

State of South Dakota

EIGHTY-SIXTH SESSION
LEGISLATIVE ASSEMBLY, 2011

518S0001

SENATE STATE AFFAIRS ENGROSSED NO. **SB 2** - 1/19/2011

Introduced by: Senators Rave, Haverly, Putnam, and Tieszen and Representatives Kirkeby, Feickert, Wink, and Wismer at the request of the Interim Bureau of Administration Agency Review Committee

1 FOR AN ACT ENTITLED, An Act to repeal, update, and make form and style revisions to
2 certain provisions related to the Bureau of Administration.

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

4 Section 1. That § 1-6-24 be repealed.

5 ~~1-6-24. No person may reproduce, duplicate, or otherwise use the logo adopted by the State~~
6 ~~Centennial Commission for celebration of the state centennial, or its facsimile, for any~~
7 ~~for-profit, commercial purpose without specific written authorization from the Bureau of~~
8 ~~Administration. A violation of this section is a Class 1 misdemeanor.~~

9 Section 2. That § 1-6-25 be repealed.

10 ~~1-6-25. No person may sell or offer for sale a replica or facsimile of the logo adopted by the~~
11 ~~State Centennial Commission for celebration of the state centennial without specific written~~
12 ~~authorization from the Bureau of Administration. A violation of this section is a Class 1~~
13 ~~misdemeanor.~~

14 Section 3. That § 1-6-26 be repealed.



1 ~~1-6-26. No person may sell or offer for sale any object or item bearing the word "South~~
2 ~~Dakota," in conjunction with the words "Centennial," "1889-1989," or "100 years," or any~~
3 ~~derivative thereof, without specific written authorization from the Bureau of Administration.~~
4 ~~A violation of this section is a Class 1 misdemeanor.~~

5 Section 4. That § 1-6-27 be repealed.

6 ~~1-6-27. The Bureau of Administration may charge a reasonable fee for the authorization~~
7 ~~granted under the terms of §§ 1-6-24 to 1-6-28, inclusive. The bureau may establish such fees~~
8 ~~by rule pursuant to chapter 1-26.~~

9 Section 5. That § 1-6-28 be repealed.

10 ~~1-6-28. The Bureau of Administration may enter into contracts for the marketing and sale~~
11 ~~of items or objects authorized under the terms of §§ 1-6-24 to 1-6-28, inclusive.~~

12 Section 6. That § 1-14-1 be amended to read as follows:

13 1-14-1. The Bureau of Administration shall continue within the Department of Executive
14 Management, and all its functions shall be performed by the Department of Executive
15 Management as provided by § 1-33-6.

16 The bureau shall maintain a central office in ~~the capitol~~ at Pierre ~~in rooms provided for the~~
17 ~~purpose~~, which shall be the official address of the bureau and the place for serving process or
18 papers of any kind upon it.

19 ~~The bureau shall have an official seal.~~

20 Section 7. That § 1-14-2 be amended to read as follows:

21 1-14-2. No person ~~shall be eligible for appointment~~ may be appointed as the commissioner
22 of administration unless ~~he holds a baccalaureate degree from a recognized institution of higher~~
23 ~~education and~~ the person has had progressively responsible experience in administration.

24 Section 8. That § 1-14-3 be amended to read as follows:

1 1-14-3. The commissioner of administration, under the general direction and control of the
2 Governor, shall execute the powers and discharge the duties vested by law in the Bureau of
3 Administration. He The commissioner shall qualify by taking and filing with the secretary of
4 state the constitutional oath of office.

5 Section 9. That § 1-14-6.1 be repealed.

6 ~~1-14-6.1. The following divisions of the Bureau of Administration are abolished:~~

7 ~~(1) The Purchasing and Printing Division;~~

8 ~~(2) The Buildings and Grounds Maintenance Division;~~

9 ~~(3) The Central Administrative Services Division;~~

10 ~~(4) The Central Data Processing Division.~~

11 ~~All their functions shall be administered by the Bureau of Administration as provided by § 1-33-~~
12 ~~8.2.~~

13 Section 10. That § 1-14-6.6 be repealed.

14 ~~1-14-6.6. The Division of Personnel within the former Department of Administration is~~
15 ~~abolished, and all its functions shall be administered by the Bureau of Personnel within the~~
16 ~~Department of Executive Management as provided by § 1-33-9.~~

17 Section 11. That § 1-14-11 be repealed.

18 ~~1-14-11. The officials and employees of the Bureau of Administration shall be allowed~~
19 ~~traveling expenses, board, and lodging incurred in performance of duty in accordance with~~
20 ~~chapter 3-9 when absent from their office.~~

21 Section 12. That § 1-14-12 be amended to read as follows:

22 ~~1-14-12. The Bureau of Administration shall be administered by the commissioner of~~
23 ~~administration and he shall:~~

24 ~~(1) Keep an exact and true inventory of all property, real and personal, belonging to the~~

1 State of South Dakota;

2 ~~(2) Prescribe uniform rules, as far as practicable, and not inconsistent with law,~~
3 ~~governing specifications for purchase of supplies, the advertisement for bids, the~~
4 ~~opening of bids, and the making of awards;~~

5 ~~(3) Inquire into and make inspection of all articles and material furnished any~~
6 ~~department, institution, or state agency, and work and labor performed, for the~~
7 ~~purpose of ascertaining that the price, quality, and amount of such articles or labor~~
8 ~~are fair, just, and reasonable, and that all requirements, expressed and implied,~~
9 ~~pertaining thereto have been complied with;~~

10 ~~(4) Provide such assistance, under the rules and regulations as hereinafter provided, as~~
11 ~~shall be necessary for the efficient performance of the official duties imposed upon~~
12 ~~the various departments and divisions by this code;~~

13 ~~(5) Supervise such central administrative services as transportation, mail and messenger~~
14 ~~services, microfilming, mimeographing and other reproduction services, typewriter~~
15 ~~and machine repair, disposal services for condemned and surplus property, and the~~
16 ~~providing of general office supplies. And whenever possible, he shall install central~~
17 ~~facilities to be used by all state agencies under such rules and regulations as the~~
18 ~~Bureau of Administration prescribes;~~

19 ~~(6) Contract for a lease or leases not to exceed three years to provide food services,~~
20 ~~candy, beverage, and tobacco concessions in the capitol building, capitol annex, Foss~~
21 ~~Building, Anderson Building, Soldiers and Sailors Memorial Building, Insurance~~
22 ~~Building, Department of Transportation Building, Public Safety Building, Kneip~~
23 ~~Building, MacKay Building, and the law enforcement training center and to supervise~~
24 ~~the fulfillment of the provisions of any such lease or leases. The issuance of such~~

1 contracts shall conform, as nearly as possible, with the requirements of chapters 5-18,
2 5-19, and 5-20;

3 ~~(7) Adopt rules in compliance with chapter 1-26 enumerating the types and classes of~~
4 ~~public personal property that shall be included in the inventory required by § 5-24-1;~~

5 ~~(8) Employ such staff and maintain facilities as necessary to operate a local government~~
6 ~~services program which shall provide or arrange for services for public corporations~~
7 ~~pursuant to the provisions of §§ 1-14-12, 1-14-12.12 to 1-14-12.18, inclusive, and 1-~~
8 ~~14-14 to 1-14-14.2, inclusive. The commissioner of administration shall administer~~
9 ~~the Bureau of Administration. The bureau shall:~~

10 (1) Keep an exact and true inventory of all property, real and personal, belonging to the
11 State of South Dakota and promulgate rules pursuant to chapter 1-26 enumerating the
12 types and classes of public personal property to be included in the inventory required
13 by § 5-24-1;

14 (2) Administer the procurement of supplies, services, and public improvements as
15 prescribed in chapters 5-18A, 5-18B, and 5-18D;

16 (3) Supervise such central administrative services as transportation, mail, records
17 management, and document reproduction services, make provisions for the supplying
18 of office supplies and furniture;

19 (4) Maintain the buildings and grounds of the capitol complex and install central
20 facilities to be used by all state agencies under such rules the Bureau of
21 Administration promulgates pursuant to chapter 1-26;

22 (5) Contract for the provision of food services, candy, and beverages in the capitol
23 complex;

24 (6) Supervise the administration of the Office of Hearings Examiners;

1 (7) Administer the federal surplus property allotted to the State of South Dakota;

2 (8) Provide for the lease of such real property as shall be necessary for the operation of
3 state government;

4 (9) Administer a program of risk management for state government;

5 (10) Contract for such services as are required by multiple state agencies, if such a
6 contract improves the efficiency of state government; and

7 (11) Any other function as may be required by statute, executive order, or administrative
8 action.

9 Section 13. That § 1-14-12.12 be repealed.

10 ~~—1-14-12.12. The Bureau of Administration, at the direction and under the control of the~~
11 ~~Governor, and subject to the provisions of §§ 1-14-12, 1-14-12.12 to 1-14-12.18, inclusive, and~~
12 ~~1-14-14 to 1-14-14.2, inclusive, may develop and administer the local government services~~
13 ~~program whose primary purpose shall be to serve statewide needs for local government services~~
14 ~~of all types as authorized to be provided by the laws of South Dakota. The Bureau of~~
15 ~~Administration may enter into contracts with public corporations of the state on a first in time~~
16 ~~basis as funding exists, as is reasonably practical and only when such corporation has been~~
17 ~~authorized to do so by the governing body of the public corporation. The commissioner of~~
18 ~~administration may coordinate and enter into agreements with persons and units of state~~
19 ~~government as may be necessary to provide services to public corporations of the state in the~~
20 ~~most cost-effective manner.~~

21 Section 14. That § 1-14-12.16 be amended to read as follows:

22 1-14-12.16. The operations of the Bureau of Administration in establishing and
23 administering §§ 1-14-12, 1-14-12.12 to 1-14-12.18, inclusive, and 1-14-14 to 1-14-14.2,
24 ~~inclusive,~~ this chapter shall be financed by means of appropriations, gifts, grants, or

1 reimbursements for services rendered. The fees and charges for services shall be designed, to
2 the extent practicable, to recover all operational costs incurred to carry out the provisions of the
3 contracts between public corporations and the Bureau of Administration.

4 Section 15. That § 1-14-12.18 be repealed.

5 ~~1-14-12.18. To effectuate the purposes of §§ 1-14-12, 1-14-12.12 to 1-14-12.18, inclusive,~~
6 ~~and 1-14-14 to 1-14-14.2, inclusive, all political subdivisions and public corporations of this~~
7 ~~state may provide and enter into an agreement for the joint exercise of governmental power with~~
8 ~~the Bureau of Administration.~~

9 Section 16. That § 1-14-13 be repealed.

10 ~~1-14-13. The commissioner of administration is empowered and it shall be his duty, to~~
11 ~~prescribe regulations, not inconsistent with law for the government of his bureau, the~~
12 ~~distribution and performance of its business, and the custody, use, and preservation of records,~~
13 ~~papers, books, and property pertaining thereto and on such other subjects as the law may~~
14 ~~specifically authorize him to make regulations.~~

15 Section 17. That § 1-14-14.1 be amended to read as follows:

16 1-14-14.1. Every political subdivision of this state may contract with the Bureau of
17 Administration pursuant to §§ ~~1-14-12, 1-14-12.12 to 1-14-12.18, inclusive, and 1-14-14 to 1-~~
18 ~~14-14.2, inclusive, this chapter~~ for the performances of all public services and functions
19 empowered by law for such subdivision. Each political subdivision may appropriate funds for
20 contracts pursuant to this section.

