any portions of the powers and discretions set forth in § 55-1B-11;

12 (8) "Custodial account," an account, established by a party with a bank as defined in 26  
13 U.S.C. 408(n), as of January 1, 2006, or with another person approved by the Internal  
14 Revenue Service as satisfying the requirements to be a nonbank trustee or a nonbank  
15 passive trustee set forth in U.S. Treasury Regulations promulgated under 26 U.S.C.  
16 408, that is governed by an instrument concerning the establishment or maintenance,  
17 or both, of an individual retirement account, qualified retirement plan, Archer  
18 medical savings account, health savings account, Coverdell education savings  
19 account, or any similar retirement or savings vehicle permitted under the Internal  
20 Revenue Code of 1986, as of January 1, 2006;

21 (9) "Custodial account owner," any party who establishes a custodial account; or has the  
22 power to designate the beneficiaries or appoint the custodian of the custodial account;  
23 or otherwise is the party who possesses the power to direct the investment,  
24 disposition, or retention of any assets in the custodial account or name an authorized

1           designee to effect the same.

2           Section 4. That chapter 55-1B be amended by adding thereto a NEW SECTION to read as  
3 follows:

4           Any governing instrument providing for a trust advisor or trust protector may also provide  
5 such trust advisor or trust protector with some, none, or all of the rights, powers, privileges,  
6 benefits, immunities, or authorities available to a trustee under South Dakota law or under the  
7 governing instrument. Unless the governing instrument provides otherwise, a trust advisor or  
8 trust protector has no greater liability to any person than would a trustee holding or benefiting  
9 from the rights, powers, privileges, benefits, immunities, or authority provided or allowed by  
10 the governing instrument to such trust advisor or trust protector.

11          Section 5. That § 55-1B-11 be amended to read as follows:

12          55-1B-11. The powers and discretions of a distribution trust advisor shall be provided in the  
13 trust instrument and may be exercised or not exercised, in the best interests of the trust, in the  
14 sole and absolute discretion of the distribution trust advisor and are binding on any other person  
15 and any other interested party, fiduciary, and excluded fiduciary. Unless the terms of the  
16 document provide otherwise, the distribution trust advisor shall direct the trustee with regard  
17 to all discretionary distributions to beneficiaries and may direct appointments pursuant to § 55-  
18 2-15. The distribution trust advisor may also provide direction regarding notification of  
19 qualified beneficiaries pursuant to § 55-2-13.

20          Section 6. That § 55-16-4 be amended to read as follows:

21          55-16-4. Neither the transferor nor any other natural person who is a nonresident of this state  
22 nor an entity that is not authorized by the law of this state to act as a trustee or whose activities  
23 are not subject to supervision as provided in § 55-16-3 may be considered a qualified person.  
24 However, nothing in this chapter precludes a transferor from appointing, removing, or replacing

1 one or more co-trustees, trust advisors, or trust protectors, ~~or other fiduciaries as defined in~~  
2 ~~subdivision 55-1B-1(4), including:~~

3 ~~(1) A fiduciary who has authority under the terms of the trust instrument to remove and~~  
4 ~~appoint qualified persons or trust advisors;~~

5 ~~(2) A fiduciary who has authority under the terms of the trust instrument to direct,~~  
6 ~~consent to, or disapprove distribution from the trust; and~~

7 ~~(3) A fiduciary whether or not such fiduciary would meet the requirements imposed by~~  
8 ~~§ 55-16-3 regardless of whether or not such trust advisor or trust protector is a~~  
9 ~~fiduciary.~~

10 Section 7. That chapter 51A-6A be amended by adding thereto a NEW SECTION to read  
11 as follows:

12 An entity may be excluded from the provisions of chapters 51A-5, 51A-6, and 51A-6A if:

13 (1) The entity is established for the exclusive purpose of acting as a trust protector,  
14 investment trust advisor, or distribution trust advisor, as defined by § 55-1B-1;

15 (2) The entity is acting in such capacity under a trust instrument which names a South  
16 Dakota trust company, a South Dakota bank with trust powers, or a national bank  
17 with trust powers as trustee;

18 (3) The entity is not engaged in trust company business with the general public as a  
19 public trust company or with any family as a private trust company;

20 (4) The entity does not hold itself out as being in the business of acting as a fiduciary for  
21 hire as either a public or private trust company;

22 (5) The entity files an annual report with the South Dakota secretary of state and  
23 provides a copy to the Division of Banking; and

24 (6) The entity agrees to be subject to examination by the Division of Banking at the

1 discretion of the director.

2 The governing documents of any such excluded entity shall limit its authorized activities to  
3 the functions permitted to a trust protector, investment trust advisor, or distribution trust advisor  
4 pursuant to chapter 55-1B and limit the performance of those functions with respect to a  
5 specifically named trust or family of trusts.

6 An entity complying with this section shall notify the director of its existence, capacity to  
7 act, and the name of the trustee for the trust or family of trusts.

8 Section 8. That § 55-2-13 be amended to read as follows:

9 55-2-13. For purposes of this section, the term, qualified beneficiary, means a beneficiary  
10 that is an entity then in existence or an individual who is twenty-one years of age or older and  
11 who, on the date the beneficiary's qualification is determined:

- 12 (1) Is a distributee or permissible distributee of trust income or principal;
- 13 (2) Would be a distributee or permissible distributee of trust income or principal if the  
14 interests of the distributees terminated on that date; or
- 15 (3) Would be a distributee or permissible distributee of trust income or principal if the  
16 trust terminated on that date. However, if the distributee is then unknown because a  
17 person holds a power to change the distributee, the trustee shall give notice only to  
18 the holder of the power.

19 Except as otherwise provided by the terms of a revocable trust, a trustee has no duty to  
20 notify the qualified beneficiaries of the trust's existence.

21 Except as otherwise provided by the terms of an irrevocable trust or otherwise directed in  
22 writing by the settlor, ~~distribution trust~~ advisor, or trust protector, the trustee shall, within sixty  
23 days after the trustee has accepted trusteeship of the trust, or within sixty days after the date the  
24 trustee acquires knowledge that a formerly revocable trust has become irrevocable, notify the

1 qualified beneficiaries of the trust's existence and of the right of the beneficiary to request a copy  
2 of the trust instrument pertaining to the beneficiary's interest in the trust.

3 ~~Subject to the previous provision~~ Except as otherwise provided by the terms of an  
4 irrevocable trust or otherwise directed in writing by the settlor, trust advisor, or trust protector,  
5 a trustee of an irrevocable trust:

6 (1) Upon request of a qualified beneficiary, shall promptly furnish to the qualified  
7 beneficiary a copy of the trust instrument;

8 (2) If notification of the trust has not been accomplished pursuant to this section within  
9 sixty days after accepting a trusteeship, shall notify the qualified beneficiaries of the  
10 acceptance and of the trustee's name, address, and telephone number;

11 (3) Shall promptly respond to a qualified beneficiary's request for information related to  
12 the administration of the trust, unless the request is unreasonable under the  
13 circumstances.

14 The settlor, trust advisor, or trust protector, may, by the terms of the governing instrument,  
15 or in writing delivered to the trustee, expand, restrict, eliminate, or otherwise modify the rights  
16 of beneficiaries to information relating to a trust.

17 A beneficiary may waive the right to the notice or information otherwise required to be  
18 furnished under this section and, with respect to future reports and other information, may  
19 withdraw a waiver previously given.

20 The change in the identity of a trustee, occurring as the result of a mere name change or a  
21 merger, consolidation, combination, or reorganization of a trustee, does not require notice.

22 If a fiduciary is bound by a duty of confidentiality with respect to a trust or its assets, a  
23 fiduciary may require that any beneficiary who is eligible to receive information pursuant to this  
24 section be bound by the duty of confidentiality that binds the trustee before receiving such

1 information from the trustee.

2 A trust advisor, trust protector, or other fiduciary designated by the terms of the trust shall  
3 keep each excluded fiduciary designated by the terms of the trust reasonably informed about:

4 (1) The administration of the trust with respect to any specific duty or function being  
5 performed by the trust advisor, trust protector, or other fiduciary to the extent that the  
6 duty or function would normally be performed by the excluded fiduciary or to the  
7 extent that providing such information to the excluded fiduciary is reasonably  
8 necessary for the excluded fiduciary to perform its duties; and

9 (2) Any other material information that the excluded fiduciary would be required to  
10 disclose to the qualified beneficiaries under this section regardless of whether the  
11 terms of the trust relieve the excluded fiduciary from providing such information to  
12 qualified beneficiaries. Neither the performance nor the failure to perform of a trust  
13 advisor, trust protector, or other fiduciary designated by the terms of the trust as  
14 provided in this subdivision shall affect the limitation on the liability of the excluded  
15 fiduciary.

16 The provisions of this section are effective for trusts created after June 30, 2002, except as  
17 otherwise directed by the settlor, trust protector, ~~or distribution~~ trust advisor, or other fiduciary  
18 designated by the terms of the trust. For trusts created before July 1, 2002, a trustee has no duty  
19 at common law or otherwise to notify a qualified beneficiary of the trust's existence unless  
20 otherwise directed by the settlor.

21 Section 9. That § 55-2-20 be amended to read as follows:

22 55-2-20. The power under § 55-2-15 may not be exercised to suspend the power to alienate  
23 trust property or extend the first trust beyond ~~any applicable termination date under the terms~~  
24 ~~of the instrument of the first trust~~ or the permissible period of any rule against perpetuities

1 applicable to the first trust.

2 Section 10. That § 55-2-15 be amended to read as follows:

3 55-2-15. Unless the terms of the governing instrument expressly provide otherwise, if a  
4 trustee ~~who has discretionary authority,~~ discretion under the terms of a testamentary governing  
5 instrument ~~or irrevocable inter vivos trust agreement,~~ to make a distribution of income or  
6 principal to; or for the benefit of; one or more beneficiaries of a trust (the "first trust"), whether  
7 or not restricted by any standard, then the trustee may instead exercise such authority discretion  
8 by appointing ~~all or part or all~~ of the income or principal subject to the power discretion in favor  
9 of a trustee of a second trust (the "second trust") under ~~an a governing instrument other than that~~  
10 ~~under which the power to distribute is created or under the same instrument, in the event that~~  
11 separate from the governing instrument of the first trust. Before exercising its discretion to  
12 appoint and distribute assets to a second trust, the trustee of the first trust ~~decides that shall~~  
13 determine whether the appointment is necessary or desirable after taking into account the  
14 purposes of the first trust, the terms and conditions of the second trust, and the consequences  
15 of the distribution. ~~However~~ For the purposes of this Act, a trustee of the first trust is a restricted  
16 trustee if either the trustee is a beneficiary of the first trust or if a beneficiary of the first trust has  
17 a power to change the trustees within the meaning of § 55-2-17. In addition, the following apply  
18 to all appointments made under this section:

19 (1) The second trust may only have as beneficiaries ~~only~~ one or more of ~~those the~~ the  
20 beneficiaries of the first trust ~~to;~~

21 (a) To or for whom a discretionary distribution of income or principal may be  
22 made from the first trust ~~and who are proper objects of the exercise of the~~  
23 ~~power, or one or more of those other beneficiaries of the first trust to;~~ or

24 (b) To or for whom a distribution of income or principal may ~~have been~~ be made

1 in the future from the first trust at a time or upon the happening of an event  
2 specified under the first trust;

3 (2) No restricted trustee of the first trust may exercise such authority over the first trust  
4 to the extent that doing so could have the effect of:

5 (a) ~~Exercise such authority to make a distribution from the first trust if the trustee~~  
6 ~~is a beneficiary of the first trust, or if any beneficiary may change the trustees~~  
7 Benefiting the restricted trustee as a beneficiary of the first trust, unless the  
8 exercise of such authority is for limited by an ascertainable standard based on  
9 or related to health, education, maintenance, or support; or

10 (b) ~~Exercise such authority to the extent that doing so would have the effect either~~  
11 ~~of (i) increasing the distributions that can be made in the future from the~~  
12 ~~second trust to the trustee of the first trust or to a beneficiary who may change~~  
13 ~~the trustees of the first trust, or (ii) removing restrictions on discretionary~~  
14 ~~distributions imposed by the agreement under which the first trust was created,~~  
15 ~~except that in either case participating in a change that is needed for~~ Removing  
16 restrictions on discretionary distributions to a beneficiary imposed by the  
17 governing instrument under which the first trust was created, except that a  
18 provision in the second trust which limits distributions by an ascertainable  
19 standard based on or related to the health, education, maintenance, or support  
20 of any such beneficiary is permitted;

21 ~~However, the~~(3) No restricted trustee of the first trust may exercise such authority over  
22 the first trust to the extent that doing so would have the effect of increasing the  
23 distributions that can be made from the second trust to the restricted trustees of the  
24 first trust or to a beneficiary who may change the trustees of the first trust within the

1 meaning of § 55-2-17 compared to the distributions that can be made to such trustee  
2 or beneficiary, as the case may be, under the first trust, unless the exercise of such  
3 authority is limited by an ascertainable standard based on or related to health,  
4 education, maintenance, or support;

5 (4) The provisions of ~~subdivision~~ subdivisions (2) and (3) only apply to restrict the  
6 authority of a trustee if either a trustee, or a beneficiary who may change the trustee,  
7 is a United States citizen or domiciliary under the Internal Revenue Code, or the trust  
8 owns property that would be subject to United States estate or gift taxes if owned  
9 directly by such a person;

10 ~~(3)~~(5) In the case of any trust contributions which have been treated as gifts qualifying for  
11 the exclusion from gift tax described in § 2503(b) of the Internal Revenue Code of  
12 1986, by reason of the application of I.R.C. § 2503(c), the governing instrument for  
13 the second trust shall provide that the beneficiary's remainder interest shall vest no  
14 later than the date upon which such interest would have vested under the terms of the  
15 governing instrument for the first trust;

16 ~~(4)~~(6) The exercise of such authority may not reduce any income interest of any income  
17 beneficiary of any of the following trusts:

18 (a) A trust for which a marital deduction has been taken for federal tax purposes  
19 under I.R.C. § 2056 or § 2523 or for state tax purposes under any comparable  
20 provision of applicable state law;

21 (b) A charitable remainder trust under I.R.C. § 664; or

22 (c) A grantor retained annuity trust under I.R.C. § 2702;

23 ~~(5)~~(7) The exercise of such authority does not apply to trust property subject to a presently  
24 exercisable power of withdrawal held by a trust beneficiary to whom, or for the

1 benefit of whom, the trustee has authority to make distributions, unless after the  
 2 exercise of such authority, such beneficiary's power ~~or~~ of withdrawal is unchanged  
 3 with respect to the trust property;

4 ~~(6)~~(8) The exercise of such authority is not prohibited by a spendthrift clause or by a  
 5 provision in the ~~trust~~ governing instrument that prohibits amendment or revocation  
 6 of the trust;

7 (9) Any appointment made by a trustee shall be considered a distribution by the trustee  
 8 pursuant to the trustee's distribution powers and authority;

9 (10) If the trustee's distribution discretion is not subject to a standard, or if the trustee's  
 10 distribution discretion is subject to a standard that does not create a support interest,  
 11 then the court may review the trustee's determination or any related appointment only  
 12 pursuant to § 55-1-43. Any other court review of the trustee's determination or any  
 13 related appointment may be made only pursuant to § 55-1-42.

14 This section applies to any trust governed by the laws of this state, including a trust whose  
 15 governing jurisdiction is transferred to this state.

16 Section 11. That § 51A-6A-13 be amended to read as follows:

17 51A-6A-13. The business of any trust company shall be managed and controlled by its  
 18 governing board and includes the authority to provide for bonus payments, in addition to  
 19 ordinary compensation, for any of its officers and employees. The governing board of a private  
 20 trust company shall consist of not less than three nor more than twelve members, all of whom  
 21 shall be elected by the owners of the trust company at any regular annual meeting, with terms  
 22 not to exceed three years. The governing board of a public trust company shall consist of not  
 23 less than five nor more than twelve members, all of whom shall be elected by the owners of the  
 24 trust company at any regular meeting held during each calendar year. If the number of board

1 members elected is less than twelve, the number of board members may be increased so long  
2 as the total number does not exceed twelve. If the number is increased, the first additional board  
3 members may be elected at a special meeting of the owners. The board members shall be elected  
4 and any vacancies filled in the manner as provided in the provisions regarding general  
5 corporations or limited liability companies, as applicable. At all times one of the directors shall  
6 be a resident of this state and at least ~~two-thirds~~ one-half of the directors shall be citizens of the  
7 United States. Any board member of any trust company who becomes indebted to the trust  
8 company on any judgment forfeits the position of board member, and the vacancy shall be filled  
9 as provided by law.

10 A public trust company chartered in South Dakota prior to July 1, 2011, if currently  
11 operating with less than five members of its governing board, shall supply evidence of  
12 compliance with this section at the same time the report of condition and fees are due as  
13 provided in § 51-6A-34 and ARSD 20:07:22:02 for calendar year 2011.

14 Section 12. That chapter 55-3 be amended by adding thereto a NEW SECTION to read as  
15 follows:

16 No beneficiary of a trust may assert a statute of limitations defense in any proceeding to  
17 modify, reform, or terminate a trust pursuant to §§ 55-3-23 to 55-3-29, inclusive.

18 Section 13. That chapter 55-1A be amended by adding thereto a NEW SECTION to read  
19 as follows:

20 A trustee may change the name of an irrevocable trust if the trustee deems such action to be  
21 in the best interests of the trust and its beneficiaries.

22 Section 14. That § 55-4-3 be amended to read as follows:

23 55-4-3. Unless it is otherwise provided by the trust instrument, or an amendment thereof,  
24 or by court order, any power vested in three or more trustees may be exercised by a majority of

1 such trustees and any power vested in two trustees shall be exercised by both of such trustees.

2 Section 15. That § 55-4-51 be amended to read as follows:

3 55-4-51. Instead of furnishing a copy of the trust instrument or a copy of a will that creates  
4 a testamentary trust to a person other than a beneficiary, one or more trustees may furnish to the  
5 person a certificate of trust signed by a trustee, settlor, grantor, or trustor, ~~or trust protector,~~  
6 containing the following:

7 (1) A statement that the trust exists, the current name of the trust if one has been given,  
8 any previous name of the trust if the name of the trust was changed, and the date the  
9 trust instrument or will was executed;

10 (2) The name of the settlor, grantor, trustor, testator, or testatrix;

11 (3) The name of each original trustee and the name and address of each trustee ~~and each~~  
12 ~~trust protector~~ currently empowered to act under the trust instrument or will on the  
13 date of the execution of the certificate of trust;

14 (4) The applicable powers of the trustee ~~and the trust protector~~ and other provisions set  
15 forth in the trust instrument or will as are selected by the person signing the  
16 certificate of trust, including those powers authorizing the trustee to sell, convey,  
17 pledge, mortgage, lease, or transfer title to any interest in property held in the trust,  
18 together with a statement setting forth the number of trustees required by the  
19 provisions of the trust instrument or will to act;

20 (5) A statement that the trust is irrevocable or, if the trust is revocable, a statement to that  
21 effect ~~and the identity of any person holding a power to revoke the trust, and, if~~  
22 ~~applicable, a statement that the trust has been terminated or revoked~~ and that the trust  
23 has not been revoked;

24 (6) A statement that the trust is not supervised by a court, or, if applicable, a statement

1 that the trust is supervised by a court, and which statement also sets forth any  
 2 restrictions imposed by the court on the trustee's ability to act as otherwise permitted  
 3 by statute or the terms of the trust instrument or will;

4 (7) If applicable, a description of any property to be conveyed by the trustee;

5 (8) A statement that the trust has not been modified or amended in any manner that  
 6 would cause the representations contained in the certificate of trust to be incorrect.

7 The person signing the certificate shall certify that the statements contained in the certificate  
 8 are true and correct. The signature of the person signing the certificate shall be acknowledged  
 9 or verified under oath before a notary public or other official authorized to administer oaths. A  
 10 certificate of trust need not contain the dispositive terms of a trust.

11 Section 16. That § 55-4-51.3 be amended to read as follows:

12 55-4-51.3. A certificate of a trustee or of trustees of a trust in support of a real property  
 13 transaction may be substantially in the following form:

14 *This instrument was prepared by:*

15 \_\_\_\_\_  
 16 \_\_\_\_\_  
 17 \_\_\_\_\_

18 *(insert name, address and phone number)*

19 CERTIFICATE

20 OF TRUST

21  
 22 STATE OF SOUTH DAKOTA )

23 : SS

24 COUNTY OF )

1 \_\_\_\_\_, being duly sworn under oath, does hereby state as follows:

2 1. A trust instrument or Will executed on \_\_\_\_\_ established a trust which is still in  
3 existence on the date this Certificate is signed. The current name of the trust, if it has been  
4 named, is \_\_\_\_\_. (Insert n/a if the Trust does not have a name). The name of the  
5 trust was/was not changed. If the name of the trust was changed, it was previously known as  
6 \_\_\_\_\_.

7 2. The name of the settlor, grantor, trustor, testator or testatrix, as the case may be, is  
8 \_\_\_\_\_.

9 3. The name of each original trustee and the name and address of each trustee and each trust  
10 protector currently empowered to act under the trust instrument or Will on the date of the  
11 execution of this Certificate of Trust is as follows:

12 \_\_\_\_\_  
13 \_\_\_\_\_.

14 4. The person who signs this certificate below certifies that the trust instrument or Will contains  
15 the following powers which are given to the trustee, which may or may not be inclusive of all  
16 of the powers given to the trustee:

17 \_\_\_\_\_,

18 ~~the following powers are given to the trust protector:~~

19 \_\_\_\_\_,

20 and further contains the following provisions (optional):

21 \_\_\_\_\_.

22 The number of trustees required to join in an action by the provisions of the trust instrument  
23 or Will to is \_\_\_\_\_.

24 5. The trust is revocable/irrevocable. ~~The following person(s) has/have the right to revoke the~~

1 trust: \_\_\_\_\_.

2 ~~The~~ If revocable, the trust has not been revoked.

3 6. The trust is/is not supervised by a court. The following restrictions are currently imposed by  
4 the court on the trustee(s) ability to act even though actions so restricted may be permitted by  
5 statute or the terms of the trust instrument or Will:

6 \_\_\_\_\_.

7 7. The Trustee intends to convey the following property owned by the Trust:

8 \_\_\_\_\_.

9 8. The trust has not been modified or amended in any manner that would cause the  
10 representations contained in this Certificate of Trust to be incorrect. The statements contained  
11 in this Certificate of Trust are true and correct.

12 \_\_\_\_\_

13 STATE OF SOUTH DAKOTA )

14 : SS

15 COUNTY OF )

16 On this, the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned officer,  
17 personally appeared , known to me or satisfactorily proven to be the person whose name is  
18 subscribed to the within instrument and acknowledged that she/he executed the same for the  
19 purposes therein contained.

20 IN WITNESS WHEREOF, I hereunto set my hand and official seal.

21 \_\_\_\_\_

22 Notary Public, South Dakota

23 My Commission expires: \_\_\_\_\_

24 Section 17. That § 55-16-15 be amended to read as follows:

1 55-16-15. Notwithstanding the provisions of §§ 55-16-9 to 55-16-14, inclusive, this chapter  
2 does not apply in any respect:

3 ~~—(1)—~~ To to any person to whom the transferor is indebted on account of an agreement or  
4 order of court for the payment of support or alimony in favor of such transferor's  
5 spouse, former spouse, or children, or for a division or distribution of property in  
6 favor of such transferor's spouse or former spouse, to the extent of such debt; ~~or~~

7 ~~—(2)—~~ To any person who suffers death, personal injury, or property damage on or before  
8 the date of a qualified disposition by a transferor, which death, personal injury, or  
9 property damage is at any time determined to have been caused in whole or in part  
10 by the act or omission of either such transferor or by another person for whom such  
11 transferor is or was vicariously liable. Subdivision (1). This exception does not apply  
12 to any claim for forced heirship or legitime.

13 Section 18. That § 55-1A-33 be amended to read as follows:

14 55-1A-33. A trustee may advance income ~~to or for the use of the beneficiaries,~~ for which  
15 advance he or make loans out of trust property to a beneficiary on terms and conditions the  
16 trustee considers to be fair and reasonable under the circumstances, for which such advance or  
17 loan the trustee shall have a lien on the future benefits of such beneficiary.

18 Section 19. That § 51A-5-18 be repealed.

19 ~~—51A-5-18. Cash held by a bank as fiduciary may be deposited to the credit of the bank as~~  
20 ~~such fiduciary either with a bank with deposit insurance or with itself, but if such funds are~~  
21 ~~deposited with itself the bank shall pledge as security United States bonds or other securities~~  
22 ~~approved by the director for the purpose in the amount of the deposit in excess of the amount~~  
23 ~~covered by deposit insurance. Deposits may represent the assets of more than one fiduciary~~  
24 ~~estate if a record is maintained of the proper allocation.~~

1 Section 20. That § 51A-5-1.1 be amended to read as follows:

2 51A-5-1.1. Banks engaging in the trust business pursuant to this chapter have all powers  
3 necessary and incidental to carrying on the trust business, including:

- 4 (1) Acting as agent, custodian, or attorney-in-fact for any person, and, in such capacity,  
5 taking and holding property on deposit for safekeeping and acting as general or  
6 special agent or attorney-in-fact in the acquisition, management, sale, assignment,  
7 transfer, encumbrance, conveyance, or other disposition of property, in the collection  
8 or disbursement of income from or principal of property and, generally in any matter  
9 incidental to any of the foregoing;
- 10 (2) Acting as registrar or transfer agent for any corporation, partnership, association,  
11 municipality, state, or public authority, and in such capacity, receiving and disbursing  
12 money, transferring, registering, and countersigning certificates of stock, bonds or  
13 other evidences of indebtedness or securities and performing any and all acts which  
14 may be incidental thereto;
- 15 (3) Acting as trustee or fiduciary under any mortgage or bond issued by a person;
- 16 (4) Acting as trustee or fiduciary under any trust established by a person;
- 17 (5) Acting as fiduciary, assignee for the benefit of creditors, receiver or trustee under or  
18 pursuant to the order or direction of any court or public official of competent  
19 jurisdiction;
- 20 (6) Acting as fiduciary, guardian, conservator, assignee, or receiver of the estate of any  
21 person and as executor of the last will and testament or administrator, fiduciary or  
22 personal representative of the estate of any deceased person when appointed by a  
23 court or public official of competent jurisdiction;
- 24 (7) Establishing and maintaining common trust funds or collective investment funds

1           pursuant to the provisions of §§ 55-6-1 to 55-6-7, inclusive; or

2       (8)   Acting in any fiduciary capacity and performing any act as a fiduciary which a trust  
3           company organized under chapter 51A-6 may perform.

