State of South Dakota

NINETIETH SESSION
LEGISLATIVE ASSEMBLY, 2015

940W0344

SENATE COMMERCE AND ENERGY

ENGROSSED NO. SB 118 - 02/05/2015

Introduced by: Senators Rampelberg, Brown, Heinert, Holien, and Novstrup (David) and Representatives Heinemann (Leslie), Bolin, Hawley, Munsterman, Sly, and Willadsen

FOR AN ACT ENTITLED, An Act to provide additional transparency for prescription drug plans.

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

Section 1. That § 58-17F-4 be amended to read as follows:

58-17F-4. Any health carrier shall provide to any prospective enrollee written information describing the terms and conditions of the plan. If the plan is described orally, easily understood, truthful, objective terms shall be used. The written information need not be provided to any prospective enrollee who makes inquiries of a general nature directly to a carrier. In the solicitation of group coverage to an employer, a carrier is not required to provide the written information required by this section to individual employees or their dependents and if no solicitation is made directly to the employees or dependents and if no request to provide the written information to the employees or dependents is made by the employer. All written plan descriptions shall be readable, easily understood, truthful, and in an objective format. The format shall be standardized among each plan that a health carrier offers so that comparison of

170 copies were printed on recycled paper by the South Dakota Legislative Research Council at a cost of $.098 per page.

the attributes of the plans is facilitated. The following specific information shall be communicated:

(1) Coverage provisions, benefits, and any exclusions by category of service, provider, and if applicable, by specific service, including prescription drugs and drugs administered in a physician office or clinic;

(2) Any and all authorization or other review requirements, including preauthorization review, and any procedures that may lead the patient to be denied coverage for or not be provided a particular service;

(3) The existence of any financial arrangements or contractual provisions with review companies or providers of health care services that would directly or indirectly limit the services offered, restrict referral, or treatment options;

(4) Explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment of coinsurance or other non-covered or out-of-plan services;

(5) A description of the accessibility and availability of services and an easily accessible online list of providers and facilities, including a list of providers participating in the managed care network and of the providers in the network who are accepting new patients, the addresses of primary care physicians and participating hospitals, and the specialty of each provider in the network. The list of providers and facilities must be updated at least once every six months; ~~and~~

(6) A description of any drug formulary provisions in the plan and the process for obtaining a copy of the current formulary upon request and the method by which an enrollee or prospective enrollee may determine whether a specific drug is available on the current formulary. There shall be a process for requesting an exception to the

formulary and instructions as to how to request an exception to the formulary and a description of an easily accessible method to obtain a prior authorization or step edit requirement for each specific drug included on the formulary; and

(7) The description of the drug formularies in subdivision (6) shall be promptly updated with any adverse change.

The provisions of this section do not apply to plans that are not actively marketed by a carrier.

Section 2. This Act is effective January 1, 2016.