21 Section 18. That § 1-14-14.3 be repealed.

22 ~~1-14-14.3. Any state agency, department, board, commission, or school district operating~~
23 ~~a postsecondary vocational-technical school as authorized by chapter 13-39, that determines that~~
24 ~~an authorized amount of contributions, interest, or penalty is uncollectible may refer the~~

1 ~~collection process to a vendor approved by the Bureau of Administration. Reasonable fees for~~
2 ~~collection, as determined by the commissioner of the Bureau of Administration, shall be added~~
3 ~~to the amount of the debt and the debtor is liable for repayment of the total amount due~~
4 ~~including the collection fee.~~

5 Section 19. That § 1-14-14.4 be repealed.

6 ~~—1-14-14.4. A separate fund is hereby established in the state treasury for the purpose of~~
7 ~~receiving payment of expenses incurred for collecting uncollectible contributions, interest, or~~
8 ~~penalties, including the actual and necessary operating expenses of the Bureau of Administration~~
9 ~~and to make expenditures out of such accounts for such operating expenses. Money in the fund~~
10 ~~may be used to pay for the actual and necessary operating expenses of the collections program~~
11 ~~within the Bureau of Administration provided that the money is budgeted in accordance with~~
12 ~~state law and appropriated through the General Appropriations Act.~~

13 Section 20. That § 1-27-9 be amended to read as follows:

14 1-27-9. As Terms used in §§ 1-27-9 to 1-27-18, inclusive, mean:

15 (1) "Local record," ~~means~~ a record of a county, municipality, township, district,
16 authority, or any public corporation or political entity whether organized and existing
17 under charter or under general law, unless the record is designated or treated as a
18 state record under state law;

19 (2) "Record," ~~means~~ a document, book, paper, photograph, sound recording, or other
20 material, regardless of physical form or characteristics, made or received pursuant to
21 law or ordinance or in connection with the transaction of official business. Library
22 and museum material made or acquired and preserved solely for reference or
23 exhibition purposes, extra copies of documents preserved only for convenience of
24 reference, and stocks of publications and of processed documents are not included

1 within the definition of records as used in §§ 1-27-9 to 1-27-18, inclusive;

2 (3) "State agency" or "agency" or "agencies," includes all state officers, boards,
3 commissions, departments, institutions, and agencies of state government;

4 (4) "State record," means:

5 (a) A record of a department, office, commission, board, or other agency, however
6 designated, of the state government;

7 (b) A record of the State Legislature;

8 (c) A record of any court of record, whether of state-wide or local jurisdiction;

9 (d) Any other record designated or treated as a state record under state law.

10 Section 21. That § 1-27-11 be amended to read as follows:

11 1-27-11. There is hereby created a board consisting of the commissioner of administration,
12 state auditor, attorney general, auditor-general, and state archivist to supervise and authorize the
13 destruction of records. The state records manager shall also serve as an ex officio member in
14 an advisory capacity only. No record shall may be destroyed or otherwise disposed of by any
15 agency of the state unless it is determined by majority vote of ~~such~~ the board that the record has
16 no further administrative, legal, fiscal, research, or historical value.

17 Section 22. That § 1-27-11.1 be amended to read as follows:

18 1-27-11.1. The board created by § 1-27-11 shall be administered under the direction and
19 supervision of the Bureau of Administration and the commissioner thereof, ~~but~~. The board shall
20 retain the quasi-judicial, quasi-legislative, advisory, other nonadministrative and special
21 budgetary functions (as defined in § 1-32-1) otherwise vested in ~~it and~~ the board. The board
22 shall exercise those functions independently of the commissioner of administration.

23 Section 23. That § 1-27-13 be amended to read as follows:

24 1-27-13. The head of each agency shall submit to the commissioner of administration, in

1 accordance with the rules, ~~regulations~~, standards, and procedures established by ~~him~~ the
2 commission, schedules proposing the length of time each state record series warrants retention
3 for administrative, legal, or fiscal purposes after it has been received by the agency.

4 Section 24. That § 1-27-14 be amended to read as follows:

5 1-27-14. The head of each agency, also, shall submit lists of state records in his or her
6 custody that are not needed in the transaction of current business and that do not have sufficient
7 administrative, legal, or fiscal value to warrant further keeping for disposal in conformity with
8 the requirements of § 1-27-11.

9 Section 25. That § 1-27-14.1 be amended to read as follows:

10 1-27-14.1. Upon termination of employment with the state, each agency head shall transfer
11 his or her records to ~~his~~ a successor or to the state archives for appraisal and permanent
12 retention, ~~unless otherwise directed by law~~. The records of any state agency shall, upon
13 termination of its existence or functions, be transferred to the custody of the archivist, ~~unless~~
14 ~~otherwise directed by law~~.

15 Section 26. That § 1-27-14.2 be amended to read as follows:

16 1-27-14.2. ~~In any case where~~ If any material of actual or potential archival significance is
17 determined by a state agency to be ~~in jeopardy~~ at risk of destruction or deterioration, and ~~such~~
18 the material is not essential to the conduct of daily business in the agency of origin, the agency
19 head ~~shall have authority to~~ may transfer ~~said~~ the records to the physical and legal custody of
20 the state archivist ~~whenever~~ if the archivist is willing and able to receive ~~them~~ the records.

21 Section 27. That § 1-27-14.3 be amended to read as follows:

22 1-27-14.3. ~~Records~~ Any record transferred to the physical custody of the archivist ~~remain~~
23 remains the legal property of the agency of origin, subject to all existing copyrights and statutory
24 provisions regulating ~~their~~ the record's usage, until such time as the agency head formally

1 transfers legal title to the archivist.

2 Section 28. That § 1-27-15 be amended to read as follows:

3 1-27-15. ~~Nonrecord~~ Any nonrecord material or materials not included within the definition
4 of records as contained in § 1-27-9 may, ~~if not otherwise prohibited by law,~~ be destroyed at any
5 time by the agency in possession of such materials without the prior approval of the
6 commissioner of administration.

7 Section 29. That § 1-27-17 be amended to read as follows:

8 1-27-17. Upon request, the commissioner of administration shall assist and advise in the
9 establishment of records management programs in the legislative and judicial branches of state
10 government ~~and~~. The commissioner may, as required by ~~them~~ each branch, provide program
11 services similar to those available to the executive branch of state government pursuant to the
12 provisions of §§ 1-27-9 to 1-27-16, inclusive.

13 Section 30. That § 1-33-8.2 be repealed.

14 ~~— 1-33-8.2. The following divisions are abolished:~~

15 ~~— (1) — The Purchasing and Printing Division formerly authorized by chapter 1-14;~~

16 ~~— (2) — The Buildings and Grounds Maintenance Division formerly authorized by chapter 1-~~
17 ~~14;~~

18 ~~— (3) — The Central Administrative Services Division formerly authorized by chapter 1-14;~~

19 ~~— (4) — The Central Data Processing Division formerly authorized by chapter 1-14;~~

20 ~~— (5) — The Division of the State Engineer created by chapter 5-13;~~

21 ~~— (6) — The Division of the State Chemist created by the former § 13-57-12.~~

22 ~~— The Bureau of Administration shall, under the direction and control of the commissioner of~~
23 ~~administration, administer all the functions of the divisions enumerated above, but those~~
24 ~~functions shall not be reallocated into more than six divisions.~~

1 Section 31. That § 2-7-13 be repealed.

2 ~~2-7-13. The Bureau of Administration, in consultation with the Legislative Research~~
3 ~~Council, shall, before the commencement of any session of the Legislature, determine whether~~
4 ~~the house and senate bills and joint resolutions of the legislative session will be printed by a~~
5 ~~private contractor, and select the printing process to be used, or whether the documents will be~~
6 ~~prepared by the use of a duplicating process.~~

7 Section 32. That § 4-8-18 be amended to read as follows:

8 4-8-18. There is hereby created a capitol communications systems internal service fund to
9 encompass the operations of the capitol telephone system, ~~the capitol mail system,~~ and any and
10 all other capitol communication systems. The commissioner of the Bureau of ~~Administration~~
11 ~~is authorized to~~ Information and Telecommunications shall apportion all expenses encountered
12 in the operation of the capitol communications systems to all state departments, agencies, and
13 institutions ~~who~~ that utilize such systems.

14 Section 33. That chapter 1-14 be amended by adding thereto a NEW SECTION to read as
15 follows:

16 There is hereby created a central mail service fund to encompass the operations of the
17 capitol central mail system. The commissioner of the Bureau of Administration shall apportion
18 all expenses encountered in the operation of the capitol central mail system to all state
19 departments, agencies, and institutions that utilize the system.

20 Section 34. That § 5-14-2 be amended to read as follows:

21 5-14-2. The construction of all capital improvements projects as defined in § 5-14-1 of state
22 agencies, boards, commissions, and institutions ~~shall be~~ are under the general charge and
23 supervision of the Bureau of Administration as provided in this chapter, ~~and the funds.~~ Funds
24 appropriated shall be paid on warrants drawn by the state auditor on vouchers duly approved by

1 the Bureau of Administration and may also be approved by the authorized representative of the
2 agency, board, commission, or institution to which the project appropriation is made.

3 Section 35. That § 5-14-5 be amended to read as follows:

4 5-14-5. The Bureau of Administration, under the direction of the State Building Committee,
5 shall, at the request of any state board that expects to appear before the Legislature for the
6 purpose of asking for any appropriation for state buildings and improvements, prepare such
7 plans and specifications and have the ~~same~~ plans and specifications ready before the Legislature
8 meets for their information; ~~providing. If~~ the services of a licensed architect or engineer are
9 deemed to be necessary for this purpose, the building committee as provided in § 5-14-3 shall
10 designate such architect or engineer.

11 Section 36. That § 5-14-7 be repealed.

12 ~~5-14-7. A revolving account is hereby established in the state treasury for the purpose of~~
13 ~~receiving payment of expenses incurred for plans, specifications, and supervision of~~
14 ~~construction, including the actual and necessary expenses of the Bureau of Administration and~~
15 ~~to make expenditures out of such accounts for such expenses.~~

16 Section 37. That § 5-14-8 be amended to read as follows:

17 5-14-8. The various agencies, boards, commissions, and institutions ~~are authorized to~~ may
18 accept and expend in addition to the amounts provided for new construction at any of the
19 institutions under their jurisdiction, any funds which may be obtained from any gift or
20 contribution from any source for ~~said~~ that purpose.

21 Section 38. That § 5-14-8.1 be amended to read as follows:

22 5-14-8.1. The South Dakota State Fine Arts Council, the State Building Committee provided
23 for in § 5-14-3, and the Bureau of Administration, ~~are authorized to~~ may accept and expend for
24 the purpose of this chapter, any funds which it may obtain from federal sources, gifts,

1 contributions, or any other source for the acquisition and installation of works of art in state
2 buildings in which the works of art shall be an integral part of the building, attached to the
3 building, or capable of display in other state buildings.

4 Section 39. That § 5-14-9 be amended to read as follows:

5 5-14-9. The Bureau of Administration shall keep the original or a copy of the plans and
6 specifications of all state buildings, of all bids submitted, and of all contracts let for their
7 erection, ~~and. The bureau~~ shall prepare and keep itemized statements of the cost of construction
8 of all such buildings.

9 Section 40. That § 5-14-10 be amended to read as follows:

10 5-14-10. No money appropriated by the state ~~shall~~ may be expended for the erection of any
11 building upon land not previously owned by the state before title thereto ~~shall have been~~ has
12 conveyed to the state by a deed duly executed and acknowledged, granting the title in fee, clear
13 of all encumbrances, without any reversionary clause or condition whatever, and the attorney
14 general ~~shall have~~ has certified that the title acquired by the state conforms to the requirements
15 of this section.

16 Section 41. That § 5-14-12 be amended to read as follows:

17 5-14-12. The standards and specifications set forth in § 5-14-13 apply to all buildings and
18 facilities used by the public which are constructed in whole or in part by the use of state, county,
19 or municipal funds, or the funds of any political subdivision of the state. All such buildings and
20 facilities constructed or remodeled after January 26, 1992, shall conform to these standards.

21 ~~These standards and specifications shall be adhered to in those buildings and facilities which~~
22 ~~were in the planning stage on January 26, 1992, and for all new constructions.~~

23 Section 42. That § 5-14-13.1 be amended to read as follows:

24 5-14-13.1. All public buildings and facilities providing facilities for the wheelchair user,

1 including ~~but not limited to~~ entrance and exit facilities, shall display at all entrances the
2 internationally recognized symbol for wheelchair users.

3 Section 43. That § 5-14-14 be amended to read as follows:

4 5-14-14. ~~It shall be the responsibility of the~~ The administrator in charge of, and authorized
5 to contract for, new construction, remodeling, alteration, or addition on behalf of the political
6 subdivision involved to shall enforce the provisions of §§ 5-14-12 and 5-14-13.

7 Section 44. That § 5-14-17 be amended to read as follows:

8 5-14-17. ~~Every~~ Each department or agency of state government operating and maintaining
9 an electrical energy producing plant is ~~hereby authorized to~~ may enter into ~~such a contract or~~
10 ~~contracts~~ with the United States of America for the purchase of electrical energy ~~which~~
11 ~~contracts.~~ The contract may include stipulations that the generation of electrical energy may be
12 discontinued; ~~and.~~ The department or agency may maintain such ~~plants~~ a plant in a serviceable
13 operating condition for standby service for the generation of electrical energy ~~when~~ if required
14 so to do by the United States.