4       Section 21. That § 51A-6A-29 be amended to read as follows:

5       51A-6A-29. A trust company may exercise the following powers necessary or incidental to  
6 carrying on a trust company business, including:

7       (1)   Act as agent, custodian, or attorney-in-fact for any person, and, in such capacity, take  
8           and hold property on deposit for safekeeping and act as general or special agent or  
9           attorney-in-fact in the acquisition, management, sale, assignment, transfer,  
10          encumbrance, conveyance, or other disposition of property, in the collection or  
11          disbursement of income from or principal of property, and generally in any matter  
12          incidental to any of the foregoing;

13      (2)   Act as registrar or transfer agent for any corporation, partnership, association, limited  
14          liability company, municipality, state, or public authority, and in such capacity,  
15          receive and disburse money, transfer, register, and countersign certificates of stock,  
16          bonds, or other evidences of indebtedness or securities, and perform any acts which  
17          may be incidental thereto;

18      (3)   Act as trustee or fiduciary under any mortgage or bond issued by a person;

19      (4)   Act as trustee or fiduciary under any trust established by a person;

20      (5)   Act as fiduciary, assignee for the benefit of creditors, receiver, or trustee under or  
21          pursuant to the order or direction of any court or public official of competent  
22          jurisdiction;

23      (6)   Act as fiduciary, guardian, conservator, assignee, or receiver of the estate of any  
24          person and as executor of the last will and testament or administrator, fiduciary, or

1 personal representative of the estate of any deceased person when appointed by a  
2 court or public official of competent jurisdiction;

3 (7) Establish and maintain common trust funds or collective investment funds pursuant  
4 to the provisions of §§ 55-6-2 to 55-6-7, inclusive; or

5 (8) Act in any fiduciary capacity and perform any act as a fiduciary which a South  
6 Dakota bank with trust powers may perform in the exercise of those trust powers.

7 Section 22. That § 51A-6A-64 be amended to read as follows:

8 51A-6A-64. Any trust company qualified to act as a fiduciary in this state may establish  
9 common trust funds or collective investment funds for the purpose of furnishing investments  
10 to itself as fiduciary, or to itself and others, as co-fiduciaries. Any trust company qualified to act  
11 as fiduciary in this state may, as such fiduciary or co-fiduciary, invest funds that it lawfully  
12 holds for investment in the common trust funds or collective investment funds, if the investment  
13 is not prohibited by the instrument, judgment, decree, or order creating the fiduciary  
14 relationship. Any common trust fund or collective investment funds shall be established and  
15 maintained according to the provisions of §§ 55-6-2 to 55-6-7, inclusive.

16 Section 23. That § 55-6-1 be amended to read as follows:

17 55-6-1. Any bank or trust company qualified to act as fiduciary in this state may establish  
18 common trust funds or collective investment funds for the purpose of furnishing investments  
19 to itself as fiduciary, or to itself and others, as cofiduciaries.

20 Any common trust fund or collective investment fund authorized by this chapter shall be  
21 established and maintained in accordance with 12 C.F.R. 9.18 as of January 1, 2011.

22 Section 24. That § 55-6-2 be amended to read as follows:

23 55-6-2. Any bank or trust company qualified to act as fiduciary in this state may, as such  
24 fiduciary or cofiduciary, invest funds which it lawfully holds for investment in interests in

1 common trust funds or collective investment funds established pursuant to § 55-6-1, if such  
 2 investment is not prohibited by the instrument, judgment, decree, or order creating such  
 3 fiduciary relationship, and if, in the case of cofiduciaries, the bank or trust company procures  
 4 the consent of its cofiduciary or cofiduciaries to such investment.

5 Section 25. That § 55-6-2.1 be amended to read as follows:

6 55-6-2.1. A bank or trust company qualified to act as a fiduciary in this state may:

7 (1) Establish and maintain common trust funds or collective investment funds for the  
 8 collective investment of funds held in any fiduciary capacity by it or by another bank  
 9 or trust company which is owned or controlled by a corporation which owns or  
 10 controls such bank or trust company;

11 (2) Invest funds which it holds in common trust funds or collective investment funds  
 12 established and maintained pursuant to subdivision (1).

13 The provisions of §§ 55-6-1 to ~~55-6-6~~ 55-6-7, inclusive, relating to common trust funds or  
 14 collective investment funds shall apply to the establishment and maintenance of common trust  
 15 funds or collective investment funds under this section.

16 This section shall apply to all fiduciary relationships.

17 Section 26. That § 55-6-3 be amended to read as follows:

18 55-6-3. The bank or trust company operating such common trust funds or collective  
 19 investment funds shall comply with the provisions of chapter 21-22 in the administration of the  
 20 trust estate.

21 Section 27. That § 55-6-6 be repealed.

22 ~~55-6-6. If any provision of this chapter or the application thereof to any person or~~  
 23 ~~circumstances is held invalid, such invalidity shall not affect the other provisions or applications~~  
 24 ~~of the chapter which can be given effect without the invalid provision or application, and to this~~

1 ~~end the provisions of this chapter are declared to be severable.~~

2 Section 28. That chapter 55-6 be amended by adding thereto a NEW SECTION to read as  
3 follows:

4 For purposes of this chapter, the term, common trust fund, is a fund as defined in 12 C.F.R.  
5 9.18(a)(1) as of January 1, 2011, and is provided exemption from taxation according to 26  
6 U.S.C. 584 as of January 1, 2011.

7 Section 29. That chapter 55-6 be amended by adding thereto a NEW SECTION to read as  
8 follows:

9 For purposes of this chapter, the term, collective investment fund, is a fund as defined in 12  
10 C.F.R. 9.18(a)(2) as of January 1, 2011, and is provided exemption from taxation according to  
11 Internal Revenue Service, Revenue Ruling 81-100, published March 30, 1981.

12 Section 30. That § 55-1-24 be amended to read as follows:

13 55-1-24. Terms used in §§ 55-1-24 to ~~55-1-43~~ 55-1-45, inclusive, mean:

14 (1) "Beneficial interest," is limited to mean a distribution interest or a remainder interest.

15 A beneficial interest specifically excludes a power of appointment or a power  
16 reserved by the settlor;

17 (2) "Beneficiary," a person that has a present or future beneficial interest in a trust,  
18 vested or contingent. The holder of a power of appointment is not a beneficiary;

19 (3) "Distribution beneficiary," a beneficiary who is an eligible distributee or permissible  
20 distributee of trust income or principal;

21 (4) "Distribution interest," a distribution interest held by a distribution beneficiary. A  
22 distribution interest may be a current distribution interest or a future distribution  
23 interest. A distribution interest may be classified as a mandatory interest, a support  
24 interest, or a discretionary interest;

1 (5) "Power of appointment," an inter-vivos or testamentary power to direct the  
2 disposition of trust property, other than a distribution decision by a trustee to a  
3 beneficiary. Powers of appointment are held by a person to whom a power has been  
4 given, not the settlor;

5 (6) "Reach," with respect to a distribution interest or power, to subject the distribution  
6 interest or power to a judgment, decree, garnishment, attachment, execution, levy,  
7 creditor's bill or other legal, equitable, or administrative process, relief, or control of  
8 any court, tribunal, agency, or other entity as provided by law;

9 (7) "Remainder interest," an interest where a trust beneficiary will receive the property  
10 outright at some time during the future;

11 (8) "Reserved power," a power held by the settlor.

12 Section 31. That § 55-1-24.1 be amended to read as follows:

13 55-1-24.1. For purposes of §§ 55-1-24 to ~~55-1-43~~ 55-1-45, inclusive, improper motive is  
14 demonstrated by action such as the following:

15 (1) A trustee refusing to make or limiting distributions to beneficiaries other than the  
16 trustee due to the trustee's self interest when the trustee also holds a beneficial  
17 interest subject to a discretionary interest; or

18 (2) A trustee making a distribution in excess of an ascertainable standard to himself or  
19 herself as beneficiary when the trustee is restricted by an ascertainable standard in the  
20 trust.

21 Section 32. That chapter 55-1 be amended by adding thereto a NEW SECTION to read as  
22 follows:

23 A withdrawal power allows a beneficiary a right to withdraw some part of the trust income  
24 or principal. The holder of a power of withdrawal is not deemed to be the settlor of the trust by

1 failing to exercise withdrawal power or letting a withdrawal power lapse.

2 Section 33. That § 55-1-31 be amended to read as follows:

3 55-1-31. Unless otherwise provided in the trust, if the settlor's spouse is named as  
4 beneficiary, the settlor's spouse is still living, and the trust is classified as a support trust, then  
5 the trustee shall consider the ~~beneficiary's~~ resources of the settlor's spouse, including the settlor's  
6 obligation of support, prior to making a distribution. In all other cases, unless otherwise  
7 provided in the trust, the trustee need not consider the beneficiary's resources in determining  
8 whether a distribution should be made.

9 Section 34. That § 55-1-35 be amended to read as follows:

10 55-1-35. A declaration in a trust that the interest of a beneficiary shall be held subject to a  
11 spendthrift trust is sufficient to restrain voluntary or involuntary alienation of a beneficial  
12 interest by a beneficiary to the maximum extent provided by law. Regardless of whether a  
13 beneficiary has any outstanding creditor, a trustee of a spendthrift trust may directly pay any  
14 expense on behalf of such beneficiary and may exhaust the income and principal of the trust for  
15 the benefit of such beneficiary. No trustee is liable to any creditor for paying the expenses of a  
16 beneficiary of a spendthrift trust.

17 Section 35. That § 55-1-36 be amended to read as follows:

18 55-1-36. If a settlor is also a beneficiary of the trust, and the transfer is a qualified transfer  
19 under chapter 55-16, the provisions of §§ 55-1-24 to 55-1-43, inclusive, also apply. Conversely,  
20 if the settlor is a beneficiary of the trust and the transfer is not a qualified transfer under chapter  
21 55-16, a provision restraining the voluntary or involuntary transfer of the settlor's beneficial  
22 interest does not prevent the settlor's creditors from satisfying claims from the settlor's interest  
23 in the trust estate, unless the transfer specifically references and is qualified as a transfer under  
24 chapter 55-16. However, regardless of whether the transfer is a qualified transfer under chapter

1 55-16, a settlor's creditors may not satisfy claims from either assets of the trust because of the  
2 existence of a discretionary power granted to the trustee by the terms of the trust instrument  
3 creating the trust, or any other provisions of law, to pay directly to the taxing authorities or to  
4 reimburse the settlor for any tax on trust income or principal which is payable by the settlor  
5 under the law imposing such tax; or reimbursements made to the settlor or direct tax payments  
6 made to a taxing authority for the settlor's benefit for any tax or trust income or principal which  
7 is payable by the trustor under the law imposing such tax.

8 Section 36. That chapter 55-1 be amended by adding thereto a NEW SECTION to read as  
9 follows:

10 Notwithstanding any other provision of law, no action of any kind, including an action to  
11 enforce a judgement entered by a court or other body having adjudicative authority, may be  
12 brought at law or in equity for an attachment or other provisional remedy against property that  
13 is the subject of a South Dakota trust or for avoidance of a transfer to a South Dakota trust  
14 unless the settlor's transfer of property was made with the intent to defraud that specific creditor.

15 Section 37. That chapter 55-1 be amended by adding thereto a NEW SECTION to read as  
16 follows:

17 A cause of action or claim for relief with respect to a fraudulent transfer of a settlor's assets  
18 pursuant to § 55-1-44 is extinguished unless the action under § 55-1-44 is brought by a creditor  
19 of the settlor who meets one of the following requirements:

20 (1) Is a creditor of the settlor before the settlor's assets are transferred to the trust, and the  
21 action under § 55-1-44 is brought within the later of:

22 (a) Three years after the transfer is made; or

23 (b) One year after the transfer is or reasonably could have been discovered by the  
24 creditor if the creditor:

- 1 (i) Can demonstrate that the creditor asserted a specific claim against the
- 2 settlor before the transfer; or
- 3 (ii) Files another action, other than an action under §55-1-44, against the
- 4 settlor that asserts a claim based on an act or omission of the settlor that
- 5 occurred before the transfer, and the action described in this subsection
- 6 is filed within three years after the transfer; or
- 7 (2) Becomes a creditor subsequent to the transfer into trust, and the action under § 55-1-
- 8 44 is brought within three years after the transfer is made.

9 Section 38. That § 51A-6A-7 be amended to read as follows:

10 51A-6A-7. Any three or more persons may organize a trust company and make and file

11 articles as provided by the laws of this state. No trust company may be organized or

12 incorporated to engage in business as such until the articles have been submitted and approved

13 in accordance with § 51A-6A-4. The name selected for the trust company may not be the name

14 of any other trust company doing business in the state, and the director shall accept or reject the

15 name. However, the approval of a trust company name by the director may not supersede any

16 person's rights pursuant to state or federal trademark law. The articles, in addition to any other

17 information required by law, shall state:

- 18 (1) That the corporation or limited liability company is formed for the purpose of
- 19 engaging in the trust company business; and
- 20 (2) The period for which such corporation or limited liability company is organized, ~~not~~
- 21 ~~exceeding twenty years~~ which may be perpetual.

22 The articles may contain any other provisions as are consistent with law. The articles shall

23 be subscribed by one or more of the organizers of the proposed trust company and shall be

24 acknowledged by them. The full amount of the capital required by § 51A-6A-19 shall be

1 subscribed before the articles are filed.

2 Section 39. That § 51A-6A-8 be amended to read as follows:

3 51A-6A-8. ~~Within one year prior~~ Prior to the expiration of the period for which it was  
4 incorporated or organized a trust company may, with the approval of at least a majority of the  
5 capital stock or ownership units of such trust company, amend its articles to extend its existence  
6 for an additional period, ~~not to exceed twenty years which may be perpetual.~~

7 Section 40. That § 55-1-20 be amended to read as follows:

8 55-1-20. Subject to the provisions of §§ 55-1-21 and 55-1-22, a trust may be performed if  
9 the trust is for a specific lawful noncharitable purpose or for lawful noncharitable purposes to  
10 be selected by the trustee. Neither the common law rule against perpetuities nor any common  
11 law rule limiting the duration of noncharitable purpose trusts is in force in this state.

12 Section 41. That § 55-1-23 be repealed.

13 ~~55-1-23. Nothing in §§ 55-1-20 to 55-1-22, inclusive, may be construed to reinstate the rule~~  
14 ~~against perpetuities in South Dakota as to any trust except trusts specifically defined in §§ 55-1-~~  
15 ~~20 to 55-1-22, inclusive, as honorary trusts or trusts for the care of specific animals.~~

16 Section 42. That § 10-40A-11 be amended to read as follows:

17 10-40A-11. A will ~~or~~ trust, or other instrument of a decedent who dies after December 31,  
18 2009, and before January 1, 2011, that contains a formula referring to the unified credit, estate  
19 tax exemption, applicable exemption amount, applicable credit amount, applicable exclusion  
20 amount, generation-skipping transfer tax exemption, GST exemption, marital deduction,  
21 maximum marital deduction, unlimited marital deduction, inclusion ratio, applicable fraction,  
22 or any section of the Internal Revenue Code relating to the federal estate tax or generation-  
23 skipping transfer tax, or that measures a share of an estate or trust based on the amount that can  
24 pass free of federal estate taxes or the amount that can pass free of federal generation-skipping

1 transfer taxes, or that is otherwise based on a similar provision of federal estate tax or  
2 generation-skipping transfer tax law, shall be deemed to refer to the federal estate tax and  
3 generation-skipping transfer tax laws as they applied with respect to estates of decedents dying  
4 ~~on December 31, 2009~~ in 2010 regardless of whether the decedent's personal representative or  
5 other fiduciary elects not to have the estate tax apply with respect to the estate. This provision  
6 does not apply with respect to a will ~~or, trust, or other instrument that is executed or amended~~  
7 ~~after December 31, 2009,~~ or that manifests an intent that a contrary rule applies ~~if the decedent~~  
8 ~~dies on a date on which there is no then-applicable federal estate or generation-skipping transfer~~  
9 ~~tax. If the federal estate or generation-skipping transfer tax becomes effective before that date,~~  
10 ~~the reference to January 1, 2011, in this section refers instead to the first date on which such tax~~  
11 ~~becomes legally effective.~~

12 Section 43. That chapter 10-40A be amended by adding thereto a NEW SECTION to read  
13 as follows:

14 The personal representative, trustee, other fiduciary, or any affected beneficiary under the  
15 will, trust, or other instrument may bring a proceeding to determine whether the decedent  
16 intended that the will, trust, or other instrument be construed in a manner other than as provided  
17 in § 10-40A-11. Any proceeding pursuant to § 10-40A-11 and sections 43 and 44 of this Act  
18 shall be commenced prior to January 1, 2012. In such a proceeding, the court may consider  
19 extrinsic evidence that contradicts the plain meaning of the will, trust, or other instrument. The  
20 court has the power to modify a provision of a will, trust, or other instrument that refers to the  
21 federal estate tax or generation skipping transfer tax laws as described in § 10-40A-11 to  
22 conform the terms to the decedent's intention or achieve the decedent's tax objectives in a  
23 manner that is not contrary to the decedent's probable intention. The court may provide that its  
24 decision, including any decision to modify a provision of a will, trust, or other instrument shall

1 be effective as of the date of the decedent's death. Any person who commences a proceeding  
2 pursuant to § 10-40A-11 and section 43 and 44 of this Act has the burden of proof, by clear and  
3 convincing evidence, and persuasion in establishing the decedent's intention that the will, trust,  
4 or other instrument be construed in a manner other than as provided in § 10-40A-11.

5 Section 44. That chapter 10-40A be amended by adding thereto a NEW SECTION to read  
6 as follows:

7 For purposes of § 10-40A-11, any interested person may enter into a binding agreement to  
8 determine whether the decedent intended that the will, trust, or other instrument shall be  
9 construed in a manner other than as provided in § 10-40A-11, and to conform the terms of the  
10 will, trust, or other instrument to the decedent's intention without court approval as provided in  
11 section 43 of this Act. Any interested person may petition the court to approve the agreement  
12 or to determine whether all interested persons are parties to the agreement, either in person or  
13 by adequate representation where permitted by law, and whether the agreement contains terms  
14 the court could have properly approved. In the case of a trust, the agreement may be by  
15 nonjudicial settlement agreement. For the purposes of this section, an interested person means  
16 any person whose consent is required in order to achieve a binding settlement were the  
17 settlement to be approved by the court.

18 Section 45. That § 10-40A-13 be amended to read as follows:

19 10-40A-13. The provisions of §§ 10-40A-11 and 10-40A-12 and sections 43 and 44 of this  
20 Act apply to decedents dying after December 31, 2009, and before January 1, 2011.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

681S0438

## HOUSE TAXATION ENGROSSED NO. **HB 1157** - 2/15/2011

Introduced by: Representatives Kirkeby, Greenfield, Hunhoff (Bernie), Kopp, Verchio, and Willadsen and Senators Maher, Haverly, Peters, and Tieszen

1 FOR AN ACT ENTITLED, An Act to revise the rate of the insurance company premium and  
2 annuity taxes applied to court appearance bonds and to establish an annual fee for certificate  
3 of authority for domestic insurers issuing court appearance bonds.

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

5 Section 1. That § 10-44-2 be amended to read as follows:

6 10-44-2. Any company doing insurance business in this state shall pay a tax at the rates  
7 specified in this section. The tax shall be paid to the Division of Insurance at the time the  
8 company files its annual statement, or, if no annual statement is required, then before March  
9 first of each year.

10 If, during the previous year, a company paid more than five thousand dollars in premium  
11 taxes in this state, the company shall submit payments equal to one-quarter of the previous year's  
12 premium taxes to the Division of Insurance on April thirtieth, July thirty-first, October thirty-  
13 first, and January thirty-first. The quarterly payments shall be credited against the amount due  
14 from the company at the time the company files its annual statement, or if no annual statement



1 is required, then on March first of each year. The director of the Division of Insurance may  
2 waive the requirement in writing for quarterly payments or reduce the amount of deposit if the  
3 director finds the requirement would impose an undue premium tax on a company because of  
4 a significant decline in sales within the state. If the sum of the quarterly payments exceeds the  
5 total taxes due, the director shall credit the overpayment against subsequent amounts due or, if  
6 requested in writing at the time the company files its annual statement, refund the overpayment  
7 to the company. If the overpayment cannot be credited, there is excess remaining after the credit  
8 is taken on the annual statement, or the refund is not requested, the division may refund the  
9 amount overpaid by May first of the following year. The rates are:

10 (1) On each domestic company, two and one-half percent of premiums, except for life  
11 insurance policies, other than credit life as defined in chapter 58-19, of a face amount  
12 of seven thousand dollars or less, for which the rate is one and one-fourth percent of  
13 premiums; and one and one-fourth percent of the consideration for annuity contracts.

14 However, the rate for life insurance~~and~~, annuities, and court appearance bonds shall  
15 be computed as follows:

16 (a) Two and one-half percent of premiums for a life policy on the first one  
17 hundred thousand dollars of annual premium, and eight one-hundredths of a  
18 percent for that portion of a policy's annual life premiums exceeding one  
19 hundred thousand dollars; ~~and~~

20 (b) One and one-fourth percent of the consideration for an annuity contract on the  
21 first five hundred thousand dollars of consideration, and eight one-hundredths  
22 of a percent for that portion of the consideration on an annuity contract  
23 exceeding five hundred thousand dollars; and

24 (c) One percent of premiums for court appearance bonds.

1 The tax also applies to premiums for insurance written on individuals residing  
2 outside this state or property located outside this state if no comparable tax is paid  
3 by the direct writing company to any other appropriate taxing authority. However, the  
4 tax applies only to premiums for insurance written after July 1, 1980, on individuals  
5 residing outside of the United States;

6 (2) On each foreign company the rate shall be computed as follows:

7 (a) Two and one-half percent of premiums, except for life insurance policies,  
8 other than credit life as defined in chapter 58-19, of a face amount of seven  
9 thousand dollars or less, for which the rate is one and one-fourth percent of  
10 premiums;

11 (b) Two and one-half percent of premiums for a life policy on the first one  
12 hundred thousand dollars of annual premium, and eight one-hundredths of a  
13 percent for the portion of a policy's annual life premiums exceeding one  
14 hundred thousand dollars; ~~and~~

15 (c) One and one-fourth percent of the consideration for an annuity contract on the  
16 first five hundred thousand dollars of consideration, and eight one-hundredths  
17 of a percent for that portion of the consideration on an annuity contract  
18 exceeding five hundred thousand dollars; and

19 (d) One percent of premiums for court appearance bonds;

20 (3) On each insurer not licensed or not authorized to do business in this state the rate  
21 shall be computed as follows:

22 (a) Two and one-half percent of premiums, except for life insurance policies,  
23 other than credit life as defined in chapter 58-19, of a face amount of seven  
24 thousand dollars or less, for which the rate is one and one- fourth percent of

1 premiums;

2 (b) Two and one-half percent of premiums for a life policy on the first one  
3 hundred thousand dollars of annual premium, and eight one-hundredths of a  
4 percent for that portion of a policy's annual life premiums exceeding one  
5 hundred thousand dollars; ~~and~~

6 (c) One and one-fourth percent of the consideration for an annuity contract on the  
7 first five hundred thousand dollars of consideration, and eight one-hundredths  
8 of a percent for that portion of the consideration on an annuity contract  
9 exceeding five hundred thousand dollars; and

10 (d) One percent of premiums for court appearance bonds;

11 (4) Fourteen dollars for each insurance policy issued or renewed for workers'  
12 compensation coverage.

13 Revenue from subdivision (4) of this section shall be deposited in the insurance operating  
14 fund of the state treasury and is dedicated to the Department of Labor for purposes of  
15 automating the administration of the workers' compensation law and supporting the Workers'  
16 Compensation Advisory Council.

17 Section 2. That § 58-2-29 be amended by adding thereto a NEW SUBDIVISION to read as  
18 follows:

19 (14) Annual renewal of certificate of authority for domestic insurer issuing court  
20 appearance bonds .... 6,000

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

427S0601

## HOUSE ENGROSSED NO. **HB 1194** - 2/22/2011

**This bill has been extensively amended (hoghoused) and may no longer be consistent with the original intention of the sponsor.**

Introduced by: Representatives Wick, Bolin, Dryden, Fargen, Kopp, Nelson (Stace), and Sly  
and Senators Rhoden, Garnos, Krebs, Rampelberg, and Rave

- 1 FOR AN ACT ENTITLED, An Act to establish the State of South Dakota endowment fund.
- 2 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:
- 3 Section 1. The State of South Dakota endowment fund may be established within the South
- 4 Dakota Community Foundation. The purpose of the endowment fund is to provide a fund for
- 5 any person who wishes to contribute to the endowment fund to further the excellent quality of
- 6 life which is unique to this state. This fund shall be administered by the South Dakota
- 7 Community Foundation. Any funds received by the state from the State of South Dakota
- 8 endowment fund shall be appropriated by the South Dakota Legislature.



# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

736S0711

HOUSE ENGROSSED NO. **HB 1208** - 2/22/2011

**This bill has been extensively amended (hoghoused) and may no longer be consistent with the original intention of the sponsor.**

Introduced by: Representatives Gosch and Lust and Senators Olson (Russell) and Brown

1 FOR AN ACT ENTITLED, An Act to repeal certain education mandates to enable the public  
2 school system to operate more economically, and to allow parents the option to receive  
3 certain notices from public schools via electronic mail.

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

5 Section 1. That § 13-10-12 be amended to read as follows:

6 13-10-12. Each person over eighteen years of age hired by a school district shall submit to  
7 a criminal background investigation, by means of fingerprint checks by the Division of Criminal  
8 Investigation and the Federal Bureau of Investigation. The school district shall submit  
9 completed fingerprint cards to the Division of Criminal Investigation before the prospective new  
10 employee enters into service. If no disqualifying record is identified at the state level, the  
11 fingerprints shall be forwarded by the Division of Criminal Investigation to the Federal Bureau  
12 of Investigation for a national criminal history record check. Any person whose employment is  
13 subject to the requirements of this section may enter into service on a temporary basis pending  
14 receipt of results of the criminal background investigation. The employing school district may,  
15 without liability, withdraw its offer of employment or terminate the temporary employment



1 without notice if the report reveals a disqualifying record. Any person whose employment is  
2 subject to the requirements of this section shall pay any fees charged for the criminal record  
3 check. ~~However, the school board or governing body may reimburse the person for the fees.~~ Any  
4 person hired to officiate, judge, adjudicate, or referee a public event sponsored by a school  
5 district is not required to submit to a criminal background investigation as required in this  
6 section. In addition, any person employed by a postsecondary technical institute is not required  
7 to submit to a criminal background investigation as required in this section, unless the person  
8 is a teacher who teaches an elementary or secondary level course in an elementary or secondary  
9 school facility, or unless the person is an employee, other than a teacher, whose work  
10 assignment includes working in an elementary or secondary school facility.