15 Section 45. That § 5-14-18 be amended to read as follows:

16 5-14-18. ~~Every~~ Any person who intentionally burns, destroys, or injures any public building
17 or improvement in this state is punishable as provided in § 22-34-1.

18 Section 46. That § 5-14-22 be amended to read as follows:

19 5-14-22. The state ~~shall have power to~~ may lease or sell on a negotiated basis and ~~to~~ convey
20 any of its real property to a municipality or county, or to a nonprofit local industrial
21 development corporation as defined by § 5-14-23 and located therein, to be used by such grantee
22 for an authorized public purpose or industrial development purpose as enumerated in § 9-54-1.
23 ~~Such~~ The lease shall be authorized on the terms and in the manner provided by the Legislature.
24 ~~Every~~ Each sale ~~shall be~~ is subject to approval by an act of the Legislature.

1 Section 47. That § 5-14-23 be amended to read as follows:

2 5-14-23. ~~Local~~ For the purposes of § 5-14-22, the term, local industrial development
3 corporation," ~~as that term is used in § 5-14-22,~~ is an enterprise incorporated under the laws of
4 the State of South Dakota, formed for the purpose of furthering the economic development of
5 a community and its environs, and with authority to promote and assist in the growth and
6 development of small business concerns in the areas covered by its operation. ~~Such~~ The
7 corporation shall be organized as a nonprofit enterprise and shall be composed of no fewer than
8 twenty-five members. A local industrial development corporation shall be principally composed
9 of and controlled by persons residing or doing business in the locality. Such persons shall
10 ordinarily constitute not less than seventy-five percent of the voting control of the local
11 development corporation. No member of the development corporation may own in excess of
12 twenty-five percent of the voting control in the development corporation if that member or that
13 member's affiliated interests have direct pecuniary interest in a project involving an application
14 under § 5-14-22. The primary objective of the local industrial development corporation ~~shall be~~
15 is to benefit the community as measured by increased employment, payroll, business volume,
16 and corresponding factors.

17 Section 48. That § 5-14-30 be amended to read as follows:

18 5-14-30. There is hereby established within the ~~bureau of administration~~ Bureau of
19 Administration the state-wide maintenance and repair fund. The ~~fund shall be maintained~~
20 ~~separately and be administered by the bureau of administration~~ bureau shall administer the fund
21 and maintain it separately in order to conduct maintenance and repair on state-owned buildings
22 pursuant to this chapter. The projects to receive funding shall be selected from a state-wide
23 maintenance and repair priority list developed by the ~~bureau of administration~~. The ~~board of~~
24 ~~regents~~ Board of Regents shall annually establish the priority for maintenance and repair

1 projects involving academic and revenue project buildings under its control. Any project of the
2 ~~board of regents~~ Board of Regents involving an academic building pursuant to § 13-51-1 may
3 be financed from the education facilities fund established under § 13-51-2 according to the order
4 of priority determined by the ~~board of regents~~. The ~~bureau of administration~~ Bureau of
5 Administration shall place on the prioritized list of projects to be financed through the
6 state-wide maintenance and repair fund any project involving an academic building that has not
7 been financed through § 13-51-2. The ~~board of regents~~ Board of Regents shall have charge of
8 the maintenance and repair of revenue bond project buildings as provided in chapter 13-51A.
9 However, in order to be eligible to receive funding, in whole or in part, from the state-wide
10 maintenance and repair fund, each agency, board, bureau, or department of state government,
11 including the ~~board of regents~~ Board of Regents, shall submit to the ~~bureau of administration~~
12 Bureau of Administration a complete list of all proposed maintenance and repair projects
13 notwithstanding other available funding sources for those projects. After the bureau of
14 ~~administration~~ determines which projects contained in the priority list are to receive funding,
15 those projects that are not to be funded through the state-wide maintenance and repair fund may
16 be financed by other funding sources. The priority list may be reprioritized if an emergency
17 arises and a written determination made by the bureau of ~~administration~~ of the basis for the
18 emergency is included with the state-wide maintenance and repair priority list.

19 Section 49. That § 5-15-1 be amended to read as follows:

20 5-15-1. The State of South Dakota declares that it is necessary that the capitol complex in
21 the city of Pierre be enlarged and beautified, ~~and the~~ The South Dakota Capitol Complex
22 Restoration and Beautification Commission ~~is charged with the duty of accomplishing~~ shall
23 accomplish that purpose in the manner provided by law ~~and herein set forth~~ this chapter.

24 Section 50. That § 5-15-1.1 be amended to read as follows:

1 5-15-1.1. The Capitol Complex Restoration and Beautification Commission shall be
2 administered under the direction and supervision of the Bureau of Administration and the
3 commissioner thereof, ~~but~~. The commission shall retain the quasi-judicial, quasi-legislative,
4 advisory, other nonadministrative and special budgetary functions ~~(, as defined in § 1-32-1)~~,
5 otherwise vested in it and shall exercise those functions independently of the commissioner of
6 administration.

7 Section 51. That § 5-15-2 be amended to read as follows:

8 5-15-2. ~~The Capitol Complex Restoration and Beautification Commission shall consist~~
9 commission consists of one nonappointed member, who shall be the mayor of Pierre or ~~his~~ the
10 mayor's designee, and seven appointed members, not all of whom may be of the same political
11 party, to be appointed by the Governor for a term of four years. ~~However, the terms of members~~
12 ~~who are first appointed after July 1, 1980, shall be: Two appointed for a term of one year; two~~
13 ~~appointed for a term of two years; and one for a term of four years, and initial terms shall be~~
14 ~~designated by the Governor.~~ Any member appointed to fill a vacancy arising from other than
15 the natural expiration of a term shall serve for only the unexpired portion of the term.

16 Section 52. That § 5-15-3 be amended to read as follows:

17 5-15-3. Each member of the ~~Capitol Complex Restoration and Beautification Commission~~
18 commission shall, within ten days after appointment, qualify by taking the oath of office and
19 giving bond to the state, with corporate surety, in the penal sum of twenty-five hundred dollars,
20 the cost to be paid by the state.

21 Section 53. That § 5-15-4 be amended to read as follows:

22 5-15-4. ~~The Capitol Complex Restoration and Beautification Commission~~ commission shall
23 meet at least twice each year and at such additional times as may be necessary. All meetings
24 shall be held at the state capitol, and a majority of its members ~~shall constitute~~ constitutes a

1 quorum. The commission shall choose a ~~chairman~~ chair, and one of its members as secretary,
2 who shall keep minutes of its meetings. ~~It~~ The commission shall make reports to the Governor
3 on the progress of its work, and to the Legislature.

4 Section 54. That § 5-15-5 be amended to read as follows:

5 5-15-5. The per diem and expenses of ~~Capitol Complex Restoration and Beautification~~
6 ~~Commission~~ commission members shall be paid by warrant of the state auditor by funds
7 appropriated therefor, on vouchers approved by the Bureau of Administration.

8 Section 55. That § 5-15-6 be amended to read as follows:

9 5-15-6. The Bureau of Administration shall employ such clerical and other help for the
10 ~~Capitol Complex Restoration and Beautification Commission~~ commission as in the bureau's
11 discretion seems necessary ~~and is hereby authorized and empowered to~~. The bureau may employ
12 such assistance and provide such supplies and equipment as may be necessary to properly carry
13 on the work of the commission.

14 Section 56. That § 5-15-7 be amended to read as follows:

15 5-15-7. ~~The Capitol Complex Restoration and Beautification Commission is authorized and~~
16 ~~directed to~~ commission shall make all necessary plans for the enlargement, restoration, and
17 beautification of the capitol complex or additions thereto, including uniform plans and
18 specifications for ~~the~~ its development ~~thereof~~.

19 Section 57. That § 5-15-8 be amended to read as follows:

20 5-15-8. ~~The Capitol Complex Restoration and Beautification Commission~~ commission shall
21 make recommendations for the development of areas immediately adjacent to the state capitol
22 complex and acquaint the people of South Dakota with the need and purpose of a
23 comprehensive long-range plan for capitol complex of sufficient and proper size to serve the
24 future needs of the state and to secure the proper growth and expansion of the city of Pierre. The

1 zone shall be designated the capitol area preservation zone and shall be zoned primarily for
2 residential purposes and for governmental purposes.

3 Section 58. That § 5-15-9 be amended to read as follows:

4 5-15-9. The ~~Capitol Complex Restoration and Beautification Commission~~ is hereby
5 ~~authorized and empowered to cause to be printed and distributed~~ commission may print and
6 distribute such pamphlets and leaflets and information as is proper and necessary to further and
7 advance the work, objects, and aims of the commission, and ~~to~~ acquaint South Dakota citizens
8 ~~therewith, by having the same ordered and supplied through the Bureau of Administration; to~~
9 with the commission. The Bureau of Administration shall supply the pamphlets and leaflets for
10 the commission. The commission may have maps, diagrams, drawings, sketches,
11 representations, preliminary surveys, and studies made in conjunction with ~~their~~ the
12 commission's work, and ~~to~~ do all the necessary things to effectuate the purposes and intent of
13 §§ 5-15-1 to 5-15-23, inclusive.

14 Section 59. That § 5-15-10 be amended to read as follows:

15 5-15-10. The ~~Capitol Complex Restoration and Beautification Commission~~ shall have the
16 ~~power to~~ commission may accept and receive gifts of money and contributions and donations
17 of real and personal property from any source, including the city of Pierre, South Dakota, a
18 municipal corporation, and the United States of America, and to use the same for the purposes
19 of §§ 5-15-1 to 5-15-23, inclusive; ~~to~~. The commission may deposit such moneys to the credit
20 of the commission, and ~~to~~ carry on a campaign for public contribution of such funds, and ~~to~~
21 expend moneys necessary therefor.

22 Section 60. That § 5-15-11 be amended to read as follows:

23 5-15-11. The ~~Capitol Complex Restoration and Beautification Commission~~ shall have the
24 ~~power to~~ commission may make all necessary surveys in connection with its work; ~~to~~, plat and

1 replat the area of the capitol complex acquired by the commission, or any part thereof, and to
2 open and dedicate streets to the use of the public in such area, granting easements therein and
3 use thereof to the city of Pierre, South Dakota, and to the public, for sewer, water, and
4 electricity, and other facilities; ~~to~~. The commission may vacate any streets or alleys in the
5 manner provided by law in the areas acquired by it the commission or bordering on or adjacent
6 thereto; ~~to~~. The commission may make agreements with the city for replacement of its facilities
7 in any vacated streets within the area; and ~~to~~ grant easements for erection and maintenance of
8 other necessary facilities and utilities.

9 Section 61. That § 5-15-12 be amended to read as follows:

10 5-15-12. The ~~Capitol Complex Restoration and Beautification Commission~~ shall have the
11 ~~power to~~ commission may acquire by gift or the exercise of the power of eminent domain in the
12 manner provided by law, ~~and not otherwise~~, real property necessary for the state capitol complex
13 enlarged as provided by the plans adopted by the commission, ~~and to~~ lease or manage any such
14 property, and ~~to~~ sell excess property of the commission.

15 Section 62. That § 5-15-13 be amended to read as follows:

16 5-15-13. The city of Pierre ~~shall have the power to~~ may convey, without compensation
17 therefor, to the state any property owned by it the city within the boundaries of the capitol
18 complex as enlarged pursuant to the plan adopted, and area determined, by the ~~Capitol Complex~~
19 ~~Restoration and Beautification Commission~~ commission.

20 Section 63. That § 5-15-14 be amended to read as follows:

21 5-15-14. The acts of the ~~Capitol Complex Restoration and Beautification Commission~~
22 commission in its exercise of the power of eminent domain on behalf of the state and in the
23 selection of the lands acquired in the action of condemnation heretofore brought by the
24 commission in the circuit court for Hughes County, South Dakota, to acquire unimproved land

1 in the area known as Hilger's Gulch in the city of Pierre adjacent to the existing capitol grounds,
2 are hereby confirmed as if heretofore expressly conferred and ~~said~~ the action is cured, validated,
3 and legalized from its inception.

4 Section 64. That § 5-15-15 be amended to read as follows:

5 5-15-15. The location of any building to be erected in the capitol complex shall be
6 determined by the majority vote of a board consisting of the Governor, ~~chairman~~ chair of the
7 ~~capitol complex restoration and beautification~~ commission, and the executive head or officer
8 of any of the branches of state government, or the ~~chairman~~ chair, commissioner, or head of any
9 department, board, commission or agency thereof, for which a new building is authorized to be
10 erected.

11 Section 65. That § 5-15-16 be amended to read as follows:

12 5-15-16. The ~~Capitol Complex Restoration and Beautification Commission~~ shall have the
13 ~~power to~~ commission may make and execute all contracts and other instruments which may be
14 required in connection with the enlargement, renovation, and beautification of the state capitol
15 grounds and other duties imposed upon the commission by §§ 5-15-1 to 5-15-23, inclusive.

16 Section 66. That § 5-15-17 be amended to read as follows:

17 5-15-17. The ~~Capitol Complex Restoration and Beautification Commission~~ shall have the
18 ~~power to~~ commission may lease, manage, control, and maintain any of the property heretofore
19 or hereafter acquired by it, and to execute lease, or rental agreements therefor as ~~it may deem~~
20 the commission deems advisable ~~not exceeding terms~~. No lease agreement may exceed a term
21 of two years, ~~which~~. The lease agreement shall be executed by the ~~chairman~~ chair and secretary.

22 Section 67. That § 5-15-18 be amended to read as follows:

23 5-15-18. The ~~Capitol Complex Restoration and Beautification Commission~~ shall have the
24 ~~power to~~ commission may sell unneeded or excess property of the commission other than real

1 property and to sever any buildings or structures from the land. The sale of any property by the
 2 commission shall be at public auction or upon sealed bids, to be held in Hughes County, South
 3 Dakota, to the highest bidder for cash. Notice of sale, containing terms of sale shall be given by
 4 the commission which shall be published in at least two of the official newspapers of ~~said~~ the
 5 county once a week for two successive weeks next before the day, on or after which the sale is
 6 to be made, which date, and the location where such auction will be held, shall be stated in the
 7 notice and shall be at least fifteen days from the first publication of notice. The right to reject
 8 any and all bids ~~shall be~~ is reserved. ~~The sale shall~~ A sale may not be made before the day set
 9 but shall be made within sixty days thereafter. ~~In the event~~ If bids or offers are used, the bids
 10 shall be in writing; and shall be filed in the office of the chairman or secretary of the
 11 commission in Pierre.

12 Section 68. That § 5-15-19 be amended to read as follows:

13 5-15-19. ~~The Capitol Complex Restoration and Beautification Commission~~ commission may
 14 make sales of structures, material, or property severed from the land, or other personal property
 15 to the public and to other state agencies, departments, or political subdivisions. Such sales to
 16 state agencies, departments, or political subdivisions shall follow the procedures for other sales;
 17 ~~except that.~~ However, no notice or advertisement for bid requirements or time of sale
 18 requirements ~~shall apply~~ applies to such sale. ~~When~~ If the sale of any such property agreed to
 19 by the commission ~~shall exceed~~ exceeds the sum of one hundred dollars, ~~such~~ the sale shall be
 20 submitted by the commission to the State Board of Finance for approval; and, if approved, a bill
 21 of sale may be executed by the commission.

22 Section 69. That § 5-15-20 be amended to read as follows:

23 5-15-20. ~~The Capitol Complex Restoration and Beautification Commission shall also have~~
 24 ~~power, as it may deem advisable, to~~ commission may dispose of, wreck, and destroy any

1 building acquired by it, its determination therefor to be approved by the State Board of Finance.

2 Section 70. That § 5-15-23 be amended to read as follows:

3 5-15-23. The ~~Capitol Complex Restoration and Beautification Commission~~ commission may
4 promulgate rules, pursuant to chapter 1-26, necessary and proper for the purposes of and not
5 inconsistent with §§ 5-15-1 to 5-15-20, inclusive.

6 Section 71. That § 5-15-24 be amended to read as follows:

7 5-15-24. ~~All that~~ A portion of the capitol grounds, as now exists and lies north of ~~Broadway~~
8 ~~in the city of Pierre shall hereafter~~ Church Street located in Hilger's Gulch shall be known as the
9 Governor's Grove. ~~It~~ The Governor's Grove shall, under the supervision of the Bureau of
10 Administration, be properly landscaped and parked and shall contain a grove of hardy,
11 long-lived trees, each one properly marked and maintained as a memorial grove to the past,
12 present, and future Governors of South Dakota, ~~and a~~. A new tree, as an addition to such grove,
13 shall be set out and properly dedicated on the first Arbor Day following the election of each
14 Governor ~~hereafter~~. This ~~park~~ grove shall be maintained as an adjunct to the ~~said~~ capitol
15 grounds and shall be used for no other memorial purpose than as is provided for in this section;
16 ~~provided, however, that~~. However, a gateway ~~thereto~~ to the grove may be provided in which
17 each county in the state shall be represented by a properly inscribed stone or marker.

18 Section 72. That § 5-15-25.1 be repealed.

19 ~~— 5-15-25.1. The Division of Veterans' Affairs shall cause to be constructed on the capitol~~
20 ~~grounds a suitable freedom memorial to the South Dakota Veterans, both living and dead, who~~
21 ~~have fought in all wars and conflicts in which the United States has engaged.~~

22 Section 73. That § 5-15-25.2 be repealed.

23 ~~— 5-15-25.2. Location of the memorial will be determined as provided by § 5-15-15.~~

24 Section 74. That § 5-15-25.3 be repealed.

1 ~~5-15-25.3. The Division of Veterans' Affairs is hereby authorized to accept gifts and private~~
2 ~~contributions for the purpose of financing this memorial. Such contributions as are received~~
3 ~~shall be deposited with the state treasurer and shall be kept by the state treasurer in a fund to be~~
4 ~~known as the veterans' freedom memorial fund, which fund shall accumulate and shall not revert~~
5 ~~to the general fund at the close of any fiscal year and such fund shall be used for the purpose of~~
6 ~~the construction of a South Dakota Veterans' Freedom Memorial carrying into effect the~~
7 ~~objectives of § 5-15-25.1. Disbursements from such fund shall be made by warrants drawn by~~
8 ~~the state auditor upon itemized vouchers duly approved by the director of veterans' affairs.~~

9 Section 75. That § 5-15-26 be amended to read as follows:

10 5-15-26. The commissioner of administration shall be the superintendent of the state capitol;
11 ~~and. The commissioner shall have the control, management manage, and supervision of~~
12 ~~supervise the buildings and grounds, and the employment of such. The commissioner shall~~
13 ~~employ engineers, carpenters, electricians, plumbers, mechanics, watchmen, policemen, elevator~~
14 ~~operators, guides, janitors, and other laborers as shall may be necessary for the proper care,~~
15 ~~safety, management, and maintenance of the capitol and grounds, and the public property there~~
16 ~~kept, and for the proper protection of the same properties from injury and deterioration.~~

17 ~~He shall, subject to chapter 3-6A, prepare and enforce the necessary rules fixing the details~~
18 ~~of service for all employees mentioned in this section.~~

19 Section 76. That § 5-15-31 be repealed.

20 ~~5-15-31. An emergency treatment station may be created in the state capitol complex for the~~
21 ~~purpose of providing adequate first aid and emergency treatment for state government officials~~
22 ~~and employees, and visitors.~~

23 Section 77. That § 5-15-32 be repealed.

24 ~~5-15-32. The secretary of health shall provide medical direction for the purposes of § 5-15-~~

1 ~~31, to include the establishment of a small nursing office in the state capitol building, the~~
2 ~~employment of a full-time registered nurse, and the training by said nurse of selected state~~
3 ~~employees in cardiopulmonary resuscitation and other emergency procedures.~~

4 Section 78. That § 5-15-33 be repealed.

5 ~~— 5-15-33. All funds expended pursuant to §§ 5-15-31 and 5-15-32 shall be paid out on~~
6 ~~warrants drawn by the state auditor on vouchers approved by the commissioner of~~
7 ~~administration or his designated agent.~~

8 Section 79. That § 5-15-34 be amended to read as follows:

9 5-15-34. The commissioner of administration may promulgate such rules and regulations
10 pursuant to chapter 1-26 as may be necessary to promote the health, safety, and general welfare,
11 to prohibit public intoxication, disturbances, and disorderly assemblies, to keep the peace, and
12 to declare what ~~shall constitute~~ constitutes a nuisance within the buildings of the capitol
13 complex and the capitol grounds. These ~~regulations~~ rules may include the regulation of hours
14 of general public accessibility to buildings within the capitol complex and the regulation of
15 obstruction, speed limits, and parking on the streets and alleys within the capitol grounds.

16 Section 80. That § 5-15-35 be amended to read as follows:

17 5-15-35. Any person who violates a ~~lawful order, rule, or regulation~~ promulgated pursuant
18 to § 5-15-34 commits a petty offense.

19 Section 81. That § 5-15-36 be amended to read as follows:

20 ~~5-15-36. The South Dakota Capitol Complex Restoration and Beautification Commission~~
21 ~~is hereby directed to~~ commission shall set policy for and oversee the restoration and
22 beautification of the state capitol complex, Pierre, South Dakota.

23 Section 82. That § 5-15-36.1 be amended to read as follows:

24 5-15-36.1. The ~~Capitol Complex Restoration and Beautification Commission~~ commission

1 shall approve any plan of renovation of the capitol complex before ~~such~~ the renovation may be
2 constructed.

3 Section 83. That § 5-15-44 be amended to read as follows:

4 5-15-44. The ~~South Dakota Capitol Complex Restoration and Beautification Commission~~
5 commission created by § 5-15-1 shall protect and preserve the integrity of the historic areas of
6 the state capitol building and shall, from time to time, propose restoration projects to restore
7 historic areas to their original appearance insofar as this objective is compatible with modern
8 use.

9 Section 84. That § 5-15-45 be amended to read as follows:

10 5-15-45. No person may alter, change, remodel, partition, cover, or conceal an historic area
11 which is a part of the state capitol building. In addition ~~to the above~~, no person ~~shall~~ may deny
12 access to an historic area traditionally open to the public by creating physical barriers to access
13 by the public except as may be necessary for public health, safety, or the safety of the property,
14 or for the orderly conduct of state business, without the approval of the ~~State Capitol Complex~~
15 ~~Restoration and Renovation Commission~~ commission. However, the commissioner of
16 administration temporarily may deny access to any area by the public or create temporary
17 barriers for a period up to ninety days if, in ~~his~~ the commissioner's judgment, it is necessary to
18 do so for the public health, safety, or the safety of the property, or to permit the orderly conduct
19 of state business.

20 Section 85. That § 5-15-50 be amended to read as follows:

21 5-15-50. The State of South Dakota accepts the gift of Mrs. Peter Norbeck of a bust of the
22 late United States Senator Norbeck and former Governor of this state, sculptured by the late
23 Gutzon Borglum, ~~the same~~ to be placed in a suitable place on the capitol grounds to be
24 determined by the ~~Capitol Complex Restoration and Beautification Commission~~ commission.

1 Section 86. That § 5-15-51 be amended to read as follows:

2 5-15-51. The granite statue of General William Henry Harrison Beadle, South Dakota
3 educator shall be permanently displayed in ~~the rotunda~~ of the state capitol on an appropriate
4 pedestal.

5 Section 87. That § 5-24-2 be amended to read as follows:

6 5-24-2. The inventories required by §§ 5-24-1 and 5-24-1.1 shall show the actual cost for
7 each item, or the estimated cost at the time of acquisition, if the actual cost cannot be
8 ascertained. In the case of gifts, the estimated fair market value at the time of acquisition shall
9 be used. The officer or employee shall retain one copy of the inventory in ~~his~~ the officer's or
10 employee's office. The others shall be filed; as provided in §§ 5-24-1.1 and 5-24-3.

11 Section 88. That § 5-24-5 be amended to read as follows:

12 5-24-5. ~~Whenever~~ If any article in the custody of any ~~such~~ officer or employee is lost or
13 destroyed, ~~he~~ the officer or employee shall make a note of the ~~same~~ loss or destruction in the
14 inventory for the current year, giving the date and circumstances of the loss or destruction.