11 The criminal investigation required by this section with respect to a student teacher  
12 completing requirements for teacher certification shall be conducted by the school district. A  
13 criminal background investigation, of a student teacher, conducted by a school district may be  
14 provided to any other school in which the student engages in student teaching. The school  
15 district conducting the criminal background investigation of a student teacher may rely upon the  
16 results of that investigation for employment of that person as an employee of the district.

17 Section 2. That ARSD 24:06:08:01 be repealed.

18 ~~24:06:08:01. Training of school bus drivers and bus attendants. School bus operators must~~  
19 ~~provide annual training for school bus drivers in accordance with the section entitled "Driver"~~  
20 ~~pages 121 to 124 and the section entitled "Bus Attendant" pages 124 and 125, in the National~~  
21 ~~School Transportation Specifications & Procedures, 2005 Revised Edition. In addition, the~~  
22 ~~following provisions apply:~~

23 ~~— (1) The State approved pre-service training program shall include a minimum of two hours~~  
24 ~~of classroom training, which will include knowledge of basic first aid procedures, and two hours~~

1 ~~of behind-the-wheel training to enable safe and efficient vehicle operation;~~  
2 ~~— (2) The annual State approved in-service program shall include a minimum of four hours~~  
3 ~~of classroom and/or behind-the-wheel training.~~

4 Section 3. That chapter 13-29 be amended by adding thereto a NEW SECTION to read as  
5 follows:

6 Each school bus driver shall receive appropriate training at least once every five years, and  
7 the school bus driver shall pay any fees charged for the training. The training shall include  
8 classroom instruction in first aid, bus safety, and the management of passengers, and also  
9 behind-the-wheel training to enable the safe and efficient operation of the bus.

10 Section 4. That chapter 13-1 be amended by adding thereto a NEW SECTION to read as  
11 follows:

12 It is the policy of the State of South Dakota that the parent or guardian of any student  
13 enrolled in a public school may opt to receive any notifications or correspondence from that  
14 school by electronic mail in lieu of regular mail if the parent or guardian provides to the school  
15 an electronic mail address to which the notifications or correspondence may be sent.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

844S0588

## HOUSE ENGROSSED NO. **HB 1217** - 2/22/2011

Introduced by: Representatives Hunt, Abdallah, Bolin, Brunner, Cronin, Feickert, Gosch, Greenfield, Hansen (Jon), Hickey, Hoffman, Hubbel, Jensen, Kirschman, Kloucek, Kopp, Magstadt, Munsterman, Nelson (Stace), Russell, Steele, Stricherz, Tornow, Tulson, Van Gerpen, Venner, and Wick and Senators Novstrup (Al), Brown, Heineman, Holien, Kraus, Lederman, Maher, Olson (Russell), Rave, Rhoden, and Schlekeway

1 FOR AN ACT ENTITLED, An Act to establish certain legislative findings pertaining to the  
2 decision of a pregnant mother considering termination of her relationship with her child by  
3 an abortion, to establish certain procedures to better insure that such decisions are voluntary,  
4 uncoerced, and informed, and to revise certain causes of action for professional negligence  
5 relating to performance of an abortion.

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

7 Section 1. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
8 as follows:

9 The Legislature finds that as abortion medicine is now practiced in South Dakota that:

10 (1) In the overwhelming majority of cases, abortion surgery and medical abortions are  
11 scheduled for a pregnant mother without the mother first meeting and consulting with  
12 a physician or establishing a traditional physician-patient relationship;

13 (2) The surgical and medical procedures are scheduled by someone other than a



1 physician, without a medical or social assessment concerning the appropriateness of  
2 such a procedure or whether the pregnant mother's decision is truly voluntary,  
3 uncoerced, and informed, or whether there has been an adequate screening for a  
4 pregnant mother with regard to the risk factors that may cause complications if the  
5 abortion is performed;

6 (3) Such practices are contrary to the best interests of the pregnant mother and her child  
7 and there is a need to protect the pregnant mother's interest in her relationship with  
8 her child and her health by passing remedial legislation;

9 (4) There exists in South Dakota a number of pregnancy help centers, as defined in this  
10 Act, which have as their central mission providing counseling, education, and other  
11 assistance to pregnant mothers to help them maintain and keep their relationship with  
12 their unborn children, and that such counseling, education, and assistance provided  
13 by these pregnancy help centers is of significant value to the pregnant mothers in  
14 helping to protect their interest in their relationship with their children; and

15 (5) It is a necessary and proper exercise of the state's authority to give precedence to the  
16 mother's fundamental interest in her relationship with her child over the irrevocable  
17 method of termination of that relationship by induced abortion.

18 Section 2. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
19 as follows:

20 The physician's common law duty to determine that the physician's patient's consent is  
21 voluntary and uncoerced and informed applies to all abortion procedures. The requirements  
22 expressly set forth in this Act, that require procedures designed to insure that a consent to an  
23 abortion is voluntary and uncoerced and informed, are an express clarification of, and are in  
24 addition to, those common law duties.

1 Section 3. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
2 as follows:

3 No surgical or medical abortion may be scheduled except by a licensed physician and only  
4 after the physician physically and personally meets with the pregnant mother, consults with her,  
5 and performs an assessment of her medical and personal circumstances. Only after the physician  
6 completes the consultation and assessment complying with the provisions of this Act, may the  
7 physician schedule a surgical or medical abortion, but in no instance may the physician schedule  
8 such surgical or medical abortion to take place in less than seventy-two hours from the  
9 completion of such consultation and assessment except in a medical emergency as set forth in  
10 § 34-23A-10.1 and subdivision 34-23A-1(5). No physician may have the pregnant mother sign  
11 a consent for the abortion on the day of this initial consultation. No physician may take a signed  
12 consent from the pregnant mother unless the pregnant mother is in the physical presence of the  
13 physician and except on the day the abortion is scheduled, and only after complying with the  
14 provisions of this Act as it pertains to the initial consultation, and only after complying with the  
15 provisions of subdivisions 34-23A-10.1(1) and (2). During the initial consultation between the  
16 physician and the pregnant mother, prior to scheduling a surgical or medical abortion, the  
17 physician shall:

- 18 (1) Do an assessment of the pregnant mother's circumstances to make a reasonable  
19 determination whether the pregnant mother's decision to submit to an abortion is the  
20 result of any coercion, subtle or otherwise. In conducting that assessment, the  
21 physician shall obtain from the pregnant mother the age or approximate age of the  
22 father of the unborn child, and the physician shall determine whether any disparity  
23 in the age between the mother and father is a factor in creating an undue influence or  
24 coercion;

- 1       (2)    Provide the written disclosure required by subdivision 34-23A-10.1(1) and discuss  
2            them with her to determine that she understands them;
- 3       (3)    Provide the pregnant mother with the names, addresses, and telephone numbers of  
4            all pregnancy help centers that are registered with the South Dakota Department of  
5            Health pursuant to this Act, and provide her with written instructions that set forth  
6            the following:
  - 7            (a)    That prior to the day of any scheduled abortion the pregnant mother must have  
8                    a consultation at a pregnancy help center at which the pregnancy help center  
9                    shall inform her about what education, counseling, and other assistance is  
10                   available to help the pregnant mother keep and care for her child, and have a  
11                   private interview to discuss her circumstances that may subject her decision  
12                   to coercion;
  - 13           (b)    That prior to signing a consent to an abortion, the physician shall first obtain  
14                   from the pregnant mother, a written statement that she obtained a consultation  
15                   with a pregnancy help center, which sets forth the name and address of the  
16                   pregnancy help center, the date and time of the consultation, and the name of  
17                   the counselor at the pregnancy help center with whom she consulted;
- 18       (4)    Conduct an assessment of the pregnant mother's health and circumstances to  
19            determine if any of the risk factors associated with abortion are present in her case,  
20            completing a form which for each factor reports whether the factor is present or not;
- 21       (5)    Discuss with the pregnant mother the results of the assessment for risk factors,  
22            reviewing with her the form and its reports with regard to each factor listed;
- 23       (6)    In the event that any risk factor is determined to be present, discuss with the pregnant  
24            mother, in such manner and detail as is appropriate so that the physician can certify

1 that the physician has made a reasonable determination that the mother understands  
2 the information, all material information about any complications associated with the  
3 risk factor, and to the extent available all information about the rate at which those  
4 complications occurs both in the general population and in the population of persons  
5 with the risk factor;

6 (7) In the event that no risk factor is determined to be present, the physician shall include  
7 in the patient's records a statement that the physician has discussed the information  
8 required by the other parts of this section and that the physician has made a  
9 reasonable determination that the mother understands the information in question;

10 (8) Records of the assessments, forms, disclosures, and instructions performed and given  
11 pursuant to this section shall be prepared by the physician and maintained as a  
12 permanent part of the pregnant mother's medical records.

13 Section 4. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
14 as follows:

15 On the day on which the abortion is scheduled, no physician may take a consent for an  
16 abortion nor may the physician perform an abortion, unless the physician has fully complied  
17 with the provisions of this Act and first obtains from the pregnant mother, a written, signed  
18 statement setting forth all information required by subsection (3)(b) of section 3 of this Act. The  
19 written statement signed by the pregnant mother shall be maintained as a permanent part of the  
20 pregnant mother's medical records.

21 Section 5. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
22 as follows:

23 The Department of Health shall maintain a registry of pregnancy help centers located in the  
24 state of South Dakota. The Department shall publish a list of all pregnancy help centers which

1 submit a written request or application to be listed on the state registry of pregnancy help  
2 centers. All pregnancy help centers seeking to be listed on the registry shall be so listed without  
3 charge, if they submit an affidavit that certifies that:

4 (1) The pregnancy help center has a facility or office in the state of South Dakota in  
5 which it routinely consults with women for the purpose of helping them keep their  
6 relationship with their unborn children;

7 (2) That one of its principal missions is to educate, counsel, and otherwise assist women  
8 to help them maintain their relationship with their unborn children;

9 (3) That they do not perform abortions at their facility, and have no affiliation with any  
10 organization or physician which performs abortions;

11 (4) That they do not now refer pregnant women for abortions, and have not referred any  
12 pregnant women for an abortion at any time in the three years immediately preceding  
13 July 1, 2011;

14 (5) That they have a medical director licensed by South Dakota to practice medicine or  
15 that they have a collaborative agreement with a physician licensed in South Dakota  
16 to practice medicine to whom women can be referred;

17 (6) That they shall provide the counseling and interviews described in this Act upon  
18 request by pregnant mothers; and

19 (7) That they shall comply with the provisions of section 11 of this Act as it relates to  
20 discussion of religious beliefs.

21 For purposes of placing the name of a pregnancy help center on the state registry of  
22 pregnancy help centers maintained by the Department of Health, it is irrelevant whether the  
23 pregnancy help center is secular or faith based. The Department of Health shall immediately  
24 provide a copy of the registry of pregnancy health centers to all physicians, facilities, and entities

1 that request it. The registry shall be regularly updated by the Department of Health in order to  
2 include a current list of pregnancy help centers and shall forward all updated lists to all  
3 physicians, facilities, and entities that previously requested the list. The Department of Health  
4 shall accept written requests or applications to be placed on the state registry of pregnancy help  
5 centers from pregnancy help centers after enactment but prior to the effective date of this Act.

6 Section 6. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
7 as follows:

8 A pregnancy help center consulted by a pregnant mother considering consenting to an  
9 abortion, as a result of the provisions of this Act, shall be permitted to interview the pregnant  
10 mother to determine whether the pregnant mother has been subject to any coercion to have an  
11 abortion, and shall be permitted to inform the pregnant mother in writing or orally, or both, what  
12 counseling, education, and assistance that is available to the pregnant mother to help her  
13 maintain her relationship with her unborn child and help her care for the child both through the  
14 pregnancy help center or any other organization, faith-based program, or governmental program.

15 During the consultation interviews provided for by this Act, the pregnancy help centers, their  
16 agents and employees, may not discuss with the pregnant mothers religion or religious beliefs,  
17 either of the mother or the counselor, unless the pregnant mother consents in writing. The  
18 pregnancy help center may, if it deems it appropriate, discuss matters pertaining to adoption.

19 The pregnancy help center is under no obligation to communicate with the abortion provider in  
20 any way, and is under no obligation to submit any written or other form of confirmation that the  
21 pregnant mother consulted with the pregnancy help center. The pregnancy help center may  
22 voluntarily provide a written statement of assessment to the abortion provider, whose name the  
23 woman shall give to the pregnancy help center, if the pregnancy help center obtains information  
24 that indicates that the pregnant mother has been subjected to coercion or that her decision to

1 consider an abortion is otherwise not voluntary or not informed. The physician shall make the  
2 physician's own independent determination whether or not a pregnant mother's consent to have  
3 an abortion is voluntary, uncoerced, and informed before having the pregnant mother sign a  
4 consent to an abortion. The physician shall review and consider any information provided by  
5 the pregnancy help center as one source of information, which in no way binds the physician,  
6 who shall make an independent determination consistent with the provisions of this Act, the  
7 common law requirements, and accepted medical standards. Any written statement or summary  
8 of assessment prepared by the pregnancy help center as a result of counseling of a pregnant  
9 mother as a result of the procedures created by this Act, may be forwarded by the pregnancy  
10 help center, in its discretion, to the abortion physician. If forwarded to the physician, the written  
11 statement or summary of assessment shall be maintained as a permanent part of the pregnant  
12 mother's medical records. Other than forwarding such documents to the abortion physician, no  
13 information obtained by the pregnancy help center from the pregnant mother may be released,  
14 without the written signed consent of the pregnant mother or unless the release is in accordance  
15 with federal, state, or local law.

16 Nothing in this Act may be construed to impose any duties or liability upon a pregnancy help  
17 center.

18 Section 7. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
19 as follows:

20 Terms as used in this Act mean:

- 21 (1) "Pregnancy help center," any entity whether it be a form of corporation, partnership,  
22 or proprietorship, whether it is for profit, or nonprofit, that has as one of its principal  
23 missions to provide education, counseling, and other assistance to help a pregnant  
24 mother maintain her relationship with her unborn child and care for her unborn child,

1 which entity has a medical director who is licensed to practice medicine in the state  
2 of South Dakota, or that it has a collaborative agreement with a physician licensed  
3 in South Dakota to practice medicine to whom women can be referred, which entity  
4 does not perform abortions and is not affiliated with any physician or entity that  
5 performs abortions, and does not now refer pregnant mothers for abortions, and has  
6 not referred any pregnant mother for abortions for the three-year period immediately  
7 preceding July 1, 2011;

8 (2) "Risk factor associated with abortion," any factor, including any physical,  
9 psychological, emotional, demographic, or situational factor, for which there is a  
10 statistical association with an increased risk of one or more complications associated  
11 with legal abortion, such that there is a less than five percent probability that the  
12 statistical association is due to sampling error. To be recognized as a risk factor  
13 associated with legal abortion, the statistical information must have been published  
14 in the English language, after 1972, in at least one peer-reviewed journal indexed by  
15 the search services maintained by the United States National Library of Medicine  
16 (PubMed or MEDLINE, or any replacement services subsequently established by the  
17 National Library) or in at least one peer-reviewed journal indexed by any search  
18 service maintained by the American Psychological Association (PsycINFO, or any  
19 replacement service) and the date of first publication must be not less than twelve  
20 months before the date of the initial consultation described in section 3 of this Act;

21 (3) "Complications associated with abortion," any adverse physical, psychological, or  
22 emotional reaction, for which there is a statistical association with legal abortion,  
23 such that there is a less than five percent probability that the statistical association is  
24 due to sampling error. To be recognized as a complication associated with legal

1 abortion, the statistical information must have been published in the English  
2 language, after 1972, in at least one peer-reviewed journal indexed by the search  
3 services maintained by the United States National Library of Medicine (PubMed or  
4 MEDLINE, or any replacement services subsequently established by the National  
5 Library) or in at least one peer-reviewed journal indexed by any search service  
6 maintained by the American Psychological Association (PsycINFO, or any  
7 replacement service) and the date of first publication must be not less than twelve  
8 months before the date of the initial consultation described in section 3 of this Act;

9 (4) "Coercion," exists if the pregnant mother has a desire to carry her unborn child and  
10 give birth, but is induced, influenced, or persuaded to submit to an abortion by  
11 another person or persons against her desire. Such inducement, influence, or  
12 persuasion may be by use of, or threat of, force, or may be by pressure or intimidation  
13 effected through psychological means, particularly by a person who has a relationship  
14 with the pregnant mother that gives that person influence over the pregnant mother.

15 Section 8. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
16 as follows:

17 Any woman who undergoes an abortion, or her survivors, where there has been an  
18 intentional, knowing, or negligent failure to comply with the provisions of sections 3 and 4 of  
19 this Act may bring a civil action, and obtain a civil penalty in the amount of ten thousand  
20 dollars, plus reasonable attorney's fees and costs, jointly and severally from the physician who  
21 performed the abortion and the abortion facility where the abortion was performed.

22 This amount shall be in addition to any damages that the woman or her survivors may be  
23 entitled to receive under any common law or statutory provisions, to the extent that she sustains  
24 any injury. This amount shall also be in addition to the amounts that the woman or other

1 survivors of the deceased unborn child may be entitled to receive under any common law or  
2 statutory provisions, including but not limited to the wrongful death statutes of this state.

3 Section 9. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
4 as follows:

5 In any civil action presenting a claim arising from a failure to comply with any of the  
6 provisions of this chapter, the following shall apply:

7 (1) The failure to comply with the requirements of this chapter relative to obtaining  
8 consent for the abortion shall create a rebuttable presumption that if the pregnant  
9 mother had been informed in accordance with the requirements of this chapter, she  
10 would have decided not to undergo the abortion;

11 (2) If the trier of fact determines that the abortion was the result of coercion, and it is  
12 determined that if the physician acted prudently, the physician would have learned  
13 of the coercion, there is a nonrebuttable presumption that the mother would not have  
14 consented to the abortion if the physician had complied with the provisions of this  
15 Act;

16 (3) If evidence is presented by a defendant to rebut the presumption set forth in  
17 subdivision (1), then the finder of fact shall determine whether this particular mother,  
18 if she had been given all of the information a reasonably prudent patient in her  
19 circumstance would consider significant, as well as all information required by this  
20 Act to be disclosed, would have consented to the abortion or declined to consent to  
21 the abortion based upon her personal background and personality, her physical and  
22 psychological condition, and her personal philosophical, religious, ethical, and moral  
23 beliefs;

24 (4) The pregnant mother has a right to rely upon the abortion doctor as her source of

1 information, and has no duty to seek any other source of information, other than from  
2 a pregnancy help center as referenced in sections 3 and 4 of this Act, prior to signing  
3 a consent to an abortion;

4 (5) No patient or other person responsible for making decisions relative to the patient's  
5 care may waive the requirements of this chapter, and any verbal or written waiver of  
6 liability for malpractice or professional negligence arising from any failure to comply  
7 with the requirements of this chapter is void and unenforceable.

8 Section 10. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
9 as follows:

10 Nothing in this Act repeals, by implication or otherwise, any provision not explicitly  
11 repealed.

12 Section 11. That chapter 34-23A be amended by adding thereto a NEW SECTION to read  
13 as follows:

14 If any provision of this Act is found to be unconstitutional or its enforcement temporarily  
15 or permanently restrained or enjoined by judicial order, the provision is severable.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

400S0643

HOUSE STATE AFFAIRS  
ENGROSSED NO. **HB 1231** - 2/16/2011

Introduced by: The Committee on State Affairs at the request of the Office of the Governor

1 FOR AN ACT ENTITLED, An Act to provide for the sale of certain surplus real estate, to  
2 appropriate the proceeds to the revolving economic development and initiative fund, and to  
3 revise certain provisions relating to the sale of certain surplus property.

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

5 Section 1. Upon the request of the Governor, the Commissioner of School and Public Lands  
6 shall sell all or any portion of the following real estate and any related personal property and  
7 improvements located on the property:

8 (1) In Aurora County:

9 (a) Certain property under the control of the Department of Corrections and  
10 described generally as the N1/2 of the NE1/4, less the North 600', Section 13,  
11 Township 103, Range 64, consisting of 42.68 acres, more or less;

12 (b) Certain property under the control of the Department of Corrections and  
13 described generally as the NW1/4, less the North 880', Section 13, Township  
14 103, Range 64, consisting of 106.72 acres, more or less; and

15 (c) Certain property under the control of the Department of Corrections and



1 described generally as the N880' of the NE1/4 of Section 14, Township 103,  
2 Range 64, consisting of 53.44 acres more or less;

3 (2) In Custer County:

4 (a) Certain property under the control of the Department of Corrections and  
5 described generally as HES#168, less Tract A and less Lot A, located in  
6 Sections 22 and 23, Township 4S, Range 4EBHM, consisting of 73.48 acres,  
7 more or less;

8 (3) In Fall River County:

9 (a) Certain property under the control of the Department of Military and Veterans  
10 Affairs and described generally as Lots 1-5, inclusive, of Block 42; and Lots  
11 13-23, inclusive, of Block 42, Second Minnekahta Addition, City of Hot  
12 Springs; and

13 (b) Certain property under the control of the Department of Military and Veterans  
14 Affairs and described generally as Lots 1-12, inclusive, of Block 1; Lots 1-12,  
15 inclusive, of Block 2; Lots 1-24, inclusive, of Block 3; Lots 1-14, inclusive,  
16 of Block 4; Lots 1-12, inclusive, of Block 6; and Lots 1-4, inclusive, of Block  
17 7, Cottage Grove Addition, City of Hot Springs;

18 (4) In Minnehaha County:

19 (a) Certain property under the control of the Department of Corrections and  
20 described generally as the SW1/4 of the NW1/4 and NW1/4 of the SW1/4,  
21 Section 7, Township 101, Range 50, consisting of 80 acres, more or less;

22 (b) Certain property under the control of the Department of Corrections and  
23 described generally as the W1/2 of the NW1/4 of the NW1/4 of Section 18,  
24 Township 101, Range 50, consisting of 20 acres, more or less;

- 1 (c) Certain property under the control of the Department of Corrections and  
2 described generally as the W1/2 of the NE1/4 and the SE1/4 of the NE1/4 of  
3 Section 12, Township 101, Range 51, consisting of 120 acres, more or less;
- 4 (d) Certain property under the control of the Department of Corrections and  
5 described generally as the N1/2 of the NW1/4 of Section 12, Township 101,  
6 Range 51, consisting of 80 acres, more or less;
- 7 (e) Certain property under the control of the Department of Corrections and  
8 described generally as the N1/2 of the SE1/4 and E1/2 of the SE1/4 of the  
9 SE1/4 of Section 12, Township 101, Range 51, consisting of 100 acres, more  
10 or less;
- 11 (f) Certain property under the control of the Department of Corrections and  
12 described generally as the NE1/4 of the NE1/4 of Section 13, Township 101,  
13 Range 51, consisting of 40 acres, more or less;
- 14 (g) Certain property under the control of the Department of Corrections and  
15 described generally as the S1/2 of the NW1/4 (except the South 806.87' of the  
16 West 810') and the N1/2 of the SW1/4 of Section 14, Township 101, Range  
17 51, consisting of 145 acres, more or less; and
- 18 (h) Certain property under the control of the Department of Corrections and  
19 described generally as a part of the SW1/4 of Section 4, Township 101, Range  
20 49, lying east of the Big Sioux River diversion channel, including Lot "H-2",  
21 except Lot B of Lot "H-2" and except Lot "H-1," consisting of 32 acres, more  
22 or less; and
- 23 (5) In Spink County:
  - 24 (a) Certain property under the control of the Department of Human Services

1 described generally as, Lot CC3, being a Subdivision of Government Lot 1 of  
2 Section 4, Township 116 North, Range 64 West of the 5th P.M. Spink County,  
3 South Dakota, containing 52.67 acres, more or less, less Hwy ROW of 2.15  
4 acres, more or less.

5 Section 2. Real property and related personal property and improvements on the property  
6 which are generally considered a part of the tracts described in section 1 of this Act but not  
7 specifically included in the legal descriptions set out in section 1 of this Act may be sold as  
8 provided in this Act as though they were specifically described in section 1 of this Act.

9 Section 3. Nothing in section 1 of this Act is intended to authorize the sale of real property  
10 under the control of the Department of Military and Veterans Affairs that is intended for use for  
11 construction of a new Veterans Home.

12 Section 4. The real property and other property described in section 1 of this Act shall be  
13 appraised by the board of appraisal established by § 5-9-3 and shall be sold according to the  
14 procedure established in §§ 5-9-6 to 5-9-9, inclusive, §§ 5-9-11 to 5-9-15, inclusive, § 5-9-28  
15 and 5-9-36, subject to all applicable constitutional reservations.

16 Section 5. Except as otherwise required by the South Dakota Constitution or applicable  
17 federal law, notwithstanding any other law to the contrary, the proceeds from the sale of the real  
18 estate and other property described in section 1 of this Act shall be deposited into the revolving  
19 economic development and initiative fund created by § 1-16G-3. The provisions of § 1-16G-7  
20 notwithstanding, the sale proceeds are hereby appropriated for the purpose of making loans and  
21 grants for economic development pursuant to chapter 1-16G.

22 Section 6. That § 5-2-2.1 be amended to read as follows:

23 5-2-2.1. The Board of Regents, ~~the Department of Corrections, and the Department of~~  
24 ~~Human Services~~ may sell extraneous real property subject to the provisions of the Constitution

1 and approval of the Legislature.

2 The proceeds from a sale of such land under the Board of Regents shall be deposited with  
3 the state treasurer and credited to a fund specifically designated as the "real property acquisition  
4 and capital improvement fund" for each institution under the Board of Regents involved in such  
5 transaction. The proceeds shall be invested by the State Investment Council in accordance with  
6 chapter 4-5. Expenditures from the fund shall be approved by the Legislature.

7 ~~The proceeds from the sale of land under the Department of Corrections and the Department~~  
8 ~~of Human Services shall be deposited in the Department of Corrections building improvement~~  
9 ~~fund and the Department of Human Services building improvement fund which are hereby~~  
10 ~~created in the state treasury.~~

11 Section 7. That § 5-2-2.3 be amended to read as follows:

12 5-2-2.3. The proceeds and accumulated interest from sale of land under the Board of  
13 Regents pursuant to § 5-2-2.1 shall be used by the Board of Regents for acquisition of real and  
14 personal property or capital improvements subject to the approval of the Legislature. For  
15 purposes of this section, the definition of capital improvement contained in § 5-14-1 applies.