15 Section 89. That § 5-24-6 be amended to read as follows:

16 5-24-6. ~~In the event of the disposition of any of the~~ If an officer or employee disposes of
17 personal property ~~above mentioned, by the respective officers,~~ without complying with the
18 requirements of this chapter, ~~such~~ the officer shall or employee, in addition to the penal penalty
19 prescribed by law, ~~he~~ is liable for the value thereof as shown by the last preceding inventory,
20 to be recovered in a civil suit.

21 Section 90. That § 5-24-7 be amended to read as follows:

22 5-24-7. ~~Every~~ Each officer enumerated in § 5-24-1, shall turn over all the public personal
23 property in ~~his~~ the officer's possession to ~~his~~ the officer's successor in office ~~and~~. Each officer
24 shall take the receipt of ~~his~~ the officer's successor for all property requiring inventory, as defined

1 in rules ~~issued~~ promulgated by the commissioner of the Bureau of Administration, ~~and~~. The
 2 officer shall file ~~such receipts~~ any receipt in the offices where ~~he~~ the officer is, by this chapter,
 3 required to file the inventory of the personal property in ~~his~~ the officer's possession.

4 ~~Every~~ Each officer enumerated in § 5-24-1 shall, upon assuming office, give a receipt to his
 5 or her predecessor for all public personal property requiring inventory, as defined in rules ~~issued~~
 6 promulgated by the commissioner of the Bureau of Administration, turned over to ~~him~~ the
 7 officer.

8 Section 91. That § 5-24-8 be amended to read as follows:

9 5-24-8. Any officer who fails to comply with any of the provisions of §§ 5-24-1 to 5-24-7,
 10 inclusive, ~~shall be~~ is guilty of a Class 2 misdemeanor.

11 Section 92. That § 5-24-11 be repealed.

12 ~~— 5-24-11. A capitol building supply room is hereby established for the purpose of supplying~~
 13 ~~office materials to the various departments of state government operating in the capitol building~~
 14 ~~and its various additions and extensions in Pierre, South Dakota. The supply room shall be~~
 15 ~~under the control and direction of the commissioner of administration and shall be open for the~~
 16 ~~convenience and service of the departments of state government during such hours as the~~
 17 ~~commissioner considers necessary. The payment for supplies purchased for the various~~
 18 ~~departments shall be made once each month to a supply internal service fund, which is hereby~~
 19 ~~created, and set aside by the treasurer and auditor of the State of South Dakota. For the purpose~~
 20 ~~of establishing this department and fund, seven thousand dollars has been appropriated to be~~
 21 ~~designated as a supply internal service fund.~~

22 Section 93. That chapter 1-14 be amended by adding thereto a NEW SECTION to read as
 23 follows:

24 The Bureau of Administration may provide a central supply program for the purpose of

1 supplying office materials to the various departments of state government. There is created a
2 supply internal service fund. The payment for supplies purchased for the various departments
3 shall be made once each month to the supply internal service fund.

4 Section 94. That § 5-24-13 be amended to read as follows:

5 5-24-13. The commissioner of administration ~~shall have the duty and power to~~ shall
6 cooperate with the United States government, the general services administration, or any other
7 duly constituted federal agency ~~thereof~~, by expending moneys and accepting federal surplus
8 commodities and property for care, exchange, and distribution of ~~same~~ them to all eligible
9 institutions. The commissioner of administration shall appoint an administrator who shall keep
10 and maintain an accurate record of all property received and distributed, ~~and the~~. The record
11 ~~shall be~~ is subject to audit by the Department of Legislative Audit.

12 Section 95. That § 5-24-16 be repealed.

13 ~~5-24-16. The provisions of § 4-8-21 do not apply to the funds appropriated by SL 2004, ch~~
14 ~~64, for the payment of insurance premiums. If by June 30, 2008, the funds appropriated by this~~
15 ~~Act for the payment of insurance premiums are not contractually obligated as a part of a written~~
16 ~~agreement between the owners of the former Homestake Mine and the authority whereby the~~
17 ~~owners will agree to convey portions of the former mine to the authority upon the terms and~~
18 ~~conditions to be set forth in the agreement, or if by June 30, 2008, the funds are contractually~~
19 ~~obligated but the written agreement is thereafter terminated by mutual agreement of the~~
20 ~~authority and the former owners of the mine, the funds appropriated by SL 2004, ch 64, for the~~
21 ~~payment of insurance premiums shall revert to the state general fund.~~

22 Section 96. That § 5-24-21 be repealed.

23 ~~5-24-21. The provisions of § 4-8-21 do not apply to the funds appropriated by SL 2004, ch~~
24 ~~14. If by June 30, 2008, the state funds appropriated by SL 2004, ch 14, are not contractually~~

1 obligated by a written agreement as provided by SL 2004, ch 14, or if by June 30, 2008, the state
2 funds are contractually obligated but the written agreement is thereafter terminated by mutual
3 agreement of the authority and the owners of the former mine, the state funds appropriated by
4 SL 2004, ch 14, shall revert to the state general fund.

5 Section 97. That § 5-25-2 be amended to read as follows:

6 5-25-2. Each office, department, institution, board, and agency of this state operating a
7 state-owned passenger automobile or automobiles motor vehicle shall keep and maintain in its
8 respective office:

- 9 (1) Accurate records of its cost of operation of ~~said automobile or automobiles~~ the motor
10 vehicle;
- 11 (2) Travel reports showing destination and miles traveled each day according to
12 speedometer registration and the total speedometer mileage at the beginning and at
13 the end of each travel period, together with all operating expenses incurred for that
14 period.

15 A copy of such travel report shall be attached to the claim or claims presented for
16 reimbursement of the travel expense covered thereby.

17 Section 98. That § 5-25-2.1 be repealed.

18 ~~5-25-2.1. All state officers and employees shall buy gasoline at self-service islands when~~
19 ~~operating a state-owned vehicle whenever circumstances permit. Such officers and employees~~
20 ~~shall be responsible as to such vehicle in their possession or under their control for performing~~
21 ~~the maintenance duties thereon ordinarily performed at non-self-service islands.~~

22 Section 99. That § 5-25-3 be repealed.

23 ~~5-25-3. The Governor is hereby authorized to effect a saving of tires, gasoline, and expense~~
24 ~~in the use of motor vehicles employed in any manner in the service of the State of South Dakota,~~

1 ~~whether owned by the state or owned by private individuals and used in state service, by~~
2 ~~appointing a commission or commissions, and such officers and employees as may be necessary,~~
3 ~~and by making such executive orders or promulgating such rules and regulations as to him may~~
4 ~~seem necessary to accomplish the purposes and intent of this section. Any or all officers or~~
5 ~~employees of the State of South Dakota may be appointed by the Governor to assist in the~~
6 ~~performance of the duties prescribed by §§ 5-25-4 to 5-25-6, inclusive, and without additional~~
7 ~~compensation.~~

8 Section 100. That § 5-25-4 be amended to read as follows:

9 5-25-4. ~~Without in any manner limiting the general powers hereinbefore prescribed, the~~
10 ~~Governor is authorized to fix the rate of pay for use of privately owned vehicles when a single~~
11 ~~person is using the vehicle, and on an ascending scale when additional passengers are carried;~~
12 ~~to grant or refuse permits to travel by motor vehicle at state expense; to require payments of the~~
13 ~~expense of said travel from different departments, officers, and agencies of the state when their~~
14 ~~personnel is traveling with other motor vehicles; to set up and The Bureau of Administration~~
15 ~~shall maintain an internal service fund under the supervision of the commissioner of~~
16 ~~administration to collect and disburse mileage payments and motor vehicle disbursements~~
17 ~~equitably between the several departments, agencies, and officers of the state; and to require~~
18 ~~travel by public conveyances when same are available.~~

19 Section 101. That § 5-25-5 be repealed.

20 ~~— 5-25-5. The provisions of chapter 49-28 shall not apply to carriage of passengers under the~~
21 ~~provisions of §§ 5-25-3 and 5-25-4.~~

22 Section 102. That § 5-25-6 be repealed.

23 ~~— 5-25-6. All state departments, agencies, officers, and employees, are hereby required to~~
24 ~~comply with the orders or with the rules and regulations which may be made or promulgated~~

1 under §§ 5-25-3 and 5-25-4, and no expense of operation of state-owned or privately owned
2 motor vehicles in state service shall be paid in cases where the provisions of said sections or
3 orders, rules, or regulations made thereunder, are not complied with.

4 Section 103. That § 5-25-7 be repealed.

5 ~~5-25-7. The provisions of §§ 5-25-3 to 5-25-6, inclusive, shall not apply to the legislative
6 or judicial departments of the state government.~~

7 Section 104. That § 23-3-2 be repealed.

8 ~~23-3-2. The commissioner of the Bureau of Administration shall designate one or more
9 persons from among the employees of the Bureau of Administration regularly employed in and
10 about the capitol and grounds who shall, upon taking and subscribing an oath to support the
11 Constitution of the United States and this state and to faithfully discharge the duties of the office
12 of policeman, be empowered to do and perform any duty which might be performed by a
13 policeman of any municipality in this state and to enforce the rules and regulations of the
14 commissioner of administration; provided that such person so appointed shall exercise the duties
15 of policemen only within the capitol complex and upon the capitol grounds.~~

16 Section 105. That § 1-15-10 be amended to read as follows:

17 1-15-10. The Department of Corrections may make contracts for service, the erection of
18 buildings, the purchase and lease of lands, materials and supplies needed, except such supplies
19 as are under the supervision of the Bureau of Administration as prescribed by chapter 5-23; and
20 ~~in carrying out such contracts~~ 5-18B. The department may expend money, exact and collect
21 penalties, and purchase, lease, and sell property within the limitations of the state and national
22 laws to carry out such contracts.

23 Section 106. That § 1-18C-5.1 be amended to read as follows:

24 1-18C-5.1. The State Historical Society Board of Trustees shall, pursuant to chapter 1-26,

1 promulgate rules to ~~identify the permanent public records subject to § 5-23-22.2 and to specify~~
 2 ~~how the notice provided for in § 5-23-22.2 shall be displayed~~ require any state agency
 3 publishing a document meant to be a permanent public record to print the document on a
 4 permanent type of paper and to specify the type of permanent paper to be used for each
 5 document. The state agency shall note the use of such paper in each document.

6 Section 107. That § 1-33B-9 be amended to read as follows:

7 1-33B-9. Guaranteed energy savings contracts are not subject to the requirements of ~~chapters~~
 8 ~~5-18 and 5-23~~ chapter 5-18A.

9 Section 108. That § 1-36A-1.11 be amended to read as follows:

10 1-36A-1.11. The Department of Human Services may make contracts for service, the
 11 erection of buildings, the purchase and lease of lands, materials, and supplies needed, except
 12 such supplies as are under the supervision of the Bureau of Administration as prescribed by
 13 ~~chapter 5-23; and in carrying out such contracts~~ 5-18B. The department may expend money,
 14 exact and collect penalties and may purchase, lease and sell property within the limitations of
 15 the state and national laws to carry out such contracts.

16 Section 109. That § 1-36A-7 be amended to read as follows:

17 1-36A-7. The Department of Human Services shall, under the direction and control of the
 18 secretary of human services, perform all the functions of the following former agencies:

- 19 (1) The Division of Service to the Blind and Visually Impaired, created by chapter 28-
 20 10;
- 21 (2) The Division of Vocational Rehabilitation, created by chapter 28-9; and
- 22 (3) ~~The committee on state purchases from service to the blind, created by chapter 5-20;~~
- 23 ~~—(4)—~~The disability determination services program in chapter 28-11.

24 Section 110. That § 2-16-7 be amended to read as follows:

1 2-16-7. Notwithstanding ~~chapter 5-18~~ chapters 5-18A and 5-18D, the South Dakota Code
2 Commission may draft specifications for material authorized for publication by § 2-16-6 and
3 advertise for and accept bids from editorial, printing, and publishing companies for production
4 of all material authorized by this chapter. The advertisement for bids shall be published twice
5 in at least three newspapers of general circulation in different parts of the state, and in such
6 additional manner as the commission may determine. The terms and conditions of the bids shall
7 be prescribed by the commission. Each contract shall be awarded to the lowest bidder which,
8 in the opinion of the commission, is the best bid consistent with the quality of editorial services,
9 printing, paper, binding, expeditious service and the best interests of the state. If the contract for
10 editorial services is separate from the contract for printing, the specifications shall be drawn in
11 such a manner as not to exclude South Dakota printing firms.