16 ~~The proceeds of the sale of land under the Department of Corrections or the Department of~~  
17 ~~Human Services pursuant to § 5-2-2.1 shall be expended in such manner as determined by the~~  
18 ~~Legislature.~~

19 Section 8. Notwithstanding the provisions of this Act or any other law to the contrary, the  
20 Governor may direct the Commissioner of School and Public Lands to sell any real estate and  
21 related personal property described in section 1 of this Act to a political subdivision within  
22 which the real estate and related personal property is located. The sale may be made without  
23 first offering the real estate and related personal property for sale to the public. The sale price  
24 shall be at least the appraised value as determined by the board of appraisal established by § 5-9-

1 3, and is subject to all applicable statutory and constitutional reservations.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

400S0644

## HOUSE STATE AFFAIRS ENGROSSED NO. **HB 1232** - 2/16/2011

Introduced by: The Committee on State Affairs at the request of the Office of the Governor

1 FOR AN ACT ENTITLED, An Act to provide for the sale of certain surplus real estate, to  
2 provide for the deposit of the proceeds, and to revise certain provisions relating to the sale  
3 of certain surplus property.

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

5 Section 1. The provisions of any law to the contrary, upon the request of the Governor, the  
6 Commissioner of School and Public Lands shall sell all or any portion of the following real  
7 estate located in Yankton County and any related personal property and improvements located  
8 on the property:

9 (a) Certain property under the control of the Department of Human Services described  
10 generally as Southeast Quarter of the Southeast Quarter (SE 1/4 SE 1/4) of Section  
11 21, Township 94 North, Range 55, West of the 5th P.M., also described as Lot 13 and  
12 that portion of Lot 14 as described in Warranty Deed, F.V. Willhite, Grantor to  
13 Yankton State Hospital (administered by the South Dakota Department of Human  
14 Services) Grantee; as recorded August 26th 1918 in Book 120 on page 388 in the  
15 County of Yankton to wit: Commencing on the West or right bank of the James or



1 Dakota River at a point where the east and west section line between sections 21 and  
2 28 of Township 94 North, of Range 55 West of the 5th P.M. intersects said bank of  
3 said river; thence west along said section line 4.51 chains; thence north to the right  
4 bank of said river, thence down said stream along the right bank of said river to the  
5 place of beginning north to the right bank of said river, and accreted land; all of  
6 Section 21, Township 94 North, range 55, West of the 5th P.M., consisting of 15  
7 acres, more or less; and

8 (b) Certain property under the control of the Department of Human Services described  
9 generally as the East 1900 feet of the South 1300 feet of Lot A being a Subdivision  
10 of the SE1/4 of Section 36 Township 94 North Range 56 West of the 5th P.M.,  
11 consisting of 56.70 acres, more or less.

12 Section 2. Real property and related personal property and improvements on the property  
13 which are generally considered a part of the tracts described in section 1 of this Act but not  
14 specifically included in the legal descriptions set out in section 1 of this Act may be sold as  
15 provided in this Act as though they were specifically described in section 1 of this Act.

16 Section 3. The real estate and other property described in section 1 of this Act shall be  
17 appraised by the board of appraisal established by §§ 5-9-3 and shall be sold according to the  
18 procedure established in §§ 5-9-6 to 5-9-9, inclusive, 5-9-11 to 5-9-15, inclusive, 5-9-28 and  
19 5-9-36, subject to all applicable constitutional reservations.

20 Section 4. The proceeds from the sale of the real estate and other property described in  
21 section 1 of this Act under the control of the Human Services Center shall be deposited into the  
22 permanent fund established by Article VIII, Section 7, of the South Dakota Constitution for the  
23 use and benefit of the Human Services Center.

24 Section 5. That § 5-2-2.1 be amended to read as follows:

1       5-2-2.1. The Board of Regents, ~~the Department of Corrections, and the Department of~~  
2 ~~Human Services~~ may sell extraneous real property subject to the provisions of the Constitution  
3 and approval of the Legislature.

4       The proceeds from a sale of such land under the Board of Regents shall be deposited with  
5 the state treasurer and credited to a fund specifically designated as the "real property acquisition  
6 and capital improvement fund" for each institution under the Board of Regents involved in such  
7 transaction. The proceeds shall be invested by the State Investment Council in accordance with  
8 chapter 4-5. Expenditures from the fund shall be approved by the Legislature.

9       ~~The proceeds from the sale of land under the Department of Corrections and the Department~~  
10 ~~of Human Services shall be deposited in the Department of Corrections building improvement~~  
11 ~~fund and the Department of Human Services building improvement fund which are hereby~~  
12 ~~created in the state treasury:~~

13       Section 6. That § 5-2-2.3 be amended to read as follows:

14       5-2-2.3. The proceeds and accumulated interest from sale of land under the Board of  
15 Regents pursuant to § 5-2-2.1 shall be used by the Board of Regents for acquisition of real and  
16 personal property or capital improvements subject to the approval of the Legislature. For  
17 purposes of this section, the definition of capital improvement contained in § 5-14-1 applies.

18       ~~The proceeds of the sale of land under the Department of Corrections or the Department of~~  
19 ~~Human Services pursuant to § 5-2-2.1 shall be expended in such manner as determined by the~~  
20 ~~Legislature:~~

21       Section 7. Notwithstanding the provisions of this Act or any other law to the contrary, the  
22 Governor may direct the Commissioner of School and Public Lands to sell any real estate and  
23 related personal property described in section 1 of this Act to a political subdivision within  
24 which the real estate and related personal property is located. The sale may be made without

1 first offering the real estate and related personal property for sale to the public. The sale price  
2 shall be at least the appraised value as determined by the board of appraisal established by § 5-9-  
3 3, and is subject to all applicable statutory and constitutional reservations.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

492S0097

## HOUSE STATE AFFAIRS ENGROSSED NO. **HB 1236** - 2/16/2011

Introduced by: Representatives Willadsen, Carson, Cronin, Deelstra, Dennert, Feinstein, Haggar, Hickey, Hoffman, Hubbel, Kloucek, Magstadt, Moser, Munsterman, Perry, Rausch, Rozum, Schaefer, Sigdestad, Sly, Stricherz, Tornow, Turbiville, Van Gerpen, and White

1 FOR AN ACT ENTITLED, An Act to provide for a temporary decrease of legislator salaries.

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

3 Section 1. That § 2-4-2 be amended to read as follows:

4 2-4-2. The salary of each member of the Legislature is ~~six thousand~~ five thousand four  
5 hundred dollars for every regular legislative session. In addition, each legislator shall receive:

6 (1) Reimbursement to be paid after the legislative session for actual mileage or its  
7 equivalent traveled to and from home not more than once each weekend or between  
8 days of recess during the regular legislative session, at state rates established by the  
9 Board of Finance;

10 (2) Expenses of one hundred ten dollars per day for each day of a regular or special  
11 legislative session as prepaid reimbursement for living expenses, including meals and  
12 lodging, laundry, cleaning and pressing of clothing, and all other uncompensated  
13 expenses as defined in § 2-4-2.1 incident to the performance of legislative services;



1           and

2           (3)   Five cents once each session for every mile of necessary travel in going to and  
3           returning from the place of meeting of the Legislature by the most usual route.

4           For each day's attendance at special sessions, each member, in addition to mileage and  
5           expenses, shall receive a per diem calculated by the director of the Legislative Research Council  
6           equal to the normal daily compensation for the regular session immediately preceding the  
7           special session.

8           Section 2. The provisions of section 1 of this Act are effective on January 1, 2012, and are  
9           repealed on January 1, 2013.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

951S0018

HOUSE LOCAL GOVERNMENT

ENGROSSED NO. **HB 1252** - 2/15/2011

**This bill has been extensively amended (hoghoused) and may no longer be consistent with the original intention of the sponsor.**

Introduced by: Representatives Kirkeby, Abdallah, Boomgarden, Brunner, Conzet, Deelstra, Dryden, Feickert, Gosch, Greenfield, Jensen, Juhnke, Kopp, Lucas, Lust, Munsterman, Olson (Betty), Romkema, Sly, Solum, and Turbiville and Senators Schlekeway, Adelstein, Haverly, Kraus, Lederman, Maher, Nygaard, Rampelberg, Rhoden, and Tieszen

1 FOR AN ACT ENTITLED, An Act to grant certain authority to municipalities and counties  
2 regarding outdoor advertising structures.

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

4 Section 1. That § 31-29-69 be amended to read as follows:

5 31-29-69. Nothing in §§ 31-29-61 to 31-29-83, inclusive, authorizes any local authority to  
6 prohibit ~~outdoor advertising~~ any on-premise sign throughout its jurisdiction. However, any the  
7 local authority may prohibit any other new outdoor advertising structures in its jurisdiction. Any  
8 such regulation and control shall be reasonable and reasonably related to the needs of the  
9 business community to adequately and properly advertise its goods and services of benefit to  
10 the traveling public.



# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

628S0622

## HOUSE JUDICIARY ENGROSSED NO. **HB 1255** - 2/16/2011

Introduced by: The Committee on Health and Human Services

1 FOR AN ACT ENTITLED, An Act to provide for the award of joint physical custody of  
2 children under certain circumstances.

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

4 Section 1. That chapter 25-5 be amended by adding thereto a NEW SECTION to read as  
5 follows:

6 If joint legal custody is awarded, pursuant to § 25-5-7.1, there is a rebuttable presumption  
7 that both parents have joint physical custody of their children. Joint physical custody of the  
8 children is defined as equal time-sharing. The burden of overcoming the presumption rests on  
9 the parent challenging the presumption. The presumption may be overcome by demonstrating  
10 that joint physical custody would not be in the best interests of the children or by one parent  
11 waiving the presumption. The clear and convincing evidentiary standard shall be used in  
12 determining if the presumption has been overcome. Upon request by either parent, the court  
13 shall hold a hearing at which the parties may introduce evidence. The court shall issue findings  
14 of fact and conclusions of law upon request by either parent. The court shall require the parents  
15 to prepare and submit a parenting plan to the court reflecting parental preferences and agreement



1 on the matters of substance concerning the child's education, upbringing, religious training,  
2 medical, and dental care. The parents shall share decision-making authority and responsibility  
3 as to the important decisions affecting the child's welfare and if parents are unable to agree, and  
4 they shall submit to, and abide by, the decision of a preselected mediator.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

400S0180

## SENATE TRANSPORTATION ENGROSSED NO. **SB 4** - 1/31/2011

Introduced by: The Committee on Transportation at the request of the Department of  
Transportation

1 FOR AN ACT ENTITLED, An Act to update certain standards governing pedestrian control  
2 signals.

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

4 Section 1. That § 32-28-9.1 be amended to read as follows:

5 32-28-9.1. Whenever special pedestrian control signals exhibiting the words, walk or don't  
6 walk, or exhibiting a lighted international pedestrian walk or don't walk symbol are in place, the  
7 signals indicate the following:

8 (1) Walk or a lighted international pedestrian walk symbol.--Pedestrians facing the signal  
9 may proceed across the roadway in the direction of the signal and shall be given the  
10 right-of-way by the drivers of all vehicles;

11 (2) Don't walk or a lighted international pedestrian don't walk symbol.--No pedestrian  
12 may start to cross the roadway in the direction of the signal, but any pedestrian who  
13 has partially completed crossing on the walk signal shall proceed to a sidewalk or  
14 safety island while the don't walk signal or lighted international pedestrian don't walk



1 symbol is showing.

2 The special pedestrian control signals shall conform to the Manual on Uniform Traffic  
3 Control Devices, ~~2003~~ 2009 Edition.

4 ~~A violation of this section~~ Any failure by a driver to comply with the provisions of this  
5 section is a Class 2 misdemeanor. ~~A violation of this section~~ Any failure by a pedestrian to  
6 comply with the provisions of this section is a petty offense.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

400S0252

## SENATE COMMERCE ENGROSSED NO. **SB 38** - 1/18/2011

Introduced by: The Committee on Commerce at the request of the Department of Revenue  
and Regulation

1 FOR AN ACT ENTITLED, An Act to establish network adequacy standards, quality assessment  
2 and improvement requirements, utilization review and benefit determination requirements,  
3 and grievance procedures for managed health care plans, and to repeal certain standards for  
4 managed health care plans.

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

6 Section 1. That § 58-17C-1 to § 58-17C-103, inclusive, be repealed.

7 Section 2. Terms used in sections 2 to 21, inclusive, of this Act mean:

- 8 (1) "Closed plan," a managed care plan or health carrier that requires covered persons to  
9 use participating providers under the terms of the managed care plan or health carrier  
10 and does not provide any benefits for out-of-network services except for emergency  
11 services;
- 12 (2) "Covered benefits" or "benefits," those health care services to which a covered person  
13 is entitled under the terms of a health benefit plan;
- 14 (3) "Covered person," a policyholder, subscriber, enrollee, or other individual



- 1 participating in a health benefit plan;
- 2 (4) "Director," the director of the Division of Insurance;
- 3 (5) "Emergency medical condition," a medical condition manifesting itself by acute  
4 symptoms of sufficient severity, including severe pain, such that a prudent layperson,  
5 who possesses an average knowledge of health and medicine, could reasonably  
6 expect that the absence of immediate medical attention would result in serious  
7 impairment to bodily functions or serious dysfunction of a bodily organ or part, or  
8 would place the person's health or, with respect to a pregnant woman, the health of  
9 the woman or her unborn child, in serious jeopardy;
- 10 (6) "Emergency services," with respect to an emergency medical condition:
- 11 (a) A medical screening examination that is within the capability of the  
12 emergency department of a hospital, including ancillary services routinely  
13 available to the emergency department to evaluate such emergency condition;  
14 and
- 15 (b) Such further medical examination and treatment, to the extent they are within  
16 the capability of the staff and facilities at a hospital to stabilize a patient;
- 17 (7) "Facility," an institution providing health care services or a health care setting,  
18 including hospitals and other licensed inpatient centers, ambulatory surgical or  
19 treatment centers, skilled nursing centers, residential treatment centers, diagnostic,  
20 laboratory, and imaging centers, and rehabilitation, and other therapeutic health  
21 settings;
- 22 (8) "Health care professional," a physician or other health care practitioner licensed,  
23 accredited, or certified to perform specified health services consistent with state law;
- 24 (9) "Health care provider" or "provider," a health care professional or a facility;

- 1 (10) "Health care services," services for the diagnosis, prevention, treatment, cure, or  
2 relief of a health condition, illness, injury, or disease;
- 3 (11) "Health carrier," an entity subject to the insurance laws and regulations of this state,  
4 or subject to the jurisdiction of the director, that contracts or offers to contract, or  
5 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any  
6 of the costs of health care services, including a sickness and accident insurance  
7 company, a health maintenance organization, a nonprofit hospital and health service  
8 corporation, or any other entity providing a plan of health insurance, health benefits,  
9 or health services;
- 10 (12) "Health indemnity plan," a health benefit plan that is not a managed care plan;
- 11 (13) "Intermediary," a person authorized to negotiate and execute provider contracts with  
12 health carriers on behalf of health care providers or on behalf of a network;
- 13 (14) "Managed care contractor," a person who establishes, operates, or maintains a  
14 network of participating providers; or contracts with an insurance company, a  
15 hospital or medical service plan, an employer, an employee organization, or any other  
16 entity providing coverage for health care services to operate a managed care plan or  
17 health carrier;
- 18 (15) "Managed care entity," a licensed insurance company, hospital or medical service  
19 plan, health maintenance organization, or an employer or employee organization, that  
20 operates a managed care plan or a managed care contractor. The term does not  
21 include a licensed insurance company unless it contracts with other entities to  
22 provide a network of participating providers;
- 23 (16) "Managed care plan," a plan operated by a managed care entity that provides for the  
24 financing or delivery of health care services, or both, to persons enrolled in the plan

1 through any of the following:

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

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

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

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

7 (18) "Open plan," a managed care plan or health carrier other than a closed plan that  
8 provides incentives, including financial incentives, for covered persons to use  
9 participating providers under the terms of the managed care plan or health carrier;

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

14 (20) "Primary care professional," a participating health care professional designated by a  
15 health carrier to supervise, coordinate or provide initial care or continuing care to a  
16 covered person, and who may be required by the health carrier to initiate a referral  
17 for specialty care and maintain supervision of health care services rendered to the  
18 covered person; and

19 (21) "Secretary," the secretary of the Department of Health.

20 Section 3. Any managed care plan shall provide for the appointment of a medical director  
21 who has an unrestricted license to practice medicine. However, a managed care plan that  
22 specializes in a specific healing art shall provide for the appointment of a director who has an  
23 unrestricted license to practice in that healing art. The director is responsible for oversight of  
24 treatment policies, protocols, quality assurance activities, and utilization management decisions

1 of the managed care plan.

2 Section 4. Any health carrier shall provide to any prospective enrollee written information  
3 describing the terms and conditions of the plan. If the plan is described orally, easily understood,  
4 truthful, objective terms shall be used. The written information need not be provided to any  
5 prospective enrollee who makes inquiries of a general nature directly to a carrier. In the  
6 solicitation of group coverage to an employer, a carrier is not required to provide the written  
7 information required by this section to individual employees or their dependents and if no  
8 solicitation is made directly to the employees or dependents and if no request to provide the  
9 written information to the employees or dependents is made by the employer. All written plan  
10 descriptions shall be readable, easily understood, truthful, and in an objective format. The  
11 format shall be standardized among each plan that a health carrier offers so that comparison of  
12 the attributes of the plans is facilitated. The following specific information shall be  
13 communicated:

- 14 (1) Coverage provisions, benefits, and any exclusions by category of service, provider,  
15 and if applicable, by specific service;
- 16 (2) Any and all authorization or other review requirements, including preauthorization  
17 review, and any procedures that may lead the patient to be denied coverage for or not  
18 be provided a particular service;
- 19 (3) The existence of any financial arrangements or contractual provisions with review  
20 companies or providers of health care services that would directly or indirectly limit  
21 the services offered, restrict referral, or treatment options;
- 22 (4) Explanation of how plan limitations impact enrollees, including information on  
23 enrollee financial responsibility for payment of coinsurance or other non-covered or  
24 out-of-plan services;

- 1       (5)    A description of the accessibility and availability of services, including a list of
- 2            providers participating in the managed care network and of the providers in the
- 3            network who are accepting new patients, the addresses of primary care physicians
- 4            and participating hospitals, and the specialty of each provider in the network; and
- 5       (6)    A description of any drug formulary provisions in the plan and the process for
- 6            obtaining a copy of the current formulary upon request. There shall be a process for
- 7            requesting an exception to the formulary and instructions as to how to request an
- 8            exception to the formulary.

9       Section 5. A health carrier providing a managed care plan shall maintain a network that is

10       sufficient in numbers and types of providers to assure that all services to covered persons will

11       be accessible without unreasonable delay. In the case of emergency services, covered persons

12       shall have access twenty-four hours a day, seven days a week. Sufficiency shall be determined

13       in accordance with the requirements of this section, and may be established by reference to any

14       reasonable criteria used by the carrier, including: provider-covered person ratios by specialty;

15       primary care provider-covered person ratios; geographic accessibility; waiting times for

16       appointments with participating providers; hours of operation; and the volume of technological

17       and specialty services available to serve the needs of covered persons requiring technologically

18       advanced or specialty care.

19       Section 6. In any case where the health carrier has an insufficient number or type of

20       participating provider to provide a covered benefit, the health carrier shall ensure that the

21       covered person obtains the covered benefit at no greater cost to the covered person than if the

22       benefit were obtained from participating providers, or shall make other arrangements acceptable

23       to the director.

24       Section 7. The health carrier shall establish and maintain adequate arrangements to ensure

1 reasonable proximity of participating providers to the business or personal residence of covered  
2 persons.

3 Section 8. The health carrier shall monitor, on an ongoing basis, the ability, clinical capacity,  
4 and legal authority of its providers to furnish all contracted benefits to covered persons. In the  
5 case of capitated plans, the health carrier shall also monitor the financial capability of the  
6 provider.

7 Section 9. In determining whether a health carrier has complied with any network adequacy  
8 provision of sections 2 to 21, inclusive, of this Act, the director shall give due consideration to  
9 the relative availability of healthcare providers in the service area and to the willingness of  
10 providers to join a network.

11 Section 10. The health carrier shall file with the director, in a manner and form defined by  
12 rules promulgated pursuant to chapter 1-26 by the director, an access plan meeting the  
13 requirements of sections 2 to 21, inclusive, of this Act, for each of the managed care plans that  
14 the carrier offers in this state. The carrier shall prepare an access plan prior to offering a new  
15 managed care plan, and shall annually update an existing access plan. The access plan shall  
16 describe or contain at least the following:

- 17 (1) The health carrier's network;
- 18 (2) The health carrier's procedures for making referrals within and outside its network;
- 19 (3) The health carrier's process for monitoring and assuring on an ongoing basis the  
20 sufficiency of the network to meet the health care needs of populations that enroll in  
21 managed care plans;
- 22 (4) The health carrier's methods for assessing the health care needs of covered persons  
23 and their satisfaction with services;
- 24 (5) The health carrier's method of informing covered persons of the plan's services and

1 features, including the plan's grievance procedures and its procedures for providing  
2 and approving emergency and specialty care;

3 (6) The health carrier's system for ensuring the coordination and continuity of care for  
4 covered persons referred to specialty physicians, for covered persons using ancillary  
5 services, including social services and other community resources, and for ensuring  
6 appropriate discharge planning;

7 (7) The health carrier's process for enabling covered persons to change primary care  
8 professionals;

9 (8) The health carrier's proposed plan for providing continuity of care in the event of  
10 contract termination between the health carrier and any of its participating providers,  
11 or in the event of the health carrier's insolvency or other inability to continue  
12 operations. The description shall explain how covered persons will be notified of the  
13 contract termination, or the health carrier's insolvency or other cessation of  
14 operations, and transferred to other providers in a timely manner; and

15 (9) Any other information required by the director to determine compliance with the  
16 provisions of sections 2 to 21, inclusive, of this Act.

17 The provisions of subdivisions (2), (4), (6), (7), and (8), of this section, and the provisions  
18 regarding primary care provider-covered person ratios and hours of operation in section 5 of this  
19 Act do not apply to discounted fee-for-service only networks.

20 Section 11. Any health carrier offering a managed care plan shall satisfy all the following  
21 requirements:

22 (1) The health carrier shall establish a mechanism by which the participating provider  
23 will be notified on an ongoing basis of the specific covered health services for which  
24 the provider will be responsible, including any limitations or conditions on services;

- 1       (2)    In no event may a participating provider collect or attempt to collect from a covered  
2            person any money owed to the provider by the health carrier nor may the provider  
3            have any recourse against covered persons for any covered charges in excess of the  
4            copayment, coinsurance, or deductible amounts specified in the coverage, including  
5            covered persons who have a health savings account;
- 6       (3)    The provisions of sections 2 to 21, inclusive, of this Act, do not require the health  
7            carrier, its intermediaries or the provider networks with which they contract, to  
8            employ specific providers or types of providers that may meet their selection criteria,  
9            or to contract with or retain more providers or types of providers than are necessary  
10           to maintain an adequate network;
- 11      (4)    The health carrier shall notify participating providers of the providers' responsibilities  
12            with respect to the health carrier's applicable administrative policies and programs,  
13            including payment terms, utilization review, quality assessment, and improvement  
14            programs, grievance procedures, data reporting requirements, confidentiality  
15            requirements, and any applicable federal or state programs;
- 16      (5)    The health carrier may not prohibit or penalize a participating provider from  
17            discussing treatment options with covered persons irrespective of the health carrier's  
18            position on the treatment options, from advocating on behalf of covered persons  
19            within the utilization review or grievance processes established by the carrier or a  
20            person contracting with the carrier or from, in good faith, reporting to state or federal  
21            authorities any act or practice by the health carrier that jeopardizes patient health or  
22            welfare;
- 23      (6)    The health carrier shall contractually require a provider to make health records  
24            available to the carrier upon request but only those health records necessary to

1 process claims, perform necessary quality assurance or quality improvement  
2 programs, or to comply with any lawful request for information from appropriate  
3 state authorities. Any person that is provided records pursuant to this section shall  
4 maintain the confidentiality of such records and may not make such records available  
5 to any other person who is not legally entitled to the records;

6 (7) The health carrier and participating provider shall provide at least sixty days written  
7 notice to each other before terminating the contract without cause. If a provider is  
8 terminated without cause or chooses to leave the network, upon request by the  
9 provider or the covered person and upon agreement by the provider to follow all  
10 applicable network requirements, the carrier shall permit the covered person to  
11 continue an ongoing course of treatment for ninety days following the effective date  
12 of contract termination. If a covered person that has entered a second trimester of  
13 pregnancy at the time of contract termination as specified in this section, the  
14 continuation of network coverage through that provider shall extend to the provision  
15 of postpartum care directly related to the delivery;

16 (8) The health carrier shall notify the participating providers of their obligations, if any,  
17 to collect applicable coinsurance, copayments, or deductibles from covered persons  
18 pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify  
19 covered persons of their personal financial obligations for noncovered services; and

20 (9) The health carrier shall establish a mechanism by which the participating providers  
21 may determine in a timely manner whether or not a person is covered by the carrier.

22 Section 12. In any contractual arrangement between a health carrier and an intermediary, the  
23 following shall apply:

24 (1) The health carrier's ultimate statutory responsibility to monitor the offering of

1 covered benefits to covered persons shall be maintained whether or not any functions  
2 or duties are contractually delegated or assigned to the intermediary;

3 (2) The health carrier may approve or disapprove participation status of a subcontracted  
4 provider in its own or a contracted network for the purpose of delivering covered  
5 benefits to the carrier's covered persons;

6 (3) The health carrier shall maintain copies of all intermediary health care subcontracts  
7 at its principal place of business in the state, or ensure that it has access to all  
8 intermediary subcontracts, including the right to make copies to facilitate regulatory  
9 review, upon twenty days prior written notice from the health carrier;

10 (4) If applicable, an intermediary shall transmit utilization documentation and claims  
11 paid documentation to the health carrier. The carrier shall monitor the timeliness and  
12 appropriateness of payments made to providers and health care services received by  
13 covered persons;

14 (5) An intermediary shall maintain the books, records, financial information, and  
15 documentation of services provided to covered persons and preserve them for  
16 examination pursuant to chapter 58-3;

17 (6) An intermediary shall allow the director access to the intermediary's books, records,  
18 financial information, and any documentation of services provided to covered  
19 persons, as necessary to determine compliance with sections 2 to 21, inclusive, of this  
20 Act; and

21 (7) The health carrier may, in the event of the intermediary's insolvency, require the  
22 assignment to the health carrier of the provisions of a provider's contract addressing  
23 the provider's obligation to furnish covered services.

24 Section 13. Any health carrier shall file with the director sample contract forms proposed

1 for use with its participating providers and intermediaries. Any health carrier shall submit  
2 material changes to a sample contract that would affect a provision required by sections 2 to 21,  
3 inclusive, of this Act, or any rules promulgated pursuant to sections 2 to 21, inclusive, of this  
4 Act, to the director for approval thirty days prior to use. Changes in provider payment rates,  
5 coinsurance, copayments, or deductibles, or other plan benefit modifications are not considered  
6 material changes for the purpose of this section. If the director takes no action within sixty days  
7 after submission of a material change to a contract by a health carrier, the change is deemed  
8 approved. The health carrier shall maintain provider and intermediary contracts and provide  
9 copies to the division or department upon request.