12 Section 111. That § 4-11-7 be amended to read as follows:

13 4-11-7. Nothing contained in this chapter ~~shall prevent~~ prevents a public corporation, ~~as~~
14 ~~defined in § 5-18-1~~, from employing a private accountant to examine and audit the books and
15 accounts thereof or of any of its officers ~~whenever~~ if the governing body or authorized official
16 ~~thereof~~ believes that the public interest requires it, provided and if such employment is first
17 approved by the auditor-general ~~within his guidelines; and, except as hereinafter provided, such~~.
18 No private audit shall not may be paid for before a copy thereof ~~shall have been~~ is filed with and
19 approved by the auditor-general. The entity receiving audit services may approve progress
20 payments proportionate to the audit work completed so long as ten percent of the amount billed
21 is withheld pending approval by the auditor-general of the final report. The auditor-general may,
22 ~~in his discretion~~, accept such audit in lieu of an examination otherwise required to be made by
23 ~~him~~ the auditor-general.

24 Section 112. That § 6-1-2 be amended to read as follows:

1 6-1-2. The provisions of § 6-1-1 are not applicable if the contract is made pursuant to any
2 one of the conditions set forth in the following subdivisions, without fraud or deceit, ~~but,~~
3 However, the contract is voidable if the provisions of the applicable subdivision ~~were~~ are not
4 fully satisfied or present at the time the contract was entered into:

5 (1) Any contract involving three thousand dollars or less regardless of whether other
6 sources of supply or services are available within the county, municipality, township,
7 or school district, if the consideration for such supplies or services is reasonable and
8 just;

9 (2) Any contract involving more than three thousand dollars but less than the amount for
10 which competitive bidding is required, and there is no other source of supply or
11 services available within the county, municipality, township, or school district if the
12 consideration for such supplies or services is reasonable and just and if the
13 accumulated total of such contracts paid during any given fiscal year does not exceed
14 the amount specified in ~~§ 5-18-3~~ § 5-18A-14;

15 (3) Any contract with any firm, association, corporation, or cooperative association for
16 which competitive bidding is not required and where other sources of supply and
17 services are available within the county, municipality, township or school district,
18 and the consideration for such supplies or services is reasonable and just, unless the
19 majority of the governing body are members or stockholders who collectively have
20 controlling interest, or any one of them is an officer or manager of any such firm,
21 association, corporation, or cooperative association, in which case any such contract
22 is null and void;

23 (4) Any contract with any firm, association, corporation, or cooperative association for
24 which competitive bidding procedures are followed pursuant to chapter ~~5-18~~ 5-18A

1 or 5-18B, and where more than one such competitive bid is submitted;

2 (5) Any contract for professional services with any individual, firm, association,
3 corporation, or cooperative, if the individual or any member of the firm, association,
4 corporation, or cooperative is an elected or appointed officer of a county,
5 municipality, township, or school district, whether or not other sources of such
6 services are available within the county, municipality, township, or school district,
7 if the consideration for such services is reasonable and just;

8 (6) Any contract for commodities, materials, supplies, or equipment found in the state
9 ~~price~~ contract list established pursuant to ~~§ 5-23-8.1~~ § 5-18D-6, at the price there
10 established or below; and

11 (7) Any contract or agreement between a governmental entity specified in § 6-1-1 and
12 a public postsecondary educational institution if an employee of the Board of Regents
13 serves as an elected or appointed officer for the governmental entity, and if the
14 employee does not receive direct compensation or payment as a result of the contract
15 or agreement.

16 Section 113. That § 7-25-7 be amended to read as follows:

17 7-25-7. ~~Whenever~~ If any county building is to be constructed, the board shall proceed as
18 required by chapter ~~5-18~~ 5-18B. The time specified for opening of bids ~~must~~ shall be at one of
19 the regular or duly adjourned sessions of the board.

20 Section 114. That § 7-25-9 be amended to read as follows:

21 7-25-9. Each bid shall contain a certified check, cashier's check, or bank money order, in the
22 sum equal to five percent of the amount of the bid. The check or money order shall be certified
23 or issued by either a state or national bank domiciled within this state made payable to the
24 county or the county treasurer ~~thereof~~. In lieu of a check or money order, a bid bond for ten

1 percent of the bid may be submitted. The bond shall be issued by a surety authorized to do
2 business in this state and payable to the county or the county treasurer ~~thereof~~ as a guaranty that
3 the bidder will enter into contract ~~should it be~~, if the contract is awarded to him the bidder, and
4 furnish a bond as ~~herein~~ provided by this chapter. ~~Should~~ If the successful bidder ~~forfeit his~~
5 forfeits a check, money order, or bid bond, the proceeds of the ~~same~~ check, money order, or bid
6 bond shall be turned into the county general fund. The ~~checks, money orders or bid bonds of all~~
7 ~~the unsuccessful bidders~~ check, money order, or bid bond of each unsuccessful bidder shall be,
8 by the board, immediately returned to the ~~respective makers thereof~~ bidder. No more time may
9 elapse between the opening of the bids and either the acceptance of the bid of the lowest
10 responsible bidder, or the rejection of all bids presented than is permitted in ~~§ 5-18-7~~
11 subdivision 5-18A-5(7).

12 Section 115. That § 9-39-20 be amended to read as follows:

13 9-39-20. The provisions of chapter ~~5-18~~ 5-18A relating to advertisement for bids and §§ 6-1-
14 1 to 6-1-4, inclusive, relative to participation in contracts by members of the governing body,
15 ~~shall~~ apply to contracts of and members of municipal utility boards.

16 Section 116. That § 9-41-1.1 be amended to read as follows:

17 9-41-1.1. Notwithstanding the provisions of chapter ~~5-18~~ 5-18A or any of the provisions of
18 Title 9 regarding the sale and purchase of property, a municipality operating a telephone system
19 pursuant to § 9-41-1 may lease and purchase equipment for resale to its customers and may
20 contract for services relating to the lease, purchase, sale, installation, and maintenance of ~~the~~
21 ~~same~~ such property, in a manner and for a price and terms determined by the governing body.
22 If practicable the governing body shall secure at least two competitive quotations and retain
23 them for its files.

24 Section 117. That § 9-42-4 be amended to read as follows:

1 9-42-4. ~~Whenever~~ If any local improvement ~~except other than~~ a sidewalk or bulkhead is
 2 ordered by the governing body, it the governing body shall have plans and specifications
 3 prepared and filed in the office of the auditor or clerk ~~and~~. The governing body shall designate
 4 a time, not less than two weeks from the date of the filing, at which sealed bids for the
 5 construction of the improvement will be received.

6 ~~It~~ The governing body shall publish notice in the official paper, or elsewhere if deemed
 7 advisable, in accordance with the provisions of ~~chapter 5-18~~ chapters 5-18A and 5-18B. The
 8 notice shall specify whether the improvement ~~will~~ shall be paid for in cash or by special
 9 assessment certificates and the rate of interest which the certificates ~~will~~ shall bear.

10 Section 118. That § 9-42-5 be amended to read as follows:

11 9-42-5. ~~All contracts~~ Any contract for the construction or repair of a public buildings
 12 building or for public works or improvements, and ~~all contracts~~ any contract for material used
 13 therefor and equipment purchased or rented in connection therewith, and ~~all contracts~~ any
 14 contract for local improvements for which a special assessments are assessment is to be levied,
 15 except as ~~herein~~ provided in this chapter and as provided in ~~chapter 5-18~~, must chapters 5-18A
 16 and 5-18B, shall be let to the lowest responsible bidder in accordance with the provisions of ~~said~~
 17 ~~chapter 5-18~~ chapters 5-18A and 5-18B.

18 The governing body ~~shall have the right to~~ may reject ~~any and~~ all bids and ~~to~~ readvertise for
 19 proposals, if none of the bids are satisfactory or if ~~they believe~~ the governing body believes any
 20 agreement has been entered into between the bidders to prevent competition.

21 Section 119. That § 9-46-4 be amended to read as follows:

22 9-46-4. If such sidewalk is not constructed, reconstructed, or repaired in the manner and
 23 within the time prescribed pursuant to § 9-46-3, the governing body by resolution may cause the
 24 work to be done by day labor or by job. If the amount of the contract is less than the amount

1 provided for in ~~§ 5-18-3~~ § 5-18A-14, it is not necessary to advertise for bids.

2 Section 120. That subdivision (4) of § 10-46-1 be amended to read as follows:

3 (4) "Fair market value," the price at which a willing seller and willing buyer will trade.

4 Fair market value shall be determined at the time of purchase. If a public corporation
5 is supplying tangible personal property or any product transferred electronically that
6 will be used in the performance of a contract, fair market value shall be determined
7 pursuant to ~~§ 5-18-5.1~~ § 5-18B-7. This definition also applies to chapter 10-45;

8 Section 121. That § 11-7-44 be amended to read as follows:

9 11-7-44. ~~All~~ Any construction work, and work of demolition or clearing, and ~~every~~ any
10 purchase of equipment, supplies, or materials, necessary in carrying out the purposes of this
11 chapter, shall be awarded pursuant to the provisions of ~~chapter 5-18~~ chapters 5-18A and 5-18B.

12 Section 122. That § 13-16-6.1 be amended to read as follows:

13 13-16-6.1. Notwithstanding the provisions of chapters ~~5-18~~ 5-18A and 13-20, if any
14 proposed installment purchase contract or lease-purchase agreement authorized under chapter
15 13-16, is to be entered into by a school district, the notice for bidders shall require the bidders
16 to state the rate of interest and the installment payment or lease-purchase schedule that would
17 have to be made by the school district in fulfillment of the contract. However, the requirement
18 of this section does not apply to any installment purchase or lease-purchase to be entered into
19 between a school district and the health and educational facilities authority.

20 Section 123. That § 13-16-9.3 be amended to read as follows:

21 13-16-9.3. Any school district using the capital outlay fund for payment of construction of
22 new facilities or construction of additions to facilities, the total of which ~~will require~~ requires
23 advertising for bids under chapter ~~5-18~~, must 5-18A, shall have a public hearing at least ten days
24 prior to the advertisement of any contract specifications. ~~Such~~ The public hearing shall be

1 advertised in the legal newspaper of the school district. Following ~~such~~ the public hearing, and
2 approval of the school board, the school district may use the capital outlay fund as provided in
3 § 13-16-6; ~~provided, however, that a.~~ No school district may ~~not~~ change the originally
4 advertised use of the fund without holding another public hearing.

5 Section 124. That § 13-20-3 be amended to read as follows:

6 13-20-3. Except for purchases made pursuant to chapter 13-34, ~~whenever~~ if any school
7 facilities are to be built or remodeled, or improvements are to be made to school sites, or ~~when~~
8 if supplies or equipment are to be purchased ~~contracts shall be let, the school board shall let~~
9 contracts in accordance with ~~chapter 5-18~~ chapters 5-18A and 5-18B and in accordance with
10 plans and specifications ~~that shall be~~ furnished by the ~~school~~ board.

11 Section 125. That § 13-20-4 be amended to read as follows:

12 13-20-4. ~~Whenever~~ If an emergency maintenance need arises caused by wind, hail, fire,
13 theft, explosion, deterioration resulting in sudden destruction to a vital piece of school
14 equipment, or a traffic accident which would necessitate the closing of school while ~~it~~ the school
15 would otherwise be in session, or which ~~will~~ would endanger the usefulness of remaining school
16 property, the school board may take immediate action to correct such emergency maintenance
17 need in accordance with the procedures provided in chapter ~~5-18~~ 5-18A. An emergency
18 maintenance need ~~shall~~ does not include the replacement of an entire school building.

19 Section 126. That § 13-20-6 be amended to read as follows:

20 13-20-6. The purchase of copyrighted material need not be submitted for bids as provided
21 in § 13-20-3 and chapter ~~5-18~~ 5-18A ~~if~~ if only one company publishes the copyrighted
22 material to be purchased.

23 Section 127. That § 13-20-7 be amended to read as follows:

24 13-20-7. ~~When~~ If supplies or equipment are to be purchased, a school board advertising

1 pursuant to § 13-20-3 may require a reasonable deposit guaranteeing the execution of contract
 2 and the furnishing of a performance bond by the successful bidder in accordance with chapters
 3 ~~5-18~~ 5-18A and 5-21. The board may accept an annual bond ~~provided that it~~ if the bid meets the
 4 requirements of chapters ~~5-18~~ 5-18A and 5-21. The board ~~shall reserve the right to~~ may reject
 5 any and all bids.