10 Section 14. The execution of a contract by a health carrier does not relieve the health carrier  
11 of its liability to any person with whom it has contracted for the provision of services, nor of its  
12 responsibility for compliance with the law or applicable regulations. Any contract shall be in  
13 writing and subject to review by the director, if requested.

14 Section 15. In addition to any other remedies permitted by law, if the director determines  
15 that a health carrier has not contracted with enough participating providers to assure that  
16 covered persons have accessible health care services in a geographic area, that a health carrier's  
17 access plan does not assure reasonable access to covered benefits, that a health carrier has  
18 entered into a contract that does not comply with sections 2 to 21, inclusive, of this Act, or that  
19 a health carrier has not complied with a provision of sections 2 to 21, inclusive, of this Act, the  
20 director may institute a corrective action that shall be followed by the health carrier or may use  
21 any of the director's other enforcement powers to obtain the health carrier's compliance with  
22 sections 2 to 21, inclusive, of this Act.

23 A covered person shall have access to emergency services twenty-four hours a day, seven  
24 days a week to treat emergency medical conditions that require immediate medical attention.

1 Section 16. Each managed care contractor, as defined in section 2 of this Act, shall register  
2 with the director prior to engaging in any managed care business in this state. The registration  
3 shall be in a format prescribed by the director. In prescribing the form or in carrying out other  
4 functions required by sections 16 to 20, inclusive, of this Act, the director shall consult with the  
5 secretary if applicable. The director or the secretary may require that the following information  
6 be submitted:

- 7 (1) Information relating to its actual or anticipated activities in this state;
- 8 (2) The status of any accreditation designation it holds or has sought;
- 9 (3) Information pertaining to its place of business, officers, and directors;
- 10 (4) Qualifications of review staff; and
- 11 (5) Any other information reasonable and necessary to monitor its activities in this state.

12 Section 17. Any managed care contractor which has previously registered in this state shall,  
13 on or before July first of each year, file with the Division of Insurance any changes to the initial  
14 or subsequent annual registration for the managed care contractor.

15 Section 18. The director or the secretary may request information from any managed care  
16 contractor at any time pertaining to its activities in this state. The managed care contractor shall  
17 respond to all requests for information within twenty days.

18 Section 19. No managed care contractor may engage in managed care activities in this state  
19 unless the managed care contractor is properly registered. The director may issue a cease and  
20 desist order against any managed care contractor which fails to comply with the requirements  
21 of sections 16 to 20, inclusive, of this Act, prohibiting the managed care contractor from  
22 engaging in managed care activities in this state.

23 Section 20. The director may require the payment of a fee in conjunction with the initial or  
24 annual registration of a managed care contractor not to exceed two hundred fifty dollars per

1 registration. The fee shall be established by rules promulgated pursuant to chapter 1-26.

2 Section 21. The director may, after consultation with the secretary, promulgate, pursuant to  
3 chapter 1-26, reasonable rules to protect the public in its purchase of network health insurance  
4 products and to achieve the goals of sections 2 to 20, inclusive, of this Act, by ensuring adequate  
5 networks and by assuring quality of health care to the public that purchases network products.

6 The rules may include:

- 7 (1) Definition of terms;
- 8 (2) Provider/covered person ratios;
- 9 (3) Geographic access requirements;
- 10 (4) Accessibility of care;
- 11 (5) Contents of reports and filings;
- 12 (6) Notification requirements;
- 13 (7) Selection criteria; and
- 14 (8) Record keeping.

15 Section 22. Terms used in sections 22 to 27, inclusive, of this Act, mean:

- 16 (1) "Closed plan," a managed care plan or health carrier that requires covered persons to  
17 use participating providers under the terms of the managed care plan or health carrier  
18 and does not provide any benefits for out-of-network services except for emergency  
19 services;
- 20 (2) "Consumer," someone in the general public who may or may not be a covered person  
21 or a purchaser of health care, including employers;
- 22 (3) "Covered benefits" or "benefits," those health care services to which a covered person  
23 is entitled under the terms of a health benefit plan;
- 24 (4) "Covered person," a policyholder, subscriber, enrollee, or other individual

- 1 participating in a health benefit plan;
- 2 (5) "Director," the director of the Division of Insurance;
- 3 (6) "Discounted fee for service," a contractual arrangement between a health carrier and  
4 a provider or network of providers under which the provider is compensated in a  
5 discounted fashion based upon each service performed and under which there is no  
6 contractual responsibility on the part of the provider to manage care, to serve as a  
7 gatekeeper or primary care provider, or to provide or assure quality of care. A  
8 contract between a provider or network of providers and a health maintenance  
9 organization is not a discounted fee for service arrangement;
- 10 (7) "Facility," an institution providing health care services or a health care setting,  
11 including hospitals and other licensed inpatient centers, ambulatory surgical or  
12 treatment centers, skilled nursing centers, residential treatment centers, diagnostic,  
13 laboratory, and imaging centers, and rehabilitation, and other therapeutic health  
14 settings;
- 15 (8) "Health care professional," a physician or other health care practitioner licensed,  
16 accredited, or certified to perform specified health services consistent with state law;
- 17 (9) "Health care provider" or "provider," a health care professional or a facility;
- 18 (10) "Health care services," services for the diagnosis, prevention, treatment, cure, or  
19 relief of a health condition, illness, injury, or disease;
- 20 (11) "Health carrier," an entity subject to the insurance laws and regulations of this state,  
21 or subject to the jurisdiction of the director, that contracts or offers to contract, or  
22 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any  
23 of the costs of health care services, including a sickness and accident insurance  
24 company, a health maintenance organization, a nonprofit hospital and health service

1 corporation, or any other entity providing a plan of health insurance, health benefits,  
2 or health services;

3 (12) "Health indemnity plan," a health benefit plan that is not a managed care plan;

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

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

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

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

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

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

21 (16) "Open plan," a managed care plan or health carrier other than a closed plan that  
22 provides incentives, including financial incentives, for covered persons to use  
23 participating providers under the terms of the managed care plan or health carrier;

24 (17) "Participating provider," a provider who, under a contract with the health carrier or

1 with its contractor or subcontractor, has agreed to provide health care services to  
2 covered persons with an expectation of receiving payment, other than coinsurance,  
3 copayments, or deductibles, directly or indirectly, from the health carrier;

4 (18) "Quality assessment," the measurement and evaluation of the quality and outcomes  
5 of medical care provided to individuals, groups, or populations;

6 (19) "Quality improvement," the effort to improve the processes and outcomes related to  
7 the provision of care within the health plan; and

8 (20) "Secretary," the secretary of the Department of Health.

9 Section 23. Any health carrier that provides managed care plans shall develop and maintain  
10 the infrastructure and disclosure systems necessary to measure the quality of health care services  
11 provided to covered persons on a regular basis and appropriate to the types of plans offered by  
12 the health carrier. A health carrier shall:

13 (1) Utilize a system designed to assess the quality of health care provided to covered  
14 persons and appropriate to the types of plans offered by the health carrier. The system  
15 shall include systematic collection, analysis, and reporting of relevant data in  
16 accordance with statutory and regulatory requirements. The level of quality  
17 assessment activities undertaken by a health plan may vary based on the plan's  
18 structure with the least amount of quality assessment activities required being those  
19 plans which are open and the provider network is simply a discounted fee for service  
20 preferred provider organization; and

21 (2) File a written description of the quality assessment program with the director in the  
22 prescribed general format, which shall include a signed certification by a corporate  
23 officer of the health carrier that the filing meets the requirements of sections 22 to 27,  
24 inclusive, of this Act.

1 Section 24. Any health carrier that issues a closed plan, or a combination plan having a  
2 closed component, shall, in addition to complying with the requirements of section 23 of this  
3 Act, develop and maintain the internal structures and activities necessary to improve the quality  
4 of care being provided. Quality improvement activities for a health carrier subject to the  
5 requirements of this section shall involve:

- 6 (1) Developing a written quality improvement plan designed to analyze both the  
7 processes and outcomes of the health care delivered to covered persons;
- 8 (2) Establishing an internal system to implement the quality improvement plan and to  
9 specifically identify opportunities to improve care and using the findings of the  
10 system to improve the health care delivered to covered persons; and
- 11 (3) Assuring that participating providers have the opportunity to participate in  
12 developing, implementing, and evaluating the quality improvement system.

13 The health carrier shall provide a copy of the quality improvement plan to the director or  
14 secretary, if requested.

15 Section 25. If the director and secretary find that the requirements of any private accrediting  
16 body meet the requirements of network adequacy, quality assurance, or quality improvement as  
17 set forth in sections 22 to 27, inclusive, of this Act, the carrier may, at the discretion of the  
18 director and secretary, be deemed to have met the applicable requirements.

19 Section 26. The Division of Insurance shall separately monitor complaints regarding  
20 managed care policies.

21 Section 27. The director may, after consultation with the secretary, promulgate, pursuant to  
22 chapter 1-26, reasonable rules to protect the public in its purchase of network health insurance  
23 products and to achieve the goals of sections 22 to 26, inclusive, of this Act, by assuring quality  
24 of health care to the public that purchases network products. The rules may include:

- 1 (1) Definition of terms;
- 2 (2) Contents of reports and filings;
- 3 (3) Record keeping;
- 4 (4) Setting of quality criteria based upon type of network; and
- 5 (5) Quality assurance plans or quality improvement plans or both.

6 Section 28. Terms used in sections 28 to 74, inclusive, of this Act, mean:

- 7 (1) "Adverse determination," any of the following:
  - 8 (a) A determination by a health carrier or the carrier's designee utilization review
  - 9 organization that, based upon the information provided, a request by a covered
  - 10 person for a benefit under the health carrier's health benefit plan upon
  - 11 application of any utilization review technique does not meet the health
  - 12 carrier's requirements for medical necessity, appropriateness, health care
  - 13 setting, level of care or effectiveness or is determined to be experimental or
  - 14 investigational and the requested benefit is therefore denied, reduced, or
  - 15 terminated or payment is not provided or made, in whole or in part, for the
  - 16 benefit;
  - 17 (b) The denial, reduction, termination, or failure to provide or make payment in
  - 18 whole or in part, for a benefit based on a determination by a health carrier or
  - 19 the carrier's designee utilization review organization of a covered person's
  - 20 eligibility to participate in the health carrier's health benefit plan;
  - 21 (c) Any prospective review or retrospective review determination that denies,
  - 22 reduces, terminates, or fails to provide or make payment, in whole or in part,
  - 23 for a benefit; or
  - 24 (d) A rescission of coverage determination;

- 1 (2) "Ambulatory review," utilization review of health care services performed or  
2 provided in an outpatient setting;
- 3 (3) "Authorized representative," a person to whom a covered person has given express  
4 written consent to represent the covered person for purposes of sections 28 to 74,  
5 inclusive, of this Act, a person authorized by law to provide substituted consent for  
6 a covered person, a family member of the covered person or the covered person's  
7 treating health care professional if the covered person is unable to provide consent,  
8 or a health care professional if the covered person's health benefit plan requires that  
9 a request for a benefit under the plan be initiated by the health care professional. For  
10 any urgent care request, the term includes a health care professional with knowledge  
11 of the covered person's medical condition;
- 12 (4) "Case management," a coordinated set of activities conducted for individual patient  
13 management of serious, complicated, protracted, or other health conditions;
- 14 (5) "Certification," a determination by a health carrier or the carrier's designee utilization  
15 review organization that a request for a benefit under the health carrier's health  
16 benefit plan has been reviewed and, based on the information provided, satisfies the  
17 health carrier's requirements for medical necessity, appropriateness, health care  
18 setting, level of care, and effectiveness;
- 19 (6) "Clinical peer," a physician or other health care professional who holds a  
20 nonrestricted license in a state of the United States and in the same or similar  
21 specialty as typically manages the medical condition, procedure, or treatment under  
22 review;
- 23 (7) "Clinical review criteria," the written screening procedures, decision abstracts,  
24 clinical protocols, and practice guidelines used by the health carrier to determine the

- 1 medical necessity and appropriateness of health care services;
- 2 (8) "Concurrent review," utilization review conducted during a patient's hospital stay or  
3 course of treatment in a facility or other inpatient or outpatient health care setting;
- 4 (9) "Covered benefits" or "benefits," those health care services to which a covered person  
5 is entitled under the terms of a health benefit plan;
- 6 (10) "Covered person," a policyholder, subscriber, enrollee, or other individual  
7 participating in a health benefit plan;
- 8 (11) "Director," the director of the Division of Insurance;
- 9 (12) "Discharge planning," the formal process for determining, prior to discharge from a  
10 facility, the coordination and management of the care that a patient receives  
11 following discharge from a facility;
- 12 (13) "Emergency medical condition," a medical condition manifesting itself by acute  
13 symptoms of sufficient severity, including severe pain, such that a prudent layperson,  
14 who possesses an average knowledge of health and medicine, could reasonably  
15 expect that the absence of immediate medical attention, would result in serious  
16 impairment to bodily functions or serious dysfunction of a bodily organ or part, or  
17 would place the person's health or, with respect to a pregnant woman, the health of  
18 the woman or her unborn child, in serious jeopardy;
- 19 (14) "Emergency services," with respect to an emergency medical condition:
- 20 (a) A medical screening examination that is within the capability of the  
21 emergency department of a hospital, including ancillary services routinely  
22 available to the emergency department to evaluate such emergency condition;  
23 and
- 24 (b) Such further medical examination and treatment, to the extent they are within

- 1 the capability of the staff and facilities at a hospital to stabilize a patient;
- 2 (15) "Facility," an institution providing health care services or a health care setting,  
3 including hospitals and other licensed inpatient centers, ambulatory surgical or  
4 treatment centers, skilled nursing centers, residential treatment centers, diagnostic,  
5 laboratory, and imaging centers, and rehabilitation, and other therapeutic health  
6 settings;
- 7 (16) "Health care professional," a physician or other health care practitioner licensed,  
8 accredited, or certified to perform specified health services consistent with state law;
- 9 (17) "Health care provider" or "provider," a health care professional or a facility;
- 10 (18) "Health care services," services for the diagnosis, prevention, treatment, cure, or  
11 relief of a health condition, illness, injury, or disease;
- 12 (19) "Health carrier," an entity subject to the insurance laws and regulations of this state,  
13 or subject to the jurisdiction of the director, that contracts or offers to contract, or  
14 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any  
15 of the costs of health care services, including a sickness and accident insurance  
16 company, a health maintenance organization, a nonprofit hospital and health service  
17 corporation, or any other entity providing a plan of health insurance, health benefits,  
18 or health services;
- 19 (20) "Managed care contractor," a person who establishes, operates, or maintains a  
20 network of participating providers; or contracts with an insurance company, a  
21 hospital or medical service plan, an employer, an employee organization, or any other  
22 entity providing coverage for health care services to operate a managed care plan or  
23 health carrier;
- 24 (21) "Managed care entity," a licensed insurance company, hospital or medical service

1 plan, health maintenance organization, or an employer or employee organization, that  
2 operates a managed care plan or a managed care contractor. The term does not  
3 include a licensed insurance company unless it contracts with other entities to  
4 provide a network of participating providers;

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

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

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

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

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

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

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

21 (26) "Rescission," a cancellation or discontinuance of coverage under a health benefit plan  
22 that has a retroactive effect. The term does not include a cancellation or  
23 discontinuance of coverage under a health benefit plan if:

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

1 or

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

5 (27) "Retrospective review," any review of a request for a benefit that is not a prospective  
6 review request, which does not include the review of a claim that is limited to  
7 veracity of documentation, or accuracy of coding, or adjudication for payment;

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

12 (29) "Secretary," the secretary of the Department of Health;

13 (30) "Stabilized," with respect to an emergency medical condition, that no material  
14 deterioration of the condition is likely, with reasonable medical probability, to result  
15 from or occur during the transfer of the individual from a facility or, with respect to  
16 a pregnant woman, the woman has delivered, including the placenta;

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

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

1 Section 29. The provisions of sections 28 to 74, inclusive, of this Act, apply to any health  
2 carrier that provides or performs utilization review services. The requirements of sections 28  
3 to 74, inclusive, of this Act, also apply to any designee of the health carrier or utilization review  
4 organization that performs utilization review functions on the carrier's behalf.

5 Section 30. If conducting utilization review or making a benefit determination for  
6 emergency services, a health carrier that provides benefits for services in an emergency  
7 department of a hospital shall comply with the provisions of sections 30 to 38, inclusive, of this  
8 Act. A health carrier shall cover emergency services necessary to screen and stabilize a covered  
9 person and may not require prior authorization of such services if a prudent layperson would  
10 have reasonably believed that an emergency medical condition existed even if the emergency  
11 services are provided on an out-of-network basis. A health carrier shall cover emergency  
12 services whether the health care provider furnishing the services is a participating provider with  
13 respect to such services. If the emergency services are provided out-of-network, the services  
14 shall be covered without imposing any administrative requirement or limitation on coverage that  
15 is more restrictive than the requirements or limitations that apply to emergency services received  
16 from network providers. Emergency services are provided out-of-network by complying with  
17 the cost sharing requirements set forth in sections 32 to 35, inclusive, of this Act, and without  
18 regard to any other term or condition of coverage other than the exclusion of or coordination of  
19 benefits, an affiliation or waiting periods as permitted under section 2704 of the Public Health  
20 Service Act, as amended to January 1, 2011, or cost sharing requirements as set forth in sections  
21 31 to 35, inclusive, of this Act.

22 Section 31. Coverage of in-network emergency services are subject to applicable  
23 copayments, coinsurance, and deductibles.

24 Section 32. Cost-sharing requirements for out-of-network emergency services expressed as

1 a copayment amount or coinsurance rate imposed with respect to a covered person cannot  
2 exceed the cost-sharing requirement imposed with respect to a covered person if the services  
3 were provided in-network.

4 Section 33. Notwithstanding section 32 of this Act, a covered person may be required to pay,  
5 in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider  
6 charges over the amount the health carrier is required to pay pursuant to this section.

7 A health carrier complies with the requirements of this section if it provides payment of  
8 emergency services provided by an out-of-network provider in an amount not less than the  
9 greatest of the following:

- 10 (1) The amount negotiated with in-network providers for emergency services, excluding  
11 any in-network copayment or coinsurance imposed with respect to the covered  
12 person;
- 13 (2) The amount of the emergency service calculated using the same method the plan uses  
14 to determine payments for out-of-network services, but using the in-network  
15 cost-sharing provisions instead of the out-of-network cost-sharing provisions; or
- 16 (3) The amount that would be paid under Medicare for the emergency services,  
17 excluding any in-network copayment or coinsurance requirements.

18 Section 34. For capitated or other health benefit plans that do not have a negotiated  
19 per-service amount for in-network providers, subdivision (1) of section 33 of this Act does not  
20 apply.

21 Section 35. If a health benefit plan has more than one negotiated amount for in-network  
22 providers for a particular emergency service, the amount in subdivision (1) of section 33 of this  
23 Act is the median of these negotiated amounts.

24 Section 36. Any cost-sharing requirement other than a copayment or coinsurance

1 requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to  
2 emergency services provided out-of-network if the cost-sharing requirement generally applies  
3 to out-of-network benefits. A deductible may be imposed with respect to out-of-network  
4 emergency services only as part of a deductible that generally applies to out-of-network benefits.  
5 If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network  
6 maximum applies to out-of-network emergency services.

7 Section 37. For immediately required post-evaluation or post-stabilization services, a health  
8 carrier shall provide access to a designated representative twenty-four hours a day, seven days  
9 a week, to facilitate review, or otherwise provide coverage with no financial penalty to the  
10 covered person.

11 Section 38. If the director and the secretary find that the requirements of any private  
12 accrediting body meet the requirements of coverage of emergency medical services as set forth  
13 in sections 29 to 37, inclusive, of this Act, the health carrier may, at the discretion of the director  
14 and secretary, be deemed to have met the applicable requirements.

15 Section 39. A health carrier is responsible for monitoring all utilization review activities  
16 carried out by, or on behalf of, the health carrier and for ensuring that all requirements of  
17 sections 28 to 74, inclusive, of this Act, and applicable rules are met. The health carrier shall  
18 also ensure that appropriate personnel have operational responsibility for the conduct of the  
19 health carrier's utilization review program.

20 Section 40. If a health carrier contracts to have a utilization review organization or other  
21 entity perform the utilization review functions required by sections 28 to 74, inclusive, of this  
22 Act, or applicable rules, the director shall hold the health carrier responsible for monitoring the  
23 activities of the utilization review organization or entity with which the health carrier contracts  
24 and for ensuring that the requirements of sections 28 to 74, inclusive, of this Act, and applicable

1 rules, are met.

2 Section 41. A health carrier that requires a request for benefits under the covered person's  
3 health plan to be subjected to utilization review shall implement a written utilization review  
4 program that describes all review activities, both delegated and nondelegated for the filing of  
5 benefit requests, the notification of utilization review and benefit determinations, and the review  
6 of adverse determinations in accordance with sections 75 to 87, inclusive, of this Act.

7 The program document shall describe the following:

- 8 (1) Procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency  
9 of health care services;
- 10 (2) Data sources and clinical review criteria used in decision-making;
- 11 (3) Mechanisms to ensure consistent application of review criteria and compatible  
12 decisions;
- 13 (4) Data collection processes and analytical methods used in assessing utilization of  
14 health care services;
- 15 (5) Provisions for assuring confidentiality of clinical and proprietary information;
- 16 (6) The organizational structure that periodically assesses utilization review activities  
17 and reports to the health carrier's governing body; and
- 18 (7) The staff position functionally responsible for day-to-day program management.

19 A health carrier shall prepare an annual summary report in the format specified of its  
20 utilization review program activities and file the report, if requested, with the director and the  
21 secretary. A health carrier shall maintain records for a minimum of six years of all benefit  
22 requests and claims and notices associated with utilization review and benefit determinations  
23 made in accordance with sections 52 to 57, inclusive, and sections 65 to 73, inclusive, of this  
24 Act. The health carrier shall make the records available for examination by covered persons and

1 the director upon request.

2 Section 42. A utilization review program shall use documented clinical review criteria that  
3 are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy.  
4 A health carrier may develop its own clinical review criteria, or it may purchase or license  
5 clinical review criteria from qualified vendors. A health carrier shall make available its clinical  
6 review criteria upon request to authorized government agencies including the Division of  
7 Insurance and the Department of Health.

8 Section 43. Qualified licensed health care professionals shall administer the utilization  
9 review program and oversee review decisions. Any adverse determination shall be evaluated by  
10 an appropriately licensed and clinically qualified health care provider.

11 Section 44. A health carrier shall issue utilization review and benefit determinations in a  
12 timely manner pursuant to the requirements of sections 52 to 57, inclusive, and sections 65 to  
13 73, inclusive, of this Act. A health carrier shall have a process to ensure that utilization  
14 reviewers apply clinical review criteria in conducting utilization review consistently.

15 If a health carrier fails to strictly adhere to the requirements of sections 52 to 57, inclusive,  
16 and sections 65 to 73, inclusive, of this Act, with respect to making utilization review and  
17 benefit determinations of a benefit request or claim, the covered person shall be deemed to have  
18 exhausted the provisions of sections 22 to 74, inclusive, of this Act, and may take action  
19 regardless of whether the health carrier asserts that the carrier substantially complied with the  
20 requirements of sections 52 to 57, inclusive, and sections 65 to 73, inclusive, of this Act, as  
21 applicable, or that any error it committed was de minimus.

22 Any covered person may file a request for external review in accordance with rules  
23 promulgated by the director. In addition to the external review rights a covered person is entitled  
24 to pursue any available remedies under state or federal law on the basis that the health carrier

1 failed to provide a reasonable internal claims and appeals process that would yield a decision  
2 on the merits of the claim.

3 Section 45. Any health carrier shall routinely assess the effectiveness and efficiency of its  
4 utilization review program.

5 Section 46. Any health carrier's data system shall be sufficient to support utilization review  
6 program activities and to generate management reports to enable the health carrier to monitor  
7 and manage health care services effectively.

8 Section 47. If a health carrier delegates any utilization review activities to a utilization  
9 review organization, the health carrier shall maintain adequate oversight, which shall include:

- 10 (1) A written description of the utilization review organization's activities and  
11 responsibilities, including reporting requirements;
- 12 (2) Evidence of formal approval of the utilization review organization program by the  
13 health carrier; and
- 14 (3) A process by which the health carrier evaluates the performance of the utilization  
15 review organization.

16 Section 48. Each health carrier shall coordinate the utilization review program with other  
17 medical management activity conducted by the carrier, such as quality assurance, credentialing,  
18 provider contracting data reporting, grievance procedures, processes for assessing member  
19 satisfaction, and risk management.

20 Section 49. Each health carrier shall provide covered persons and participating providers  
21 with access to its review staff by a toll-free number or collect call telephone line.

22 Section 50. If conducting a utilization review, the health carrier shall collect only the  
23 information necessary, including pertinent clinical information, to make the utilization review  
24 or benefit determination.

1 Section 51. In conducting utilization review, the health carrier shall ensure that the review  
2 is conducted in a manner to ensure the independence and impartiality of the individuals involved  
3 in making the utilization review or benefit determination.

4 In ensuring the independence and impartiality of individuals involved in making the  
5 utilization review or benefit determination, no health carrier may make decisions regarding  
6 hiring, compensation, termination, promotion, or other similar matters based upon the likelihood  
7 that the individual will support the denial of benefits.

8 Section 52. A health carrier shall maintain written procedures pursuant to sections 28 to 74,  
9 inclusive, of this Act, for making standard utilization review and benefit determinations on  
10 requests submitted to the health carrier by covered persons or their authorized representatives  
11 for benefits and for notifying covered persons and their authorized representatives of its  
12 determinations with respect to these requests within the specified time frames required under  
13 sections 28 to 74, inclusive, of this Act. If a period of time is extended as permitted by sections  
14 28 to 74, inclusive, of this Act, due to a claimant's failure to submit information necessary to  
15 decide a prospective, retrospective, or disability claim, the period for making the benefit  
16 determination shall be tolled from the date on which the notification of the extension is sent to  
17 the claimant until the date on which the claimant responds to the request for additional  
18 information.

19 Section 53. For any prospective review determination, other than allowed by this section,  
20 a health carrier shall make the determination and notify the covered person or, if applicable, the  
21 covered person's authorized representative of the determination, whether the carrier certifies the  
22 provision of the benefit or not, within a reasonable period of time appropriate to the covered  
23 person's medical condition, but in no event later than fifteen days after the date the health carrier  
24 receives the request. If the determination is an adverse determination, the health carrier shall

1 make the notification of the adverse determination in accordance with section 57 of this Act.

2 The time period for making a determination and notifying the covered person or, if  
3 applicable, the covered person's authorized representative, of the determination pursuant to this  
4 section may be extended once by the health carrier for up to fifteen days, if the health carrier:

5 (1) Determines that an extension is necessary due to matters beyond the health carrier's  
6 control; and

7 (2) Notifies the covered person or, if applicable, the covered person's authorized  
8 representative, prior to the expiration of the initial fifteen-day time period, of the  
9 circumstances requiring the extension of time and the date by which the health carrier  
10 expects to make a determination.

11 If the extension is necessary due to the failure of the covered person or the covered person's  
12 authorized representative to submit information necessary to reach a determination on the  
13 request, the notice of extension shall specifically describe the required information necessary  
14 to complete the request and give the covered person or, if applicable, the covered person's  
15 authorized representative at least forty-five days from the date of receipt of the notice to provide  
16 the specified information.

17 If the health carrier receives a prospective review request from a covered person or the  
18 covered person's authorized representative that fails to meet the health carrier's filing  
19 procedures, the health carrier shall notify the covered person or, if applicable, the covered  
20 person's authorized representative of this failure and provide in the notice information on the  
21 proper procedures to be followed for filing a request. This notice shall be provided as soon as  
22 possible, but in no event later than five days following the date of the failure. The health carrier  
23 may provide the notice orally or, if requested by the covered person or the covered person's  
24 authorized representative, in writing. The provisions only apply in a case of failure that is a

1 communication by a covered person or the covered person's authorized representative that is  
2 received by a person or organizational unit of the health carrier responsible for handling benefit  
3 matters and is a communication that refers to a specific covered person, a specific medical  
4 condition or symptom, and a specific health care service, treatment, or provider for which  
5 certification is being requested.

6 Section 54. For concurrent review determinations, if a health carrier has certified an ongoing  
7 course of treatment to be provided over a period of time or number of treatments:

8 (1) Any reduction or termination by the health carrier during the course of treatment  
9 before the end of the period or number treatments, other than by health benefit plan  
10 amendment or termination of the health benefit plan, shall constitute an adverse  
11 determination; and

12 (2) The health carrier shall notify the covered person of the adverse determination in  
13 accordance with section 57 of this Act at a time sufficiently in advance of the  
14 reduction or termination to allow the covered person or, if applicable, the covered  
15 person's authorized representative, to file a grievance to request a review of the  
16 adverse determination pursuant to sections 75 to 87, inclusive, of this Act, and obtain  
17 a determination with respect to that review of the adverse determination before the  
18 benefit is reduced or terminated.

19 The health care service or treatment that is the subject of the adverse determination shall be  
20 continued without liability to the covered person until the covered person has been notified of  
21 the determination by the health carrier with respect to the internal review request made pursuant  
22 to sections 75 to 87, inclusive, of this Act.

23 Section 55. For retrospective review determinations, the health carrier shall make the  
24 determination within a reasonable period of time, but in no event later than thirty days after the

1 date of receiving the benefit request.

2 In the case of a certification, the health carrier may notify in writing the covered person and  
3 the provider rendering the service.

4 If the determination is an adverse determination, the health carrier shall provide notice of  
5 the adverse determination to the covered person or, if applicable, the covered person's  
6 authorized representative, in accordance with section 57 of this Act. The time period for making  
7 a determination and notifying the covered person or, if applicable, the covered person's  
8 authorized representative, of the determination pursuant to this section may be extended once  
9 by the health carrier for up to fifteen days, if the health carrier:

- 10 (1) Determines that an extension is necessary due to matters beyond the health carrier's  
11 control; and
- 12 (2) Notifies the covered person or, if applicable, the covered person's authorized  
13 representative, prior to the expiration of the initial thirty-day time period, of the  
14 circumstances requiring the extension of time and the date by which the health carrier  
15 expects to make a determination.

16 If the extension under this section is necessary due to the failure of the covered person or,  
17 if applicable, the covered person's authorized representative to submit information necessary to  
18 reach a determination on the request, the notice of extension shall specifically describe the  
19 required information necessary to complete the request and give the covered person or, if  
20 applicable, the covered person's authorized representative at least forty-five days from the date  
21 of receipt of the notice to provide the specified information.

22 Section 56. For purposes of calculating the time periods within which a determination is  
23 required to be made for prospective and retrospective reviews, the time period within which the  
24 determination is required to be made begins on the date the request is received by the health

1 carrier in accordance with the health carrier's procedures established pursuant to section 41 of  
2 this Act. If the time period for making the determination for a prospective or retrospective  
3 review is extended due to the covered person or, if applicable, the covered person's authorized  
4 representative's failure to submit the information necessary to make the determination, the time  
5 period for making the determination shall be tolled from the date on which the health carrier  
6 sends the notification of the extension to the covered person or, if applicable, the covered  
7 person's authorized representative, until the earlier of: the date on which the covered person or,  
8 if applicable, the covered person's authorized representative, responds to the request for  
9 additional information or the date on which the specified information was to have been  
10 submitted. If the covered person or the covered person's authorized representative fails to submit  
11 the information before the end of the period of the extension, as specified in sections 53 and 55  
12 of this Act, the health carrier may deny the certification of the requested benefit.

13 Section 57. Any notification of an adverse determination under this section shall, in a  
14 manner which is designed to be understood by the covered person, set forth:

- 15 (1) Information sufficient to identify the benefit request or claim involved, including the  
16 date of service, if applicable, the health care provider, the claim amount, if  
17 applicable, the diagnosis code and its corresponding meaning, and the treatment code  
18 and its corresponding meaning;
- 19 (2) The specific reason or reasons for the adverse determination, including the denial  
20 code and its corresponding meaning, as well as a description of the health carrier's  
21 standard, if any, that was used in denying the benefit request or claim;
- 22 (3) A reference to the specific plan provision on which the determination is based;
- 23 (4) A description of additional material or information necessary for the covered person  
24 to complete the benefit request, including an explanation of why the material or

- 1 information is necessary to complete the request;
- 2 (5) A description of the health carrier's grievance procedures established pursuant to  
3 sections 75 to 87, inclusive, of this Act, including time limits applicable to those  
4 procedures;
- 5 (6) If the health carrier relied upon an internal rule, guideline, protocol, or other similar  
6 criterion to make the adverse determination, either the specific rule, guideline,  
7 protocol, or other similar criterion or a statement that a specific rule, guideline,  
8 protocol, or other similar criterion was relied upon to make the adverse determination  
9 and that a copy of the rule, guideline, protocol, or other similar criterion will be  
10 provided free of charge to the covered person upon request;
- 11 (7) If the adverse determination is based on a medical necessity or experimental or  
12 investigational treatment or similar exclusion or limit, either an explanation of the  
13 scientific or clinical judgment for making the determination, applying the terms of  
14 the health benefit plan to the covered person's medical circumstances or a statement  
15 that an explanation will be provided to the covered person free of charge upon  
16 request;
- 17 (8) If applicable, instructions for requesting:
- 18 (a) A copy of the rule, guideline, protocol, or other similar criterion relied upon  
19 in making the adverse determination, as provided in subdivision (6) of this  
20 section; or
- 21 (b) The written statement of the scientific or clinical rationale for the adverse  
22 determination, as provided in subdivision (7) of this section; and
- 23 (9) A statement explaining the availability of and the right of the covered person, as  
24 appropriate, to contact the Division of Insurance at any time for assistance or, upon

1 completion of the health carrier's grievance procedure process as provided under  
2 sections 75 to 87, inclusive, of this Act, to file a civil suit in a court of competent  
3 jurisdiction.

4 If the adverse determination is a rescission, the health carrier shall provide, in addition to  
5 any applicable disclosures required under section 57 of this Act, clear identification of the  
6 alleged fraudulent practice or omission or the intentional misrepresentation of material fact, an  
7 explanation as to why the act, practice, or omission was fraudulent or was an intentional  
8 misrepresentation of a material fact, and the effective date of the rescission.

9 A health carrier may provide the notice required under this section in writing or  
10 electronically.

11 If the adverse determination is a rescission, the health carrier shall provide advance notice  
12 of the rescission determination required by rules promulgated by the director, in addition to any  
13 applicable disclosures required under this section.

14 The health carrier shall provide clear identification of the alleged fraudulent act, practice,  
15 or omission or the intentional misrepresentation of material fact.

16 The health carrier shall provide an explanation as to why the act, practice, or omission was  
17 fraudulent or was an intentional misrepresentation of a material fact.

18 The health carrier shall provide notice that the covered person or the covered person's  
19 authorized representative, prior to the date the advance notice of the proposed rescission ends,  
20 may immediately file a grievance to request a review of the adverse determination to rescind  
21 coverage pursuant to sections 75 to 88, inclusive of this Act.

22 The health carrier shall provide a description of the health carrier's grievance procedures  
23 established pursuant to Section 75 to 88, inclusive, of this Act, including any time limits  
24 applicable to those procedures.

1       The health carrier shall provide the date when the advance notice ends and the date back to  
2 which the coverage will be retroactively rescinded.

3       Section 58. In the certificate of coverage or member handbook provided to covered persons,  
4 a health carrier shall include a clear and comprehensive description of its utilization review  
5 procedures, including the procedures for obtaining review of adverse determinations, and a  
6 statement of rights and responsibilities of covered persons with respect to those procedures. A  
7 health carrier shall include a summary of its utilization review and benefit determination  
8 procedures in materials intended for prospective covered persons. A health carrier shall print  
9 on its membership cards a toll-free telephone number to call for utilization review and benefit  
10 decisions.

11       Section 59. If the director and the secretary find that the requirements of any private  
12 accrediting body meet the requirements of utilization review as set forth in sections 28 to 74,  
13 inclusive, of this Act, the health carrier may, at the discretion of the director and secretary, be  
14 deemed to have met the applicable requirements.

15       Section 60. Any utilization review organization which engages in utilization review  
16 activities in this state shall register with the Division of Insurance prior to conducting business  
17 in this state. The registration shall be in a format prescribed by the director. In prescribing the  
18 form or in carrying out other functions required sections 60 to 64, inclusive, of this Act, the  
19 director shall consult with the secretary if applicable. The director or the secretary may require  
20 that the following information be submitted:

- 21       (1) Information relating to its actual or anticipated activities in this state;
- 22       (2) The status of any accreditation designation it holds or has sought;
- 23       (3) Information pertaining to its place of business, officers, and directors;
- 24       (4) Qualifications of review staff; and

1 (5) Any other information reasonable and necessary to monitor its activities in this state.

2 Section 61. Any utilization review organization which has previously registered in this state  
3 shall, on or before July first of each year, file with the Division of Insurance any changes to the  
4 initial or subsequent annual registration for the utilization review organization.

5 Section 62. The director or the secretary may request information from any utilization  
6 review organization at any time pertaining to its activities in this state. The utilization review  
7 organization shall respond to all requests for information within twenty days.

8 Section 63. A utilization review organization may not engage in utilization review in this  
9 state unless the utilization review organization is properly registered. The director may issue a  
10 cease and desist order against any utilization review organization which fails to comply with the  
11 requirements of sections 60 to 64, inclusive, of this Act, prohibiting the utilization review  
12 organization from engaging in utilization review activities in this state.

13 Section 64. The director may require the payment of a fee in conjunction with the initial or  
14 annual registration of a utilization review organization not to exceed two hundred fifty dollars  
15 per registration. The fee shall be established by rules promulgated pursuant to chapter 1-26.

16 Section 65. Each health carrier shall establish written procedures, in accordance with  
17 sections 65 to 73, inclusive, of this Act, for receiving benefit requests from covered persons or  
18 their authorized representatives and for making and notifying covered persons or their  
19 authorized representatives of expedited utilization review and benefit determinations with  
20 respect to urgent care requests and concurrent review urgent care requests.

21 Section 66. If the covered person or, if applicable, the covered person's authorized  
22 representative has failed to provide sufficient information for the health carrier to make a  
23 determination, the health carrier shall notify the covered person or, if applicable, the covered  
24 person's authorized representative, either orally or, if requested by the covered person or the

1 covered person's authorized representative, in writing of this failure and state what specific  
2 information is needed as soon as possible, but in no event later than twenty-four hours after  
3 receipt of the request.

4 Section 67. If the benefit request involves a prospective review urgent care request, the  
5 provisions of section 66 of this Act apply only in the case of a failure that:

6 (1) Is a communication by a covered person or, if applicable, the covered person's  
7 authorized representative, that is received by a person or organizational unit of the  
8 health carrier responsible for handling benefit matters; and

9 (2) Is a communication that refers to a specific covered person, a specific medical  
10 condition or symptom, and a specific health care service, treatment, or provider for  
11 which approval is being requested.

12 Section 68. For an urgent care request, unless the covered person or the covered person's  
13 authorized representative has failed to provide sufficient information for the health carrier to  
14 determine whether, or to what extent, the benefits requested are covered benefits or payable  
15 under the health carrier's health benefit plan, the health carrier shall notify the covered person  
16 or, if applicable, the covered person's authorized representative of the health carrier's  
17 determination with respect to the request, whether or not the determination is an adverse  
18 determination, as soon as possible, taking into account the medical condition of the covered  
19 person, but in no event later than twenty-four hours after the date of the receipt of the request  
20 by the health carrier. If the health carrier's determination is an adverse determination, the health  
21 carrier shall provide notice of the adverse determination in accordance with section 73 of this  
22 Act.

23 Section 69. The health carrier shall provide the covered person or, if applicable, the covered  
24 person's authorized representative, a reasonable period of time to submit the necessary

1 information, taking into account the circumstances, but in no event less than forty-eight hours  
2 after the date of notifying the covered person or the covered person's authorized representative  
3 of the failure to submit sufficient information, as provided in sections 66 and 67 of this Act.

4 Section 70. The health carrier shall notify the covered person or, if applicable, the covered  
5 person's authorized representative, of its determination with respect to the urgent care request  
6 as soon as possible, but in no event more than forty-eight hours after the earlier of:

- 7 (1) The health carrier's receipt of the requested specified information; or
- 8 (2) The end of the period provided for the covered person or, if applicable, the covered  
9 person's authorized representative, to submit the requested specified information.

10 If the covered person or the covered person's authorized representative fails to submit the  
11 information before the end of the period of the extension, as specified in section 69 of this Act,  
12 the health carrier may deny the certification of the requested benefit. If the health carrier's  
13 determination is an adverse determination, the health carrier shall provide notice of the adverse  
14 determination in accordance with section 57 of this Act.

15 Section 71. For concurrent review urgent care requests involving a request by the covered  
16 person or the covered person's authorized representative to extend the course of treatment  
17 beyond the initial period of time or the number of treatments, if the request is made at least  
18 twenty-four hours prior to the expiration of the prescribed period of time or number of  
19 treatments, the health carrier shall make a determination with respect to the request and notify  
20 the covered person or, if applicable, the covered person's authorized representative, of the  
21 determination, whether it is an adverse determination or not, as soon as possible, taking into  
22 account the covered person's medical condition but in no event more than twenty-four hours  
23 after the date of the health carrier's receipt of the request. If the health carrier's determination  
24 is an adverse determination, the health carrier shall provide notice of the adverse determination

1 in accordance with section 73 of this Act.

2 Section 72. For purposes of calculating the time periods within which a determination is  
3 required to be made under sections 68 to 70, inclusive, of this Act, the time period within which  
4 the determination is required to be made shall begin on the date the request is filed with the  
5 health carrier in accordance with the health carrier's procedures established pursuant to section  
6 41 of this Act for filing a request without regard to whether all of the information necessary to  
7 make the determination accompanies the filing.

8 Section 73. If a health carrier's determination with respect to sections 65 to 72, inclusive,  
9 of this Act, is an adverse determination, the health carrier shall provide notice of the adverse  
10 determination in accordance with this section. A notification of an adverse determination under  
11 this section shall, in a manner calculated to be understood by the covered person, set forth:

- 12 (1) Information sufficient to identify the benefit request or claim involved, including the  
13 date of service, if applicable, the health care provider, the claim amount, if  
14 applicable, the diagnosis code and its corresponding meaning and the treatment code  
15 and its corresponding meaning;
- 16 (2) The specific reason or reasons for the adverse determination, including the denial  
17 code and its corresponding meaning, as well as a description of the health carrier's  
18 standard, if any, that was used in denying the benefit request or claim;
- 19 (3) A reference to the specific plan provisions on which the determination is based;
- 20 (4) A description of any additional material or information necessary for the covered  
21 person to complete the request, including an explanation of why the material or  
22 information is necessary to complete the request;
- 23 (5) A description of the health carrier's internal review procedures established pursuant  
24 to sections 75 to 87, inclusive, of this Act, including any time limits applicable to

- 1           those procedures;
- 2       (6)   A description of the health carrier’s expedited review procedures established pursuant  
3           to sections 84 to 88, inclusive, of this Act;
- 4       (7)   If the health carrier relied upon an internal rule, guideline, protocol, or other similar  
5           criterion to make the adverse determination, either the specific rule, guideline,  
6           protocol, or other similar criterion or a statement that a specific rule, guideline,  
7           protocol, or other similar criterion was relied upon to make the adverse determination  
8           and that a copy of the rule, guideline, protocol, or other similar criterion will be  
9           provided free of charge to the covered person upon request;
- 10      (8)   If the adverse determination is based on a medical necessity or experimental or  
11           investigation treatment or similar exclusion or limit, either an explanation of the  
12           scientific or clinical judgment for making the determination, applying the terms of  
13           the health benefit plan to the covered person’s medical circumstances, or a statement  
14           that an explanation will be provided to the covered person free of charge upon  
15           request;
- 16      (9)   If applicable, instructions for requesting:
- 17           (a)   A copy of the rule, guideline, protocol, or other similar criterion relied upon  
18                 in making the adverse determination in accordance with subdivision (7) of this  
19                 section; or
- 20           (b)   The written statement of the scientific or clinical rationale for the adverse  
21                 determination in accordance with subdivision (8) of this section; and
- 22      (10)  A statement explaining the availability of and the right of the covered person, as  
23           appropriate, to contact the Division of Insurance at any time for assistance or, upon  
24           completion of the health carrier’s grievance procedure process as provided under

1 sections 75 to 87, inclusive, of this Act, to file a civil suit in a court of competent  
2 jurisdiction.

3 A health carrier may provide the notice required under this section orally, in writing or  
4 electronically. If notice of the adverse determination is provided orally, the health carrier shall  
5 provide written or electronic notice of the adverse determination within three days following the  
6 oral notification.

7 Section 74. The director may, after consultation with the secretary, promulgate rules,  
8 pursuant to chapter 1-26, to carry out the provisions of sections 28 to 73, inclusive, of this Act.  
9 The rules shall provide for a timely administration of utilization review by the public and assure  
10 that utilization review decisions are made in a fair and clinically acceptable manner. The rules  
11 may include the following:

- 12 (1) Definition of terms;
- 13 (2) Timing, form, and content of reports;
- 14 (3) Application of clinical criteria as it relates to utilization review;
- 15 (4) Written determinations; and
- 16 (5) Utilization review procedures.

17 The director may promulgate rules, pursuant to chapter 1-26, pertaining to claims for group  
18 disability income plans. The rules shall be consistent with applicable federal requirements  
19 included in 29 CFR Part 2560 as amended to January 1, 2011.

20 Section 75. Terms used in sections 75 to 88, inclusive, of this Act, mean:

- 21 (1) "Adverse determination," any of the following:
  - 22 (a) A determination by a health carrier or the carrier's designee utilization review
  - 23 organization that, based upon the information provided, a request by a covered
  - 24 person for a benefit under the health carrier's health benefit plan upon

1 application of any utilization review technique does not meet the health  
2 carrier's requirements for medical necessity, appropriateness, health care  
3 setting, level of care or effectiveness or is determined to be experimental or  
4 investigational and the requested benefit is therefore denied, reduced, or  
5 terminated or payment is not provided or made, in whole or in part, for the  
6 benefit;

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

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

14 (d) A rescission of coverage determination;

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

17 (3) "Authorized representative," a person to whom a covered person has given express  
18 written consent to represent the covered person for purposes of sections 75 to 88,  
19 inclusive, of this Act, a person authorized by law to provide substituted consent for  
20 a covered person, a family member of the covered person or the covered person's  
21 treating health care professional if the covered person is unable to provide consent,  
22 or a health care professional if the covered person's health benefit plan requires that  
23 a request for a benefit under the plan be initiated by the health care professional. For  
24 any urgent care request, the term includes a health care professional with knowledge

- 1 of the covered person's medical condition;
- 2 (4) "Case management," a coordinated set of activities conducted for individual patient  
3 management of serious, complicated, protracted, or other health conditions;
- 4 (5) "Certification," a determination by a health carrier or the carrier's designee utilization  
5 review organization that a request for a benefit under the health carrier's health  
6 benefit plan has been reviewed and, based on the information provided, satisfies the  
7 health carrier's requirements for medical necessity, appropriateness, health care  
8 setting, level of care, and effectiveness;
- 9 (6) "Clinical peer," a physician or other health care professional who holds a  
10 non-restricted license in a state of the United States and in the same or similar  
11 specialty as typically manages the medical condition, procedure, or treatment under  
12 review;
- 13 (7) "Clinical review criteria," written screening procedures, decision abstracts, clinical  
14 protocols, and practice guidelines used by the health carrier to determine the medical  
15 necessity and appropriateness of health care services;
- 16 (8) "Closed plan," a managed care plan or health carrier that requires covered persons to  
17 use participating providers under the terms of the managed care plan or health carrier  
18 and does not provide any benefits for out-of-network services except for emergency  
19 services;
- 20 (9) "Concurrent review," utilization review conducted during a patient's hospital stay or  
21 course of treatment in a facility or other inpatient or outpatient health care setting;
- 22 (10) "Covered benefits" or "benefits," those health care services to which a covered person  
23 is entitled under the terms of a health benefit plan;
- 24 (11) "Covered person," a policyholder, subscriber, enrollee, or other individual

- 1 participating in a health benefit plan;
- 2 (12) "Director," the director of the Division of Insurance;
- 3 (13) "Discharge planning," the formal process for determining, prior to discharge from a  
4 facility, the coordination and management of the care that a patient receives  
5 following discharge from a facility;
- 6 (14) "Discounted fee for service," a contractual arrangement between a health carrier and  
7 a provider or network of providers under which the provider is compensated in a  
8 discounted fashion based upon each service performed and under which there is no  
9 contractual responsibility on the part of the provider to manage care, to serve as a  
10 gatekeeper or primary care provider, or to provide or assure quality of care. A  
11 contract between a provider or network of providers and a health maintenance  
12 organization is not a discounted fee for service arrangement;
- 13 (15) "Emergency medical condition," a medical condition manifesting itself by acute  
14 symptoms of sufficient severity, including severe pain, such that a prudent layperson,  
15 who possesses an average knowledge of health and medicine, could reasonably  
16 expect that the absence of immediate medical attention would result in serious  
17 impairment to bodily functions or serious dysfunction of a bodily organ or part, or  
18 would place the person's health or, with respect to a pregnant woman, the health of  
19 the woman or her unborn child, in serious jeopardy;
- 20 (16) "Emergency services," with respect to an emergency medical condition:
- 21 (a) A medical screening examination that is within the capability of the  
22 emergency department of a hospital, including ancillary services routinely  
23 available to the emergency department to evaluate such emergency condition;  
24 and

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

3 (17) "Facility," an institution providing health care services or a health care setting,  
4 including hospitals and other licensed inpatient centers, ambulatory surgical or  
5 treatment centers, skilled nursing centers, residential treatment centers, diagnostic,  
6 laboratory, and imaging centers, and rehabilitation, and other therapeutic health  
7 settings;

8 (18) "Final adverse determination," an adverse determination that as been upheld by the  
9 health carrier at the completion of the internal appeals process applicable pursuant  
10 to sections 79 to 87, inclusive, of this Act, or an adverse determination that with  
11 respect to which the internal appeals process has been deemed exhausted in  
12 accordance with section 78 of this Act;

13 (19) "Grievance," a written complaint, or oral complaint if the complaint involves an  
14 urgent care request, submitted by or on behalf of a covered person regarding:

- 15 (a) Availability, delivery, or quality of health care services;
- 16 (b) Claims payment, handling, or reimbursement for health care services; or
- 17 (c) Any other matter pertaining to the contractual relationship between a covered  
18 person and the health carrier.

19 A request for an expedited review need not be in writing;

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

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

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

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

8 (24) "Health indemnity plan," a health benefit plan that is not a managed care plan;

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

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

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

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

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

24 (c) Financial incentives for persons enrolled in the plan to use the participating

- 1 providers and procedures provided for by the plan;
- 2 (28) "Network," the group of participating providers providing services to a health carrier;
- 3 (29) "Open plan," a managed care plan or health carrier other than a closed plan that  
4 provides incentives, including financial incentives, for covered persons to use  
5 participating providers under the terms of the managed care plan or health carrier;
- 6 (30) "Participating provider," a provider who, under a contract with the health carrier or  
7 with its contractor or subcontractor, has agreed to provide health care services to  
8 covered persons with an expectation of receiving payment, other than coinsurance,  
9 copayments, or deductibles, directly or indirectly, from the health carrier;
- 10 (31) "Prospective review," utilization review conducted prior to an admission or the  
11 provision of a health care service or a course of treatment in accordance with a health  
12 carrier's requirement that the health care service or course of treatment, in whole or  
13 in part, be approved prior to its provision;
- 14 (32) "Rescission," a cancellation or discontinuance of coverage under a health benefit plan  
15 that has a retroactive effect. The term does not include a cancellation or  
16 discontinuance of coverage under a health benefit plan if:
- 17 (a) The cancellation or discontinuance of coverage has only a prospective effect;  
18 or
- 19 (b) The cancellation or discontinuance of coverage is effective retroactively to the  
20 extent it is attributable to a failure to timely pay required premiums or  
21 contributions towards the cost of coverage;
- 22 (33) "Retrospective review," any review of a request for a benefit that is not a prospective  
23 review request, which does not include the review of a claim that is limited to  
24 veracity of documentation, or accuracy of coding, or adjudication for payment;

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

5 (35) "Secretary," the secretary of the Department of Health;

6 (36) "Stabilized," with respect to an emergency medical condition, that no material  
7 deterioration of the condition is likely, with reasonable medical probability, to result  
8 from or occur during the transfer of the individual from a facility or, with respect to  
9 a pregnant woman, the woman has delivered, including the placenta;

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

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

18 Section 76. Each health carrier shall maintain in a register written records to document all  
19 grievances received including the notices and claims associated with the grievances during a  
20 calendar year. A request for a first level review of a grievance involving an adverse  
21 determination shall be processed in compliance with sections 79 to 83, inclusive, of this Act,  
22 and is required to be included in the register. For each grievance the register shall contain the  
23 following information:

24 (1) A general description of the reason for the grievance;

- 1 (2) The date received;
- 2 (3) The date of each review or, if applicable, review meeting;
- 3 (4) Resolution at each level of the grievance, if applicable;
- 4 (5) Date of resolution at each level, if applicable; and
- 5 (6) Name of the covered person for whom the grievance was filed.