6 Section 128. That § 13-20-7.1 be amended to read as follows:

7 13-20-7.1. ~~When~~ If school facilities are to be built or remodeled or improvements are to be
 8 made to school sites, the school board advertising pursuant to § 13-20-3 shall require a
 9 reasonable deposit guaranteeing the execution of the contract and the furnishing of a
 10 performance bond by the successful bidder in accordance with chapters ~~5-18 and 5-21~~ 5-18A
 11 and 5-18B. The board ~~shall reserve the right to~~ may reject any and all bids.

12 Section 129. That § 13-49-16 be amended to read as follows:

13 13-49-16. ~~All contracts~~ Any contract for the erection and repair of ~~buildings~~ any building
 14 and the purchase of ordinary supplies shall be let in accordance with ~~chapter 5-18~~ chapters 5-
 15 18A and 5-18B except in the case of coal needed by the institutions.

16 Section 130. That § 13-49-34 be amended to read as follows:

17 13-49-34. Notwithstanding the provisions of ~~chapters 5-23 or 5-24~~ chapter 5-24A, if the
 18 Board of Regents assesses a special student fee to students in order to lease personal computers
 19 for the use of those students at a university, the Board of Regents may, upon the expiration of
 20 the lease, acquire the computers and offer them for resale to students, staff, or alumni through
 21 a university bookstore or to any political subdivision of the state or in bulk at fair market value
 22 on the resale market.

23 Section 131. That § 23A-37-13 be amended to read as follows:

24 23A-37-13. Any controlled weapon or firearm used in violation of chapter 22-14 shall be

1 disposed of as follows:

- 2 (1) If it is stolen, it shall be returned to the lawful owner upon proof of ownership; ~~or~~
- 3 (2) If it is illegal, it shall be destroyed pursuant to law; or
- 4 (3) If it is neither stolen nor illegal, it shall be delivered to the arresting agency or, at the
- 5 direction of the attorney general, to the South Dakota Forensic Laboratory for
- 6 scientific examination purposes, for lawful use or disposal.

7 In the case of a disposition pursuant to subdivision (3), the arresting agency or forensic
8 laboratory may use, trade-in, destroy, or sell, as provided in ~~§ 5-23-32, 5-24-9.2 or chapter 5-~~
9 24A or § 6-13-6, the controlled weapon or firearm.

10 Section 132. That § 23A-40-7 be amended to read as follows:

11 23A-40-7. The board of county commissioners of each county and the governing body of
12 any municipality shall provide for the representation of indigent persons described in § 23A-40-
13 6. ~~They~~ The board or body shall provide this representation by any or all of the following:

- 14 (1) Establishing and maintaining an office of a public defender;
- 15 (2) Arranging with the courts in the county to appoint attorneys on an equitable basis
- 16 through a systematic, coordinated plan; or
- 17 (3) Contracting with any attorney licensed to practice law in this state.

18 In those counties which have established an office of public defender, any proceedings after
19 judgment may be assigned to the public defender. The provisions of ~~§ 5-18-2~~ chapter 5-18A do
20 not apply to this section.

21 Section 133. That § 31-12-12 be amended to read as follows:

22 31-12-12. Any road, tile, ~~and~~ or culvert construction, repair work, or materials ~~therefor~~ upon
23 the county highway system, for which the county highway superintendent's estimated cost equals
24 or is less than the amount provided for in ~~§ 5-18-3~~ § 5-18A-14, may be advertised and let at a

1 public letting by the board of county commissioners, may be let privately at a cost not to exceed
2 the county highway superintendent's estimate, or may be built by day labor.

3 Section 134. That § 31-12-13 be amended to read as follows:

4 31-12-13. Any road, tile, or culvert construction, repair work, or materials therefor on the
5 county highway system, for which the county highway superintendent's estimated cost exceeds
6 the amount provided for in ~~§ 5-18-3~~ § 5-18A-14, shall be advertised and let at a public letting
7 by the board of county commissioners or may be built by day labor. The board may reject all
8 bids, in which ~~event it~~ case the board may readvertise or let privately by submitting the contract
9 to the Department of Transportation for approval.

10 Section 135. That § 31-12-14 be amended to read as follows:

11 31-12-14. If the cost of any road, bridge, tile, or culvert construction, repair work, or
12 materials upon a county highway system or secondary roads exceeds the amount provided for
13 in ~~§ 5-18-3~~ § 5-18A-14 or any less amount for which work bids are to be called for, and after
14 plans and specifications therefor have been prepared and filed in the office of the county auditor,
15 the board having charge shall designate a time not less than twenty days from the date of such
16 filing, at which sealed bids for such work or materials will be received, ~~and~~ The board shall
17 cause notice thereof to be published once each week for two successive weeks in one of the
18 official newspapers of the county. ~~Such~~ The notice shall state where plans and specifications
19 may be examined, when and where bids will be opened, a brief statement of the principal items
20 of work and materials contemplated by the improvement, and the location of the same, the
21 amount of the certified check or bidder's bond to be required, and such further notice as the
22 board having supervision may deem advisable. Bids may be received at any special or regular
23 meeting of ~~such~~ the board. ~~Such~~ The board may ~~in its discretion~~ refuse to accept any bids
24 submitted.

1 Section 136. That § 31-12-27.1 be amended to read as follows:

2 31-12-27.1. Any county may contract with residents served by county roads for the
3 construction, maintenance, and improvement of county roads or any portion thereof serving
4 county residents. ~~Whenever it shall appear to~~ If the board of county commissioners ~~of any~~
5 ~~county by, upon~~ a petition ~~presented~~ by a resident ~~or residents~~ within the county, ~~a copy of~~
6 ~~which petition shall be~~ filed in the office of the county auditor of the county ~~of which the~~
7 ~~petitioner or petitioners are residents of,~~ determines that it ~~will be to~~ is in the best interest of the
8 petitioner ~~or petitioners~~ and in the public interest that the petitioner ~~or petitioners~~ enter into an
9 agreement in writing with the board of county commissioners of such county for the
10 construction, maintenance, or improvement of county roads or any portion thereof, the board
11 of county commissioners may, ~~in its discretion,~~ enter into an agreement in writing with the
12 petitioner ~~or petitioners~~ to construct, maintain, or improve any such county road or portion
13 thereof to be specifically designated, at and for a price to be paid to the county to be expressed
14 in the agreement. ~~If it shall appear to~~ the board of county commissioners determines that it ~~will~~
15 ~~be to~~ is in the public interest to enter into such an agreement, ~~it shall be lawful for it to~~ the board
16 may do so and ~~such~~ the county may, by and through its highway department and with the
17 personnel and equipment thereof or by privately let contract pursuant to ~~§ 5-18-13~~ § 5-18A-9,
18 perform or cause to be performed such construction, maintenance, and improvement specified
19 in the written agreement under the supervision and control of the county highway
20 superintendent. The prices specified in the contract shall be paid to the county or if privately let,
21 to the person performing the work by the resident ~~or residents~~ petitioning upon estimates
22 certified to by the county highway superintendent.

23 Section 137. That § 31-17-14 be amended to read as follows:

24 31-17-14. The court, by its judgment in an action pursuant to § 31-17-11 ~~shall have the right~~

1 to, may determine the necessity and extent of any construction, improvement, or repair of such
2 highway; the right to enforce equal contribution to the costs thereof by both townships; and the
3 right to require the board of supervisors of both townships to jointly meet and advertise for bids
4 and enter into a contract for the construction, improvement, or repair of such highway in the
5 manner provided by §§ ~~5-18-3 and 5-18-5~~ §§ 5-18A-14 and 5-18B-10.

6 Section 138. That § 33-12-28 be amended to read as follows:

7 33-12-28. The provisions of chapters ~~5-18, 5-19 and 5-21~~ 5-18A, 5-18B, and 5-18D,
8 governing contracts by public corporations, apply to contracts and purchases by the adjutant
9 general and the Department of Military and Veterans Affairs. However, in case of insurrection,
10 invasion, tumult, riot, breach of the peace, imminent danger thereof, or other great emergency,
11 the Governor may, upon the certificate of the adjutant general, temporarily suspend the
12 operation of law and direct the quartermaster general to purchase in the open market any
13 necessary military property or supplies. The adjutant general shall report to the Governor the
14 amount of property and supplies purchased and the prices paid.

15 Section 139. That § 34-31-8 be amended to read as follows:

16 34-31-8. Notwithstanding the provisions of ~~§ 5-23-2~~ § 5-18D-25, the Department of
17 Agriculture may purchase used motor vehicles and equipment at auctions of federal and state
18 surplus property, or from public and private utility companies, irrespective of whether or not the
19 sellers of the vehicles are licensed dealers as required by ~~§ 5-23-2~~ § 5-18D-25, for distribution
20 to fire departments or districts for fire suppression. The department may charge recipients for
21 reasonable direct and indirect costs of providing such rural fire equipment, vehicles, and
22 supplies to counties and rural fire departments or districts. The department may administer
23 federal and state cost assistance programs related to such rural fire protection.

24 Section 140. That § 34A-5-41 be amended to read as follows:

1 34A-5-41. The board of trustees of any sanitary district incorporated under this chapter may
2 submit to the voters of the district at an annual election or a special election called and held in
3 accordance with chapter 9-13 the question whether the district shall be authorized to acquire and
4 operate a water system, or the application for incorporation filed in accordance with § 34A-5-6
5 may request such authority. Upon approval of the grant of such authority by a majority of the
6 qualified electors voting on the question, or upon entry of the order incorporating the district if
7 the application has requested such authority, the board of trustees ~~shall be authorized to~~ may
8 acquire and operate water mains, hydrants, intakes, wells, storage tanks and reservoirs, treatment
9 plants, and all other facilities used or useful for the supply and distribution of water, and ~~to~~
10 acquire and operate any of such facilities, and ~~to~~ contract for the service of any such facilities
11 owned by the adjacent municipality or for the use of district facilities by the municipality; and
12 in connection with all such matters the district and its board of trustees ~~shall have~~ has all powers
13 herein granted with reference to sewer facilities. In the exercise of such powers the board of
14 trustees may purchase any existing facilities used or useful therefor, or may contract for the
15 construction of any such facilities in the manner provided in chapters ~~5-18 and 5-19~~ 5-18A and
16 5-18B.

17 Section 141. That § 34A-6-63.1 be amended to read as follows:

18 34A-6-63.1. The governing body of any county, municipality, or political subdivision of the
19 state may, by ordinance or resolution, establish policies, requirements, and procedures for the
20 purchase, acquisition, sale, or transfer of any solid waste, as defined in § 34A-6-1.3; solid waste
21 by-products; recyclable materials, as defined in § 34A-6-61; and scrap materials by any solid
22 waste or recycling system or facility that is owned or operated by the county, municipality, or
23 political subdivision or by any other facility or program that is owned or operated by the county,
24 municipality, or political subdivision. Policies and requirements established pursuant to this

1 section shall conform to state statutes and rules related to solid waste and recycling.

2 Such purchases, acquisitions, sales, and transfers are exempt from the requirements of
3 chapters ~~5-18~~ 5-18A and 6-13. If the governing body determines that it ~~would be~~ is in the best
4 interests of the county, municipality, or political subdivision, the governing body may attempt
5 to identify additional prospective buyers or sellers and may negotiate the conditions of such
6 transactions with prospective buyers or sellers, including price, delivery, transport, quantity, and
7 length of contract, to obtain the price or conditions most advantageous to the governing body.
8 The governing body may authorize procedures for adjusting prices to meet changing market
9 conditions not within the control of the purchaser or seller. No governing board member and no
10 officer of the county, municipality, or political subdivision may purchase or acquire the
11 materials described in this section unless such materials are available for sale to or acquisition
12 by the general public.

13 Section 142. That § 34A-16-27 be amended to read as follows:

14 34A-16-27. ~~Chapter 5-18 applies~~ The provisions of chapter 5-18A apply to purchases by the
15 district.

16 Section 143. That § 42-7A-5 be amended to read as follows:

17 42-7A-5. ~~When~~ If entering into ~~contracts~~ any contract pursuant to subdivision 42-7A-4(3),
18 the executive director shall utilize an open and competitive bid process which reflects the best
19 interest of the State of South Dakota. ~~Such contracts are~~ Any such contract is exempt from the
20 provisions of ~~chapter 5-23~~ chapters 5-18A and 5-18D. The executive director shall consider all
21 relevant factors including security, competence, experience, timely performance, and
22 maximization of net revenues to the state. ~~Contracts~~ Any contract entered into pursuant to
23 subdivision 42-7A-4(3) for major procurements are subject to the approval of the commission
24 and are subject to the provisions of ~~chapter 5-18~~ chapters 5-18A and 5-18D.