6 The register shall be maintained in a manner that is reasonably clear and accessible to the  
7 director. A health carrier shall retain the register compiled for a calendar year for five years.

8 Section 77. Each health carrier shall submit to the director, at least annually, a report in the  
9 format specified by the director. The report shall include for each type of health benefit plan  
10 offered by the health carrier:

- 11 (1) The certificate of compliance required by section 78 of this Act;
- 12 (2) The number of covered lives;
- 13 (3) The total number of grievances;
- 14 (4) The number of grievances resolved at each level, if applicable, and their resolution;
- 15 (5) The number of grievances appealed to the director of which the health carrier has  
16 been informed;
- 17 (6) The number of grievances referred to alternative dispute resolution procedures or  
18 resulting in litigation; and
- 19 (7) A synopsis of actions being taken to correct problems identified.

20 Section 78. Except as specified in sections 75 to 88, inclusive, of this Act, each health  
21 carrier shall use written procedures for receiving and resolving grievances from covered  
22 persons, as provided in sections 79 to 83, inclusive, of this Act. If a health carrier fails to strictly  
23 adhere to the requirements of sections 79 to 82, inclusive, or sections 84 to 87, inclusive, of this  
24 Act, with respect to receiving and resolving grievances involving an adverse determination, the

1 covered person shall be deemed to have exhausted the provisions of sections 75 to 88, inclusive,  
2 of this Act, and may take action regardless of whether the health carrier asserts that the carrier  
3 substantially complied with the requirements of sections 79 to 82, inclusive, or sections 84 to  
4 87, inclusive, of this Act, or that any error the carrier committed was de minimus.

5 A covered person may file a request for external review in accordance with rules  
6 promulgated by the director. In addition a covered person is entitled to pursue any available  
7 remedies under state or federal law on the basis that the health carrier failed to provide a  
8 reasonable internal claims and appeals process that would yield a decision on the merits of the  
9 claim.

10 A health carrier shall file with the director a copy of the procedures required under this  
11 section, including all forms used to process requests made pursuant to sections 79 to 83,  
12 inclusive, of this Act. Any subsequent material modifications to the documents also shall be  
13 filed. The director may disapprove a filing received in accordance with this section that fails to  
14 comply with sections 75 to 88, inclusive, of this Act, or applicable rules. In addition, a health  
15 carrier shall file annually with the director, as part of its annual report required by sections 76  
16 and 77 of this Act, a certificate of compliance stating that the health carrier has established and  
17 maintains, for each of its health benefit plans, grievance procedures that fully comply with the  
18 provisions of sections 75 to 88, inclusive, of this Act. A description of the grievance procedures  
19 required under this section shall be set forth in or attached to the policy, certificate, membership  
20 booklet, outline of coverage, or other evidence of coverage provided to covered persons. The  
21 grievance procedure documents shall include a statement of a covered person's right to contact  
22 the Division of Insurance for assistance at any time. The statement shall include the telephone  
23 number and address of the Division of Insurance.

24 Section 79. Within one hundred eighty days after the date of receipt of a notice of an adverse

1 determination sent pursuant to sections 28 to 74, inclusive, of this Act, any covered person or  
2 the covered person's authorized representative may file a grievance with the health carrier  
3 requesting a first level review of the adverse determination. The health carrier shall provide the  
4 covered person with the name, address, and telephone number of a person or organizational unit  
5 designated to coordinate the first level review on behalf of the health carrier. In providing for  
6 a first level review under this section, the health carrier shall ensure that the review conducted  
7 in a manner under this section to ensure the independence and impartiality of the individuals  
8 involved in making the first level review decision. In ensuring the independence and impartiality  
9 of individuals involved in making the first level review decision, no health carrier may make  
10 decisions related to such individuals regarding hiring, compensation, termination, promotion  
11 or other similar matters based upon the likelihood that the individual will support the denial of  
12 benefits.

13 The health carrier shall designate one or more health care providers who have appropriate  
14 training and experience in the field of medicine involved in the medical judgment to evaluate  
15 the adverse determination. No health care provider may have been involved in the initial adverse  
16 determination. In conducting the review, a reviewer shall take into consideration all comments,  
17 documents, records, and other information regarding the request for services submitted by the  
18 covered person or the covered person's authorized representative, without regard to whether the  
19 information was submitted or considered in making the initial adverse determination.

20 Section 80. No covered person has the right to attend, or to have a representative in  
21 attendance, at the first level review. However, the covered person or, if applicable, the covered  
22 person's authorized representative may:

- 23 (1) Submit written comments, documents, records, and other material relating to the  
24 request for benefits for the review or reviewers to consider when conducting the

1 review; and

2 (2) Receive from the health carrier, upon request and free of charge, reasonable access  
3 to, and copies of all documents, records and other information relevant to the covered  
4 person's request for benefits. A document, record, or other information shall be  
5 considered relevant to a covered person's request for benefits if the document, record,  
6 or other information:

7 (a) Was relied upon in making the benefit determination;

8 (b) Was submitted, considered, or generated in the course of making the adverse  
9 determination, without regard to whether the document, record, or other  
10 information was relied upon in making the benefit determination;

11 (c) Demonstrates that, in making the benefit determination, the health carrier, or  
12 its designated representatives consistently applied required administrative  
13 procedures and safeguards with respect to the covered person as other  
14 similarly situated covered persons; or

15 (d) Constitutes a statement of policy or guidance with respect to the health benefit  
16 plan concerning the denied health care service or treatment for the covered  
17 person's diagnosis, without regard to whether the advice or statement was  
18 relied upon in making the benefit determination.

19 The health carrier shall make the provisions of this section known to the covered person or,  
20 if applicable, the covered person's authorized representative within three working days after the  
21 date of receipt of the grievance.

22 Section 81. A health carrier shall notify and issue a decision in writing or electronically to  
23 the covered person or, if applicable, the covered person's authorized representative, within the  
24 following time frames:

1       (1) With respect to a grievance requesting a first level review of an adverse  
2           determination involving a prospective review request, the health carrier shall notify  
3           and issue a decision within a reasonable period of time that is appropriate given the  
4           covered person's medical condition, but no later than thirty days after the date of the  
5           health carrier's receipt of the grievance requesting the first level review made  
6           pursuant to section 79 of this Act; or

7       (2) With respect to a grievance requesting a first level review of an adverse  
8           determination involving a retrospective review request, the health carrier shall notify  
9           and issue a decision within a reasonable period of time, but no later than sixty days  
10          after the date of the health carrier's receipt of the grievance requesting the first level  
11          review made pursuant to section 79 of this Act.

12       For purposes of calculating the time periods within which a determination is required to be  
13       made and notice provided under this section, the time period shall begin on the date the  
14       grievance requesting the review is filed with the health carrier in accordance with the health  
15       carrier's procedures established pursuant to section 78 of this Act for filing a request, without  
16       regard to whether all of the information necessary to make the determination accompanies the  
17       filing.

18       Section 82. Prior to issuing a decision in accordance with the timeframes provided in section  
19       81 of this Act, the health carrier shall provide free of charge to covered person, or the covered  
20       person's authorized representative, any new or additional evidence, relied upon or generated by  
21       the health carrier, or at the direction of the health carrier, in connection with the grievance  
22       sufficiently in advance of the date the decision is required to be provided to permit the covered  
23       person, or the covered person's authorized representative, a reasonable opportunity to respond  
24       prior to that date.

1 Before the health carrier issues or provides notice of a final adverse determination in  
2 accordance with the timeframes provided in section 81 of this Act that is based on new or  
3 additional rationale, the health carrier shall provide the new or additional rationale to the  
4 covered person, or the covered person's authorized representative, free of charge as soon as  
5 possible and sufficiently in advance of the date the notice of final adverse determination is to  
6 be provided to permit the covered person, or the covered person's authorized representative a  
7 reasonable opportunity to respond prior to that date.

8 Section 83. The decision issued pursuant to section 81 of this Act shall set forth in a manner  
9 calculated to be understood by the covered person or, if applicable, the covered person's  
10 authorized representative and include the following:

- 11 (1) The titles and qualifying credentials of any person participating in the first level  
12 review process (the reviewer);
- 13 (2) Information sufficient to identify the claim involved with respect to the grievance,  
14 including the date of service, the health care provider, if applicable, the claim  
15 amount, the diagnosis code and its corresponding meaning, and the treatment code  
16 and its corresponding meaning;
- 17 (3) A statement of the reviewer's understanding of the covered person's grievance;
- 18 (4) The reviewer's decision in clear terms and the contract basis or medical rationale in  
19 sufficient detail for the covered person to respond further to the health carrier's  
20 position;
- 21 (5) A reference to the evidence or documentation used as the basis for the decision;
- 22 (6) For a first level review decision issued pursuant to section 81 of this Act that upholds  
23 the grievance denial:
  - 24 (a) The specific reason or reasons for the final internal adverse determination,

1 including the denial code and its corresponding meaning, as well as a  
2 description of the health carrier's standard, if any, that was used in reaching the  
3 denial;

4 (b) The reference to the specific plan provisions on which the determination is  
5 based;

6 (c) A statement that the covered person is entitled to receive, upon request and  
7 free of charge, reasonable access to, and copies of, all documents, records and  
8 other information relevant, as the term relevant is defined in section 80 of this  
9 Act to the covered person's benefit request;

10 (d) If the health carrier relied upon an internal rule, guideline, protocol, or other  
11 similar criterion to make the final adverse determination, either the specific  
12 rule, guideline, protocol or other similar criterion or a statement that a specific  
13 rule, guideline, protocol, or other similar criterion was relied upon to make the  
14 final adverse determination and that a copy of the rule, guideline, protocol or  
15 other similar criterion will be provided free of charge to the covered person  
16 upon request;

17 (e) If the final adverse determination is based on a medical necessity or  
18 experimental or investigational treatment or similar exclusion or limit, either  
19 an explanation of the scientific or clinical judgment for making the  
20 determination, applying the terms of the health benefit plan to the covered  
21 person's medical circumstances or a statement that an explanation will be  
22 provided to the covered person free of charge upon request; and

23 (f) If applicable, instructions for requesting:

24 (i) A copy of the rule, guideline, protocol, or other similar criterion relied

1                   upon in making the final adverse determination, as provided in  
2                   subsection (d) of this section; or

3                   (ii) The written statement of the scientific or clinical rationale for the  
4                   determination, as provided in subsection (e) of this section;

5       (7) If applicable, a statement indicating:

6           (a) A description of the procedures for obtaining an independent external review  
7           of the final adverse determination pursuant to rules promulgated by the  
8           director; and

9           (b) The covered person's right to bring a civil action in a court of competent  
10           jurisdiction;

11       (8) If applicable, the following statement: "You and your plan may have other voluntary  
12           alternative dispute resolution options, such as mediation. One way to find out what  
13           may be available is to contact your state insurance director.";

14       (9) Notice of the covered person's right to contact the Division of Insurance for  
15           assistance at any time, including the telephone number and address of the Division  
16           of Insurance.

17       Section 84. Each health carrier shall establish written procedures for the expedited review  
18       of urgent care requests of grievances involving an adverse determination. In addition, a health  
19       carrier shall provide expedited review of a grievance involving an adverse determination with  
20       respect to concurrent review urgent care requests involving an admission, availability of care,  
21       continued stay, or health care service for a covered person who has received emergency services,  
22       but has not been discharged from a facility. The procedures shall allow a covered person or the  
23       covered person's authorized representative to request an expedited review under this section  
24       orally or in writing.

1 Each health carrier shall appoint at least one appropriate clinical peer in the same or similar  
2 specialty as would typically manage the case being reviewed to review the adverse  
3 determination. The clinical peer may not have been involved in making the initial adverse  
4 determination.

5 Section 85. In an expedited review that is not an initial determination for benefits, all  
6 necessary information, including the health carrier's decision, shall be transmitted between the  
7 health carrier and the covered person or, if applicable, the covered person's authorized  
8 representative, by telephone, facsimile, or the most expeditious method available.

9 Section 86. An expedited review decision, that is not an initial determination for benefits,  
10 shall be made and the covered person or, if applicable, the covered person's authorized  
11 representative, shall be notified of the decision in accordance with section 87 of this Act as  
12 expeditiously as the covered person's medical condition requires, but in no event more than  
13 seventy-two hours after the date of receipt of the request for the expedited review. If the  
14 expedited review is of a grievance involving an adverse determination with respect to a  
15 concurrent review urgent care request, the service shall be continued without liability to the  
16 covered person until the covered person has been notified of the determination.

17 For purposes of calculating the time periods within which a decision is required to be made  
18 under this section, the time period within which the decision is required to be made shall begin  
19 on the date the request is filed with the health carrier in accordance with the health carrier's  
20 procedures established pursuant to section 78 of this Act for filing a request, without regard to  
21 whether all of the information necessary to make the determination accompanies the filing.

22 Section 87. A notification of a decision under sections 84 to 87, inclusive, of this Act, shall,  
23 in a manner calculated to be understood by the covered person or, if applicable, the covered  
24 person's authorized representative, set forth the following:

- 1 (1) The titles and qualifying credentials of any person participating in the expedited  
2 review process (the reviewer);
- 3 (2) Information sufficient to identify the claim involved with respect to the grievance,  
4 including the date of service, the health care provider, if applicable, the claim  
5 amount, the diagnosis code and its corresponding meaning, and the treatment code  
6 and its corresponding meaning;
- 7 (3) A statement of the reviewer's understanding of the covered person's grievance;
- 8 (4) The reviewer's decision in clear terms and the contract basis or medical rationale in  
9 sufficient detail for the covered person to respond further to the health carrier's  
10 position;
- 11 (5) A reference to the evidence or documentation used as the basis for the decision;
- 12 (6) If the decision involves a final adverse determination, the notice shall provide:
  - 13 (a) The specific reason or reasons for the final adverse determination, including  
14 the denial code and its corresponding meaning, as well as a description of the  
15 health carrier's standard, if any, that was used in reaching the denial;
  - 16 (b) A reference to the specific plan provisions on which the determination is  
17 based;
  - 18 (c) A description of any additional material or information necessary for the  
19 covered person to complete the request, including an explanation of why the  
20 material or information is necessary to complete the request;
  - 21 (d) If the health carrier relied upon an internal rule, guideline, protocol, or other  
22 similar criterion to make the adverse determination, either the specific rule,  
23 guideline, protocol, or other similar criterion or a statement that a specific rule,  
24 guideline, protocol, or other similar criterion was relied upon to make the

1 adverse determination and that a copy of the rule, guideline, protocol, or other  
2 similar criterion will be provided free of charge to the covered person upon  
3 request;

4 (e) If the final adverse determination is based on a medical necessity or  
5 experimental or investigational treatment or similar exclusion or limit, either  
6 an explanation of the scientific or clinical judgment for making the  
7 determination, applying the terms of the health benefit plan to the covered  
8 person's medical circumstances or a statement that an explanation will be  
9 provided to the covered person free of charge upon request;

10 (f) If applicable, instructions for requesting:

11 (i) A copy of the rule, guideline, protocol, or other similar criterion relied  
12 upon in making the adverse determination as provided in subsection (d)  
13 of this section; or

14 (ii) The written statement of the scientific or clinical rationale for the  
15 adverse determination as provided in subsection (e) of this section;

16 (g) A statement describing the procedures for obtaining an independent external  
17 review of the adverse determination pursuant to rules promulgated by the  
18 director;

19 (h) A statement indicating the covered person's right to bring a civil action in a  
20 court of competent jurisdiction;

21 (i) The following statement: "You and your plan may have other voluntary  
22 alternative dispute resolution options, such as mediation. One way to find out  
23 what may be available is to contact your state insurance director."; and

24 (j) A notice of the covered person's right to contact the Division of Insurance for

1 assistance at any time, including the telephone number and address of the  
2 Division of Insurance.

3 A health carrier may provide the notice required under this section orally, in writing, or  
4 electronically. If notice of the adverse determination is provided orally, the health carrier shall  
5 provide written or electronic notice of the adverse determination within three days following the  
6 date of the oral notification.

7 Section 88. The director, in consultation with the secretary, shall promulgate rules, pursuant  
8 to chapter 1-26, to establish time frames relative to the filing of grievances, the disposition of  
9 grievances, and the response to the aggrieved person. Rules may also be promulgated covering  
10 definition of terms, grievance procedures, and content of reports.

11 Section 89. For the purposes of sections 2 to 21, inclusive, of this Act, the term, health  
12 benefit plan, means a policy, contract, certificate, or agreement entered into, offered, or issued  
13 by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of  
14 health care services. The term includes short-term and catastrophic health insurance policies,  
15 and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this  
16 definition.

17 The term does not include coverage only for accident, or disability income insurance, or any  
18 combination thereof; coverage issued as a supplement to liability insurance; liability insurance,  
19 including general liability insurance and automobile liability insurance; workers' compensation  
20 or similar insurance; automobile medical payment insurance; credit-only insurance; coverage  
21 for on-site medical clinics; and other similar insurance coverage, specified in federal regulations  
22 issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which  
23 benefits for medical care are secondary or incidental to other insurance benefits.

24 The term does not include the following benefits if they are provided under a separate

1 policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:  
2 limited scope dental or vision benefits; benefits for long-term care, nursing home care, home  
3 health care, community-based care, or any combination thereof; or other similar, limited benefits  
4 specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to  
5 January 1, 2011.

6 The term does not include the following benefits if the benefits are provided under a  
7 separate policy, certificate, or contract of insurance, there is no coordination between the  
8 provision of the benefits and any exclusion of benefits under any group health plan maintained  
9 by the same plan sponsor, and the benefits are paid with respect to an event without regard to  
10 whether benefits are provided with respect to such an event under any group health plan  
11 maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital  
12 indemnity or other fixed indemnity insurance.

13 The term does not include the following if offered as a separate policy, certificate, or  
14 contract of insurance: medicare supplemental health insurance as defined under Section  
15 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to  
16 the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and  
17 Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or  
18 similar supplemental coverage provided to coverage under a group health plan.

19 Section 90. For the purposes of sections 22 to 27, inclusive, of this Act, the term, health  
20 benefit plan, means a policy, contract, certificate, or agreement entered into, offered, or issued  
21 by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of  
22 health care services. The term includes short-term and catastrophic health insurance policies,  
23 and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this  
24 definition.

1 The term does not include coverage only for accident, or disability income insurance, or any  
2 combination thereof; coverage issued as a supplement to liability insurance; liability insurance,  
3 including general liability insurance and automobile liability insurance; workers' compensation  
4 or similar insurance; automobile medical payment insurance; credit-only insurance; coverage  
5 for on-site medical clinics; and other similar insurance coverage, specified in federal regulations  
6 issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which  
7 benefits for medical care are secondary or incidental to other insurance benefits.

8 The term does not include the following benefits if they are provided under a separate  
9 policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:  
10 limited scope dental or vision benefits; benefits for long-term care, nursing home care, home  
11 health care, community-based care, or any combination thereof; or other similar, limited benefits  
12 specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to  
13 January 1, 2011.

14 The term does not include the following benefits if the benefits are provided under a  
15 separate policy, certificate, or contract of insurance, there is no coordination between the  
16 provision of the benefits and any exclusion of benefits under any group health plan maintained  
17 by the same plan sponsor, and the benefits are paid with respect to an event without regard to  
18 whether benefits are provided with respect to such an event under any group health plan  
19 maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital  
20 indemnity or other fixed indemnity insurance.

21 The term does not include the following if offered as a separate policy, certificate, or  
22 contract of insurance: medicare supplemental health insurance as defined under Section  
23 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to  
24 the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and

1 Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or  
2 similar supplemental coverage provided to coverage under a group health plan.

3 Section 91. For the purposes of sections 28 to 74, inclusive, of this Act, the term, health  
4 benefit plan, means a policy, contract, certificate, or agreement entered into, offered, or issued  
5 by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of  
6 health care services. The term includes short-term and catastrophic health insurance policies,  
7 and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this  
8 definition.

9 The term does not include coverage only for accident, or disability income insurance, or any  
10 combination thereof; coverage issued as a supplement to liability insurance; liability insurance,  
11 including general liability insurance and automobile liability insurance; workers' compensation  
12 or similar insurance; automobile medical payment insurance; credit-only insurance; coverage  
13 for on-site medical clinics; and other similar insurance coverage, specified in federal regulations  
14 issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which  
15 benefits for medical care are secondary or incidental to other insurance benefits.

16 The term does not include the following benefits if they are provided under a separate  
17 policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:  
18 limited scope dental or vision benefits; benefits for long-term care, nursing home care, home  
19 health care, community-based care, or any combination thereof; or other similar, limited benefits  
20 specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to  
21 January 1, 2011.

22 The term does not include the following benefits if the benefits are provided under a  
23 separate policy, certificate, or contract of insurance, there is no coordination between the  
24 provision of the benefits and any exclusion of benefits under any group health plan maintained

1 by the same plan sponsor, and the benefits are paid with respect to an event without regard to  
2 whether benefits are provided with respect to such an event under any group health plan  
3 maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital  
4 indemnity or other fixed indemnity insurance.

5 The term does not include the following if offered as a separate policy, certificate, or  
6 contract of insurance: medicare supplemental health insurance as defined under Section  
7 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to  
8 the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and  
9 Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or  
10 similar supplemental coverage provided to coverage under a group health plan.

11 Section 92. For the purposes of sections 28 to 74, inclusive, of this Act, the term, urgent care  
12 request means a request for a health care service or course of treatment with respect to which  
13 the time periods for making a nonurgent care request determination:

- 14 (1) Could seriously jeopardize the life or health of the covered person or the ability of  
15 the covered person to regain maximum function; or
- 16 (2) In the opinion of a physician with knowledge of the covered person's medical  
17 condition, would subject the covered person to severe pain that cannot be adequately  
18 managed without the health care service or treatment that is the subject of the request.

19 Except as provided in subdivision (1) of this section, in determining whether a request is to  
20 be treated as an urgent care request, an individual acting on behalf of the health carrier shall  
21 apply the judgment of a prudent layperson who possesses an average knowledge of health and  
22 medicine. Any request that a physician with knowledge of the covered person's medical  
23 condition determines is an urgent care request within the meaning of subdivisions (1) and (2)  
24 of this section shall be treated as an urgent care request.

1 Section 93. For the purposes of sections 75 to 88, inclusive, of this Act, the term, health  
2 benefit plan, means a policy, contract, certificate, or agreement entered into, offered, or issued  
3 by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of  
4 health care services. The term includes short-term and catastrophic health insurance policies,  
5 and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this  
6 definition.

7 The term does not include coverage only for accident, or disability income insurance, or any  
8 combination thereof; coverage issued as a supplement to liability insurance; liability insurance,  
9 including general liability insurance and automobile liability insurance; workers' compensation  
10 or similar insurance; automobile medical payment insurance; credit-only insurance; coverage  
11 for on-site medical clinics; and other similar insurance coverage, specified in federal regulations  
12 issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which  
13 benefits for medical care are secondary or incidental to other insurance benefits.

14 The term does not include the following benefits if they are provided under a separate  
15 policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:  
16 limited scope dental or vision benefits; benefits for long-term care, nursing home care, home  
17 health care, community-based care, or any combination thereof; or other similar, limited benefits  
18 specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to  
19 January 1, 2011.

20 The term does not include the following benefits if the benefits are provided under a  
21 separate policy, certificate, or contract of insurance, there is no coordination between the  
22 provision of the benefits and any exclusion of benefits under any group health plan maintained  
23 by the same plan sponsor, and the benefits are paid with respect to an event without regard to  
24 whether benefits are provided with respect to such an event under any group health plan

1 maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital  
2 indemnity or other fixed indemnity insurance.

3 The term does not include the following if offered as a separate policy, certificate, or  
4 contract of insurance: medicare supplemental health insurance as defined under Section  
5 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to  
6 the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and  
7 Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or  
8 similar supplemental coverage provided to coverage under a group health plan.

9 Section 94. For the purposes of sections 75 to 88, inclusive, of this Act, the term, urgent care  
10 request means a request for a health care service or course of treatment with respect to which  
11 the time periods for making a nonurgent care request determination:

- 12 (1) Could seriously jeopardize the life or health of the covered person or the ability of  
13 the covered person to regain maximum function; or
- 14 (2) In the opinion of a physician with knowledge of the covered person's medical  
15 condition, would subject the covered person to severe pain that cannot be adequately  
16 managed without the health care service or treatment that is the subject of the request.

17 Except as provided in subdivision (1) of this section, in determining whether a request is to  
18 be treated as an urgent care request, an individual acting on behalf of the health carrier shall  
19 apply the judgment of a prudent layperson who possesses an average knowledge of health and  
20 medicine. Any request that a physician with knowledge of the covered person's medical  
21 condition determines is an urgent care request within the meaning of subdivisions (1) and (2)  
22 of this section shall be treated as an urgent care request.

23 Section 95. That § 58-1-24 be amended to read as follows:

24 58-1-24. Terms used in §§ 58-1-25 and 58-18-87 mean:

- 1 (1) "Genetic information," information about genes, gene products, and inherited  
2 characteristics that may derive from the individual or a family member. ~~This~~ The  
3 term includes information regarding carrier status and information derived from  
4 laboratory tests that identify mutations in specific genes or chromosomes, physical  
5 medical examinations, family histories, and direct analysis of genes or chromosomes;
- 6 (2) "Genetic test," a test of human DNA, RNA, chromosomes, or genes performed in  
7 order to identify the presence or absence of an inherited variation, alteration, or  
8 mutation which is associated with predisposition to disease, illness, impairment, or  
9 other disorder. Genetic test does not mean a routine physical measurement; a  
10 chemical, blood, or urine analysis; a test for drugs or HIV infection; any test  
11 commonly accepted in clinical practice; or any test performed due to the presence of  
12 signs, symptoms, or other manifestations of a disease, illness, impairment, or other  
13 disorder;
- 14 (3) "Health carrier," any person who provides health insurance in this state. The term  
15 includes a licensed insurance company, a prepaid hospital or medical service plan,  
16 a health maintenance organization, a multiple employer welfare arrangement, a  
17 fraternal benefit contract, or any person providing a plan of health insurance subject  
18 to state insurance regulation;
- 19 (4) "Health insurance," insurance provided pursuant to chapters 58-17 (except disability  
20 income insurance), ~~58-17C~~ sections 2 to 94, inclusive, of this Act, 58-18 (except  
21 disability income insurance), 58-18B, 58-38, 58-40, and 58-41; and
- 22 (5) "Individual," an applicant for coverage or a person already covered by a health  
23 carrier.