1 Section 144. That § 46-6-31 be amended to read as follows:

2 46-6-31. The chief engineer, ~~when~~ if plugging or otherwise controlling a well pursuant to
3 the provisions of §§ 46-6-29 and 46-6-30, shall comply with the bidding provisions of ~~chapter~~
4 ~~5-18~~ chapters 5-18A and 5-18B unless ~~he~~ the chief engineer determines that compliance with
5 those provisions will result in harm to health or property or will result in an unreasonable waste
6 of water.

7 Section 145. That § 46-7-5.1 be amended to read as follows:

8 46-7-5.1. Upon failure or refusal of an owner of unsafe works to make the changes necessary
9 to secure the safety of the works pursuant to the chief engineer's order or order of the board ~~as~~
10 ~~applicable~~, the chief engineer may enter upon the property where the works are located and
11 make the necessary changes. The cost of the work shall be borne by the owner of the works and
12 may be recorded as a lien against any property of the owner until paid. This section does not
13 limit any other remedy against the owner of the works. The chief engineer shall comply with the
14 bidding provisions of ~~chapter 5-18~~ chapters 5-18A and 5-18B unless ~~he~~ the chief engineer
15 determines that compliance with those provisions will result in harm to public health or
16 property.

17 Section 146. That § 46-7-5.2 be amended to read as follows:

18 46-7-5.2. Notwithstanding the pendency of any notice, order, or protest pursuant to § 46-7-5,
19 the chief engineer may immediately breach or repair any works if, in ~~his~~ the chief engineer's
20 judgment, it is necessary to protect human life from imminent danger. The cost of the work in
21 such cases shall be borne by the owner of the works and may be recorded as a lien against any
22 property of the owner until paid. The provisions of ~~chapter 5-18~~ chapters 5-18A and 5-18B are
23 not applicable to this section. This section does not limit any other remedy against the owner
24 of the works.

1 Section 147. That § 46A-1-80.1 be amended to read as follows:

2 46A-1-80.1. All interest, title, and rights of ownership in the two eight-inch dredges and one
3 ten-inch dredge and associated equipment and any money are hereby transferred to the South
4 Dakota Lakes and Streams Association, for use in the restoration of lakes and streams, with
5 priority given to lakes and streams in South Dakota. This transfer is effective only for so long
6 as the dredges are owned by the association and are used for the above purpose. If the South
7 Dakota Lakes and Streams Association ceases to exist or apply the dredges to the above
8 purpose, all right, title, and interest in the dredges ~~shall~~ revert to the State of South Dakota. In
9 the event of such reversion, the Bureau of Administration shall sell the dredges to the highest
10 bidder, notwithstanding any requirements of chapter ~~5-23~~ 5-24A in regard to minimum bids.

11 Section 148. That § 46A-9-52 be amended to read as follows:

12 46A-9-52. ~~All~~ Any water user district ~~contracts~~ contract for the construction, alteration,
13 extension, or improvement of any works, or any part or section thereof, or any building, for the
14 use of the district, or for the purchase of any materials, machinery, or apparatus therefor ~~shall~~
15 ~~be is~~ governed by ~~chapter 5-18~~ chapters 5-18A and 5-18B.

16 Section 149. That § 46A-9-53 be amended to read as follows:

17 46A-9-53. Before publication of any advertisement pursuant to chapter ~~5-18~~ 5-18A, plans
18 and specifications for the proposed construction work or materials shall be prepared and filed
19 at the principal office or place of business of the water user district. The advertisement shall be
20 published as required by ~~§ 5-18-3~~ § 5-18A-14 and, in the discretion of the board of directors of
21 the district, may be published in such additional newspapers or trade or technical periodicals as
22 may be selected by the board in order to give proper notice of the receiving of bids. The
23 advertisement shall designate the nature of construction work proposed to be done or materials
24 proposed to be purchased.

1 Section 150. That § 46A-10A-75 be amended to read as follows:

2 46A-10A-75. At any time after adopting a drainage plan or other official control, a board
3 may construct drainage or let contracts for its construction. A contract may be for construction
4 of an entire drainage project, for any portion thereof, or for material and labor separately, and
5 the contract shall be let by competitive bid. A board ~~has the right to~~ may reject any bid. The
6 lowest responsible and capable bidder shall be accepted. If a responsible and capable landowner
7 affected by the project submits one of several low bids, ~~he~~ the landowner shall be given contract
8 preference. If a contract is let, the contractor shall post a bond in the amount of the contract,
9 conditioned on faithful performance of the contract and full completion of the contract to the
10 satisfaction of the board. For purposes of bids on a proposed project, all plans and specifications
11 for the project shall be filed in the office of the county auditor. If, in the judgment of the board,
12 the entire project or any part thereof can be constructed for less money than the amount of the
13 lowest bid submitted, the board may hire the necessary labor and purchase the necessary
14 material for the construction without letting contracts, the provisions of ~~chapter 5-18~~ chapters
15 5-18A and 5-18B notwithstanding.

16 Section 151. That § 46A-10A-116 be amended to read as follows:

17 46A-10A-116. The board of trustees may control, supervise, and manage the district. Subject
18 to the legal controls for drainage management under § 46A-10A-20, the board of trustees may,
19 in conformity with any applicable local, state, and federal laws, rules, ordinances, and
20 regulations:

- 21 (1) Clean out, repair, and maintain an existing drainage ditch;
- 22 (2) Deepen, widen, or enlarge a drainage ditch;
- 23 (3) Create a new drainage ditch, or relocate an existing drainage ditch;
- 24 (4) Extend an existing drainage ditch;

- 1 (5) Acquire lands for right-of-way for ditches by purchase or condemnation or any other
2 lawful method in conformity with chapter 21-35 and any other provision of state law;
- 3 (6) Repair levies, dikes, and barriers for the purpose of drainage;
- 4 (7) Regulate the flow and direction of water to prevent downstream flooding;
- 5 (8) Employ or contract with an engineer, hydrologist, surveyor, appraiser, assessor, legal
6 counsel, or any other specialists as they deem necessary to carry out the powers and
7 duties conferred by §§ 46A-10A-98 to 46A-10A-123, inclusive;
- 8 (9) Let contracts for construction, maintenance, repair, or other necessary work pursuant
9 to the provisions of ~~chapter 5-18~~ chapters 5-18A and 5-18B and § 46A-10A-75. No
10 member of the board of trustees may have any interest in any contract or employment
11 entered into pursuant to this subdivision or subdivision (8);
- 12 (10) Request the county commission or township board of supervisors to replace, repair,
13 remove, and enlarge public highway culverts and bridges, pursuant to §§ 46A-10A-
14 76, 31-12-19, 31-14-2, and 31-14-27;
- 15 (11) Grant a request by a landowner to annex the landowner's land to the district and
16 apportion the costs of clean out, maintenance, or construction according to the
17 benefits received and subject to approval by a majority of the eligible landowners
18 voting in a special election held by the board of trustees in conjunction with the
19 district's annual election; and
- 20 (12) Reclassify benefits and apportion costs of clean out, extension, enlargement, repairs,
21 or improvements among landowners benefitting therefrom, if the landowners have
22 land located within the drainage district.

23 Section 152. That § 54-13-6 be amended to read as follows:

24 54-13-6. The Department of Agriculture, in the administration of this chapter, may contract

1 with one or more established agencies of state government, nonprofit corporations, or
2 individuals to provide mediation services for borrowers and creditors and to provide financial
3 preparation assistance for borrowers involved in mediation. Any contract executed under this
4 section is exempt from ~~chapter 5-18~~ chapters 5-18A and 5-18D. The contract may include such
5 terms and conditions as the board deems appropriate.

6 Section 153. That subdivision (13) of § 5-18A-22 be amended to read as follows:

7 (13) Any authority authorized by chapters 1-16A, 1-16B, 1-16E, 1-16G, 1-16H, 1-16J, 5-
8 12, or 11-11;

9 Section 154. That § 5-18A-17 be amended to read as follows:

10 5-18A-17. No state officer or employee who approves, awards, or administers a contract
11 involving the expenditure of public funds or the sale or lease of property, may have an interest
12 in a contract that is within the scope of the officer's or employee's official duties. This
13 prohibition includes any state officer or employee who, in his or her official capacity,
14 recommends the approval or award of the contract or who supervises a person who approves,
15 awards, or administers the contract. This prohibition does not include any state officer who
16 serves without compensation or who may be paid per diem pursuant to § 4-7-10.4. Any contract
17 made in violation of this section is void. Any state officer or employee who knowingly violates
18 this section is guilty of a Class 2 misdemeanor.

State of South Dakota

EIGHTY-SIXTH SESSION
LEGISLATIVE ASSEMBLY, 2011

400S0212

SENATE HEALTH AND HUMAN SERVICES

ENGROSSED NO. **SB 14** - 1/19/2011

Introduced by: The Committee on Health and Human Services at the request of the
Department of Social Services

1 FOR AN ACT ENTITLED, An Act to require the mandatory reporting of abuse or neglect of
2 elderly or disabled adults.

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

4 Section 1. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as
5 follows:

6 Any person who is a:

- 7 (1) Physician, dentist, doctor of osteopathy, chiropractor, optometrist, podiatrist,
8 religious healing practitioner, hospital intern or resident, nurse, paramedic,
9 emergency medical technician, social worker, or any health care professional;
- 10 (2) Long-term care ombudsman;
- 11 (3) Psychologist, licensed mental health professional, or counselor engaged in
12 professional counseling; or
- 13 (4) State, county, or municipal criminal justice employee or law enforcement officer;
- 14 who knows, or has reasonable cause to suspect, that an elder or disabled adult has been or is



1 being abused or neglected, shall, within twenty-four hours, report such knowledge or suspicion
2 orally or in writing to the state's attorney of the county in which the elder or disabled adult
3 resides or is present, to the Department of Social Services, or to a law enforcement officer. Any
4 person who knowingly fails to make the required report is guilty of a Class 1 misdemeanor.

5 Section 2. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as
6 follows:

7 Any staff member of a nursing facility, assisted living facility, adult day care center, or
8 community support provider, or any residential care giver, individual providing homemaker
9 services, victim advocate, or hospital personnel engaged in the admission, examination, care,
10 or treatment of elderly or disabled adults who knows, or has reasonable cause to suspect, that
11 an elderly or disabled adult has been or is being abused or neglected, shall, within twenty-four
12 hours, notify the person in charge of the institution where the elderly or disabled adult resides
13 or is present, or the person in charge of the entity providing the service to the elderly or disabled
14 adult, of the suspected abuse or neglect. The person in charge shall report the information in
15 accordance with the provisions of section 1 of this Act. Any person who knowingly fails to
16 make the required report is guilty of a Class 1 misdemeanor.

17 Section 3. That chapter 22-46 be amended by adding thereto a NEW SECTION to read as
18 follows:

19 Any person who knows or has reason to suspect that an elderly or disabled adult has been
20 abused or neglected as defined in § 22-46-2 or 22-46-3 may report that information, regardless
21 of whether that person is one of the mandatory reporters listed in this Act.

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 has 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

400S0165

SENATE TAXATION ENGROSSED NO. **SB 40** - 1/19/2011

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

1 FOR AN ACT ENTITLED, An Act to provide that the uniform administration of certain state
2 taxes apply to the telecommunications gross receipts tax and to limit the application of the
3 uniform administration of certain state taxes.

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

5 Section 1. That § 10-59-1 be amended to read as follows:

6 10-59-1. The provisions of this chapter may only apply to ~~any~~ proceedings commenced
7 under this chapter concerning the taxes or, the fees, or the persons subject to the taxes or fees
8 imposed by, and to or any civil or criminal investigation authorized by, chapters 10-33A, 10-39,
9 10-39A, 10-39B, 10-43, 10-45, 10-45D, 10-46, 10-46A, 10-46B, 10-46C, 10-46E, 10-47B, 10-
10 52, 10-52A, 32-3, 32-3A, 32-5, 32-5B, 32-6B, 32-9, 32-10, and 34A-13 and §§ 22-25-48, 49-31-
11 51, 50-4-13 to 50-4-17, inclusive, and the provisions of chapter 10-45B.