24 Section 96. That § 58-17-143 be amended to read as follows:

1       58-17-143. The board may, directly or indirectly, enter into preferred provider contracts to  
2 obtain discounts on goods or services from out-of-state providers. If health care goods or  
3 services are provided pursuant to a preferred provider contract and the goods or services are  
4 either not readily available in this state or are emergency services as defined by ~~§ 58-17C-27~~  
5 section 28 of this Act, the provisions of that contract shall govern the reimbursement rate. The  
6 payment by the risk pool for any services received from out-of-network providers in other states,  
7 other than emergency treatment as defined in ~~§ 58-17C-27~~ section 28 of this Act, is limited to  
8 one hundred fifteen percent of South Dakota's medicaid reimbursement. Emergency treatment,  
9 as defined in ~~§ 58-17C-27~~ section 28 of this Act, that is from an out-of-state provider that is an  
10 out-of-network provider, to the extent that such services are payable under the plan, may be  
11 reimbursed by the risk pool at an amount that does not exceed the amount determined to be  
12 reasonable by the plan administrator.

13       Section 97. That § 58-17D-2 be amended to read as follows:

14       58-17D-2. A utilization review organization that conducts utilization reviews solely for  
15 property and casualty insurers in this state pursuant to policies issued in this state is not subject  
16 to ~~chapter 58-17C~~ this Act except that any such utilization review organization shall register in  
17 the same manner as prescribed for utilization review organizations pursuant to ~~chapter 58-17C~~  
18 sections 60 to 64, inclusive, of this Act.

19       Section 98. That § 58-17E-9 be amended to read as follows:

20       58-17E-9. Any discount medical plan organization that is not offered directly by a health  
21 carrier as provided by this chapter, shall register in a format as prescribed by the director and  
22 shall file reports and conduct business under the same standards as required of utilization review  
23 organizations in accordance with provisions of ~~§§ 58-17C-65 to 58-17C-66, inclusive~~ sections  
24 61 to 62, inclusive, of this Act. No health carrier may offer or provide coverage through a person

1 not registered but required to be registered pursuant to §§ 58-17E-9, 58-17E-39, 58-17E-41, and  
2 58-17E-45, inclusive. Any plan or program that is registered pursuant to ~~§ 58-17C-20~~ section  
3 16 of this Act is not required to maintain a separate registration pursuant to §§ 58-17E-9, 58-  
4 17E-39, 58-17E-41, and 58-17E-45, inclusive. Any plan or program of discounted goods or  
5 services that is offered by a health carrier in conjunction with a health benefit plan, as defined  
6 in §§ 58-18-42 and 58-17-66(9), a medicare supplement policy as defined in § 58-17A-1, or  
7 other insurance product that is offered by an authorized insurer and that is subject to the  
8 jurisdiction of the director is not required to be registered pursuant to §§ 58-17E-9, 58-17E-39,  
9 58-17E-41, and 58-17E-45, inclusive.

10 Section 99. That § 58-33-93 be amended to read as follows:

11 58-33-93. Terms used in §§ 58-33-93 to 58-33-116, inclusive, mean:

- 12 (1) "Admitted insurer," an insurer licensed to do an insurance business in this state  
13 including an entity authorized pursuant to § 58-18-88, a health maintenance  
14 organization or nonprofit hospital, or medical service corporation under the laws of  
15 this state;
- 16 (2) "Arrangement," a fund, trust, plan, program, or other mechanism by which a person  
17 provides, or attempts to provide, health care benefits;
- 18 (3) "Employee leasing arrangement," a labor leasing, staff leasing, employee leasing,  
19 professional employer organization, contract labor, extended employee staffing or  
20 supply, or other arrangement, under contract or otherwise, whereby one business or  
21 entity represents that it leases or provides its workers to another business or entity;
- 22 (4) "Employee welfare benefit plan" or "health benefit plan," a plan, fund, or program  
23 which is or was established or maintained by an employer or by an employee  
24 organization, or by both, to the extent that the plan, fund, or program is or was

1 established or maintained for the purpose of providing for its participants or their  
2 beneficiaries, through the purchase of insurance or otherwise, medical, surgical or  
3 hospital care or benefits, or benefits in the event of sickness, accident, disability,  
4 death, or unemployment;

5 (5) "Fully insured," for the health care benefits or coverage provided or offered by or  
6 through a health benefit plan or arrangement:

7 (a) An admitted insurer is directly obligated by contract to each participant to  
8 provide all of the coverage under the plan or arrangement; and

9 (b) The liability and responsibility of the admitted insurer to provide covered  
10 services or for payment of benefits is not contingent, and is directly to the  
11 individual employee, member, or dependent;

12 (6) "Licensee," a person that is, or that is required to be, licensed or registered under the  
13 laws of this state as a producer, third party administrator, insurer, or preferred  
14 provider organization;

15 (7) "MEWA," multiple employer welfare arrangement;

16 (8) "MEWA contact," the individual or position designated by the division to be the  
17 MEWA contact as identified on the division web site;

18 (9) "Nonadmitted insurer," an insurer not licensed to do insurance business in this state;

19 (10) "Preferred provider organization," an entity that engages in the business of offering  
20 a network of health care providers, whether or not on a risk basis, to employers,  
21 insurers, or any other person who provides a health benefit plan including a managed  
22 care contractor registered or required to be registered pursuant to ~~chapter 58-17C~~  
23 section 16 of this Act;

24 (11) "Producer," a person required to be licensed pursuant to chapter 58-30 of this state

1 to sell, solicit, or negotiate insurance;

2 (12) "Professional employer organization," an arrangement, under contract or otherwise,  
3 whereby one business or entity represents that it co-employs or leases workers to  
4 another business or entity for an ongoing and extended, rather than a temporary or  
5 project-specific, relationship;

6 (13) "Third party administrator" or "administrator," has the meaning provided in chapter  
7 58-29D.

8 Section 100. That § 58-37A-39 be amended to read as follows:

9 58-37A-39. In addition to the provisions contained in this chapter, the following chapters  
10 and provisions of the South Dakota Code also apply to fraternal benefit societies, to the extent  
11 applicable and not in conflict with the express provisions of this chapter and the reasonable  
12 implications of this chapter:

13 (1) Chapter 47-6;

14 (2) Chapter 58-1;

15 (3) Chapter 58-2, with the exception of § 58-2-29;

16 (4) Chapter 58-3;

17 (5) Chapter 58-4;

18 (6) Chapter 58-5;

19 (7) Sections 58-6-8, 58-6-46, and 58-6-47;

20 (8) Chapters 58-15, 58-17, 58-17A, 58-17B, and 58-18;

21 (9) Chapter 58-29B;

22 (10) Chapter 58-30;

23 (11) Chapter 58-33;

24 (12) ~~Chapters 58-17C~~ Sections 2 to 94, inclusive, of this Act, and chapter 58-33A.

1 Section 101. That § 58-41-12 be amended to read as follows:

2 58-41-12. Upon receipt of an application for issuance of a certificate of authority, the  
3 director shall forthwith transmit copies of such application and accompanying documents to the  
4 secretary. The secretary shall determine whether the applicant for a certificate of authority has:

5 (1) Demonstrated the willingness and potential ability to assure that health care services  
6 will be provided in a manner to assure both the availability and accessibility of  
7 adequate personnel and facilities consistent with the requirements of §§ ~~58-17C-7 to~~  
8 ~~58-17C-15, inclusive~~ sections 2 to 21, inclusive, of this Act;

9 (2) Arrangements, established in accordance with regulations promulgated by the  
10 secretary for an ongoing quality of health care assurance program consistent with the  
11 requirements of §§ ~~58-17C-7 to 58-17C-15, inclusive~~ sections 2 to 21, inclusive, of  
12 this Act, concerning health care processes and outcomes;

13 (3) A procedure, established in accordance with regulations promulgated by the  
14 secretary, to develop, compile, evaluate, and report statistics relating to the cost of  
15 its operations, the pattern of utilization of its services, the availability and  
16 accessibility of its services, and such other matters as may be reasonably required by  
17 the secretary; and

18 (4) Reasonable provisions for emergency and out-of-area health care services.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

400S0241

## HOUSE TAXATION ENGROSSED NO. **SB 39** - 2/8/2011

Introduced by: The Committee on Taxation at the request of the Department of Revenue and Regulation

1 FOR AN ACT ENTITLED, An Act to revise certain provisions regarding what organizations  
2 qualify for an exemption from sales tax as a relief agency or a religious educational  
3 institution.

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

5 Section 1. That § 10-45-10 be amended to read as follows:

6 10-45-10. There are hereby specifically exempted from the provisions of this chapter and  
7 from the computation of the amount of tax imposed by it, the gross receipts from sales of  
8 tangible personal property, any product transferred electronically, and services to the United  
9 States, to the State of South Dakota or to any other state of the United States or the District of  
10 Columbia if the other state provides a reciprocal exemption for South Dakota, to public or  
11 municipal corporations of the State of South Dakota or of any other state of the United States  
12 or the District of Columbia if the other state provides a reciprocal exemption to South Dakota  
13 public or municipal corporations, to any nonprofit charitable organization maintaining a  
14 physical location within this state which devotes its resources exclusively to the relief of the



1 poor, distressed or underprivileged, and has been recognized as an exempt organization under  
2 § 501(c)(3) of the Internal Revenue Code, or to any Indian tribe.

3 Section 2. That § 10-45-14 be amended to read as follows:

4 10-45-14. There are specifically exempted from the provisions of this chapter and from the  
5 computation of the amount of tax imposed by it, the gross receipts from sales of tangible  
6 personal property, any product transferred electronically, and services to and for use by religious  
7 educational institutions, private educational institutions currently recognized as exempt under  
8 section 501(c)(3) of the Internal Revenue Code as in effect on January 1, ~~1983~~ 2011, and  
9 nonprofit, charitable hospitals when purchases are made by authorized officials, payment made  
10 from the institution funds and title to the property retained in the name of such institution. For  
11 the purposes of this section, a private educational institution shall be defined as an institution  
12 currently recognized as exempt under section 501(c)(3) of the Internal Revenue Code as in  
13 effect on January 1, ~~1983~~ 2011, maintaining a campus physically located within this state; and  
14 accredited by the South Dakota Department of Education or the North Central Association of  
15 Colleges and Schools. For the purposes of this section, a religious educational institution shall  
16 be defined as an institution currently recognized as exempt under section 501(c)(3) of the  
17 Internal Revenue Code as in effect on January 1, 2011, that maintains a campus physically  
18 located within this state.

19 This exemption does not extend to sales to or purchases of tangible personal property or any  
20 product transferred electronically for the personal use of officials, members or employees of  
21 such institutions or to sales to or purchases of tangible personal property or any product  
22 transferred electronically used in the operation of a taxable retail business.

23 The exemption provided in this section does not, in any manner, relieve the institution from  
24 the payment of the additional and further license fee imposed on the registration of motor

1 vehicles.

2 ~~All institutions~~ Each institution claiming this exemption shall prepare and maintain a list of  
3 all purchases on which the exemption was claimed, fully itemized, showing name and address  
4 of vendors, description of property purchased, date or dates of purchase, purchase price, and  
5 brief explanation of use or intended use.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

750S0508

## SENATE LOCAL GOVERNMENT ENGROSSED NO. **SB 62** - 1/26/2011

Introduced by: Senators Nelson (Tom), Nygaard, and Tieszen and Representatives  
Turbiville, Magstadt, and Munsterman

1 FOR AN ACT ENTITLED, An Act to revise procedures and amounts relating to compensation  
2 and expense reimbursement for sanitary district board members.

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

4 Section 1. That § 34A-5-23 be amended to read as follows:

5 34A-5-23. ~~Any member of the board of trustees may receive travel and subsistence expense~~  
6 ~~in accordance with the rules promulgated by the State Board of Finance. In addition, per diem,~~  
7 ~~not to exceed one hundred twenty dollars per day, may be paid each member for each day of~~  
8 ~~actual service for attending meetings, hearings, or investigations of the sanitary district board.~~  
9 ~~Travel, subsistence, and per diem shall be paid on vouchers duly verified and approved~~  
10 ~~according to the rules promulgated by the Board of Finance. Each sanitary district board of~~  
11 ~~trustees shall establish amounts to reimburse board members for expenses for lodging, meals,~~  
12 ~~and mileage and to provide compensation for each day of actual service for traveling to,~~  
13 ~~attending, and returning from meetings, hearings, or investigations of the sanitary district board.~~  
14 Such reimbursement and compensation shall be paid on vouchers duly verified and approved



1 according to the rules promulgated by the Board of Finance.

# State of South Dakota

EIGHTY-SIXTH SESSION  
LEGISLATIVE ASSEMBLY, 2011

591S0312

SENATE ENGROSSED NO. **SB 90** - 2/2/2011

Introduced by: Senator Gray and Representative Turbiville

1 FOR AN ACT ENTITLED, An Act to revise certain provisions concerning tax incremental  
2 districts.

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

4 Section 1. That § 11-9-1 be amended to read as follows:

5 11-9-1. Terms used in this chapter mean:

6 (1) "Department of Revenue and Regulation," the South Dakota Department of Revenue  
7 and Regulation;

8 (2) "Governing body," the board of trustees, the board of commissioners, the board of  
9 county commissioners, or the common council of a municipality;

10 (3) "Grant," the transfer for a governmental purpose of money or property to a transferee  
11 that is not a related party to or an agent of the municipality;

12 (4) "Municipality," any incorporated city or town in this state and, for purposes of this  
13 chapter only, any county in this state;

14 ~~(4)~~(5) "Planning commission," a planning commission created under chapter 11-6 or a  
15 municipal planning committee of a governing body of a municipality which has no



1 planning commission or, if the municipality is a county having no planning  
2 commission or planning committee, its board of county commissioners;

3 ~~(5)~~(6) "Project plan," the properly approved plan for the development or redevelopment of  
4 a tax incremental district including all properly approved amendments thereto;

5 ~~(6)~~(7) "Tax incremental district," a contiguous geographic area within a municipality  
6 defined and created by resolution of the governing body;

7 ~~(7)~~(8) "Taxable property," all real and personal taxable property located in a tax incremental  
8 district;

9 ~~(8)~~(9) "Tax increment valuation," is the total value of the tax incremental district minus the  
10 tax incremental base pursuant to § 11-9-19.

11 Section 2. That § 11-9-2 be amended to read as follows:

12 11-9-2. A municipality may exercise those powers necessary and convenient to carry out the  
13 purposes of this chapter, including the power to:

14 (1) Create tax incremental districts and to define their boundaries;

15 (2) Prepare project plans, approve the plans, and implement the provisions and purposes  
16 of the plans, including the acquisition by purchase or condemnation of real and  
17 personal property within the tax incremental district and the sale, lease, or other  
18 disposition of such property to private individuals, partnerships, corporations, or  
19 other entities at a price less than the cost of such acquisition and of any site  
20 improvements undertaken by the municipality pursuant to a project plan;

21 (3) Issue tax incremental bonds ~~and notes~~;

22 (4) Deposit moneys into the special fund of any tax incremental district; and

23 (5) Enter into any contracts or agreements, including agreements with bondholders,  
24 determined by the governing body to be necessary or convenient to implement the

1 provisions and effectuate the purposes of project plans. The contracts or agreements  
 2 may include conditions, restrictions, or covenants which run with the land or  
 3 otherwise regulate the use of land or which establish a minimum market value for the  
 4 land and completed improvements to be constructed thereon until a specified date,  
 5 which date may not be later than the date of termination of the tax incremental  
 6 district pursuant to § 11-9-46. Any contract or agreement which provides for the  
 7 payment of a specified sum of money at a specified future date shall be entered into  
 8 in accordance with chapter 6-8B.

9 Section 3. That § 11-9-8 be amended to read as follows:

10 11-9-8. To implement the provisions of this chapter, the resolution required by § 11-9-5  
 11 shall contain findings that:

12 (1) Not less than twenty-five percent, by area, of the real property within the district is  
 13 a blighted area or not less than fifty percent, by area, of the real property within the  
 14 district will stimulate and develop the general economic welfare and prosperity of the  
 15 state through the promotion and advancement of industrial, commercial,  
 16 manufacturing, agricultural, or natural resources; and

17 (2) The improvement of the area is likely to enhance significantly the value of  
 18 substantially all of the other real property in the district.

19 It is not necessary to identify the specific parcels meeting the criteria. No county may create  
 20 a tax incremental district located, in whole or in part, within a municipality, unless the  
 21 governing body of ~~such~~ the municipality has consented thereto by resolution.

22 Section 4. That § 11-9-13 be amended to read as follows:

23 11-9-13. ~~In order to implement the provisions of this chapter, the~~ The planning commission  
 24 shall ~~prepare and~~ adopt a project plan for each tax incremental district and submit the plan to

1 the governing body. The plan shall include a statement listing:

- 2 (1) The kind, number, and location of all proposed public works or improvements within  
3 the district;
- 4 (2) An economic feasibility study;
- 5 (3) A detailed list of estimated project costs;
- 6 (4) A fiscal impact statement which shows the impact of the tax increment district, both  
7 until and after the bonds are repaid, upon all entities levying taxes upon property in  
8 the district; and
- 9 (5) A description of the methods of financing all estimated project costs and the time  
10 when related costs or monetary obligations are to be incurred.

11 No expenditure may be provided for in the plan more than five years after a district is  
12 created unless an amendment is adopted by the governing body under § 11-9-23.

13 Section 5. That § 11-9-14 be amended to read as follows:

14 11-9-14. "Project costs" are any expenditures made or estimated to be made, or monetary  
15 obligations incurred or estimated to be incurred, by a municipality which are listed in a project  
16 plan as grants, costs of public works, or improvements within a tax incremental district, plus any  
17 costs incidental thereto, diminished by any income, special assessments, or other revenues, other  
18 than tax increments, received, or reasonably expected to be received, by the municipality in  
19 connection with the implementation of the plan.

20 Section 6. That § 11-9-15 be amended to read as follows:

21 11-9-15. Project costs include, ~~but are not limited to:~~

- 22 (1) Capital costs, including the actual costs of the construction of public works or  
23 improvements, buildings, structures, and permanent fixtures; the demolition,  
24 alteration, remodeling, repair, or reconstruction of existing buildings, structures, and

1 permanent fixtures; the acquisition of equipment; the clearing and grading of land;  
2 and the amount of interest payable on tax incremental bonds ~~or notes~~ issued pursuant  
3 to this chapter until such time as positive tax increments to be received from the  
4 district, as estimated by the project plan, are sufficient to pay the principal of and  
5 interest on the tax incremental bonds ~~or notes~~ when due;

6 (2) Financing costs, including all interest paid to holders of evidences of indebtedness  
7 issued to pay for project costs, any premium paid over the principal amount thereof  
8 because of the redemption of such obligations prior to maturity and a reserve for the  
9 payment of principal of and interest on such obligations in an amount determined by  
10 the governing body to be reasonably required for the marketability of such  
11 obligations;

12 (3) Real property assembly costs, including the actual cost of the acquisition by a  
13 municipality of real or personal property within a tax incremental district less any  
14 proceeds to be received by the municipality from the sale, lease, or other disposition  
15 of such property pursuant to a project plan;

16 (4) Professional service costs, including those costs incurred for architectural, planning,  
17 engineering, and legal advice and services;

18 (5) Imputed administrative costs, including reasonable charges for the time spent by  
19 municipal employees in connection with the implementation of a project plan;

20 (6) Relocation costs;

21 (7) Organizational costs, including the costs of conducting environmental impact and  
22 other studies and the costs of informing the public of the creation of tax incremental  
23 districts and the implementation of project plans; and

24 (8) Payments and grants made, at the discretion of the governing body, which are found

1 to be necessary or convenient to the creation of tax incremental districts ~~or~~, the  
 2 implementation of project plans, or to stimulate and develop the general economic  
 3 welfare and prosperity of the state.

4 Section 7. That § 11-9-25 be amended to read as follows:

5 11-9-25. Positive tax increments of a tax incremental district shall be allocated to the  
 6 municipality which created the district for each year from the date when the district is created  
 7 until the earlier of:

8 ~~— (1) That time, after the completion of all public improvements specified in the plan or~~  
 9 ~~amendments, when the municipality has received aggregate tax increments of the~~  
 10 ~~district in an amount equal to the aggregate of all expenditures previously made or~~  
 11 ~~monetary obligations previously incurred for project costs for the district; or~~

12 ~~— (2) Fifteen years after the last expenditure identified in the plan has been made or until~~  
 13 ~~retirement of all outstanding tax incremental bonds or notes issued pursuant to § 11-~~  
 14 ~~9-35 have matured municipality or county has been reimbursed for expenditures~~  
 15 ~~previously made, has paid all monetary obligations, and has retired all outstanding~~  
 16 ~~tax incremental bonds. However, in no event may the positive tax increments be~~  
 17 ~~allocated longer than twenty years after the calendar year of creation.~~

18 Section 8. That § 11-9-30 be amended to read as follows:

19 11-9-30. Payment of project costs may be made by any of the following methods or by any  
 20 combination thereof:

- 21 (1) Payment by the municipality from the special fund of the tax incremental district;
- 22 (2) Payment out of the municipality's ~~general~~ funds;
- 23 (3) Payment out of the proceeds of the sale of municipal ~~improvement~~ bonds issued by  
 24 the municipality under ~~chapter 9-44~~ chapters 10-52 or 10-52A;

1 (4) Payment out of the proceeds of revenue bonds issued by the municipality under  
2 chapter 9-54; or

3 (5) Payment out of the proceeds of the sale of tax incremental bonds ~~or notes~~ issued by  
4 the municipality under this chapter.

5 Section 9. That § 11-9-32 be amended to read as follows:

6 11-9-32. Moneys shall be paid out of the special fund created under § 11-9-31 only to pay  
7 project costs or grants of the district, to reimburse the municipality for the payments, or to  
8 satisfy claims of holders of tax incremental bonds ~~or notes~~ issued for the district.

9 Section 10. That § 11-9-33 be amended to read as follows:

10 11-9-33. For the purpose of paying project costs, the governing body may issue tax  
11 incremental bonds ~~or notes~~ payable out of positive tax increments.

12 Section 11. That § 11-9-34 be amended to read as follows:

13 11-9-34. Tax incremental bonds ~~or notes~~, contracts, or agreements shall be authorized by  
14 resolution of the governing body without the necessity of a referendum or any voter's approval.

15 Section 12. That § 11-9-35 be amended to read as follows:

16 11-9-35. Tax incremental bonds ~~or notes~~ may not be issued in an amount exceeding the  
17 aggregate project costs. The bonds ~~or notes~~ may not mature later than twenty years from the date  
18 thereof. The bonds ~~or notes~~ may contain a provision authorizing the redemption thereof, in  
19 whole or in part, at stipulated prices, at the option of the municipality, on any interest payment  
20 date and shall provide the method of selecting the bonds ~~or notes~~ to be redeemed. The principal  
21 and interest on the bonds ~~and notes~~ may be payable at any time and at any place. The bonds ~~or~~  
22 ~~notes~~ may be payable to their bearer or may be registered as to the principal or principal and  
23 interest. The bonds ~~or notes~~ may be in any denominations.

24 Section 13. That § 11-9-36 be amended to read as follows:

1 11-9-36. Tax incremental bonds ~~or notes~~ are payable only out of the special fund created  
2 under § 11-9-31. Each bond ~~or note~~ shall contain such recitals as are necessary to show that it  
3 the bond is only so payable and that ~~it~~ the bond does not constitute a general indebtedness of the  
4 municipality or a charge against its general taxing power.

5 Section 14. That § 11-9-37 be amended to read as follows:

6 11-9-37. The governing body shall irrevocably pledge all or a stated percentage of the  
7 special fund created under § 11-9-31 to the payment of the bonds ~~or notes~~. The special fund or  
8 designated part thereof may thereafter be used only for the payment of the bonds ~~or notes~~ and  
9 interest until they have been fully paid, and any holder of the bonds ~~or notes~~ or of any coupons  
10 appertaining thereto shall have a lien against the special fund for payment of the bonds ~~or notes~~  
11 and interest and may either at law or in equity protect and enforce the lien.

12 Section 15. That § 11-9-38 be amended to read as follows:

13 11-9-38. Each bond ~~or note~~ issued under the provisions of this chapter and all interest  
14 coupons appurtenant thereto are declared to be negotiable instruments. Bonds so issued are not  
15 general obligation bonds and are payable only from the tax increment of the project as provided  
16 in this chapter.

17 Section 16. That § 11-9-39 be amended to read as follows:

18 11-9-39. To increase the security and marketability of its tax incremental bonds ~~or notes~~, a  
19 municipality may:

- 20 (1) Create a lien for the benefit of the bondholders upon any public improvements or  
21 public works financed thereby or the revenues therefrom; or
- 22 (2) Make covenants and do any and all acts, not inconsistent with the South Dakota  
23 Constitution, necessary, convenient, or desirable in order to additionally secure bonds  
24 ~~or notes~~ or to make the bonds ~~or notes~~ more marketable according to the best

1 judgment of the governing body, including the establishment of a reserve for the  
2 payment of principal of and interest on the bonds ~~or notes~~ funded from the proceeds  
3 of such bonds ~~or notes~~ or other revenues, including tax increments, of the  
4 municipality; or

5 (3) Comply with both subdivisions (1) and (2) of this section.

6 Section 17. That § 11-9-39.1 be amended to read as follows:

7 11-9-39.1. The State of South Dakota does hereby pledge to and agree with the holders of  
8 any bonds ~~or notes~~ issued under this chapter that the state will not alter the rights vested in the  
9 bond holders until such ~~notes or~~ bonds, together with the interest thereon, with interest on any  
10 unpaid installments of interest, and all costs and expenses in connection with any action or  
11 proceeding by or on behalf of such holders, are fully met and discharged.

12 Section 18. That § 11-9-40 be amended to read as follows:

13 11-9-40. Tax incremental bonds ~~or notes~~ may be sold at public or private sale at a price  
14 which the governing body deems in the best interests of the municipality. ~~Insofar as they are~~  
15 ~~consistent with this chapter, the provisions of chapter 9-25 relating to procedures for issuance,~~  
16 ~~form, contents, execution, negotiation, and registration of municipal bonds and notes shall be~~  
17 ~~followed.~~

18 Section 19. That § 11-9-46 be amended to read as follows:

19 11-9-46. The existence of a tax incremental district shall terminate when:

- 20 (1) Positive tax increments are no longer allocable to a district under § 11-9-25; or  
21 (2) The governing body, by resolution, dissolves the district, after payment or provision  
22 for payment of all project costs, grants, and all tax incremental bonds of the district.

23 Section 20. That § 11-9-45 be amended to read as follows:

24 11-9-45. After all project costs and all tax incremental bonds ~~and notes~~ of the district have

1    been paid or provided for subject to any agreement with bondholders, if any moneys remain in  
2    the fund, they shall be paid to the treasurer of each county, school district, or other tax-levying  
3    municipality or to the general fund of the municipality in such amounts as belong to each  
4    respectively, having due regard for what portion of such moneys, if any, represents tax  
5    increments not allocated to the municipality and what portion thereof, if any, represents  
6    voluntary deposits of the municipality into the fund.