



# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

490C0116

HOUSE HEALTH AND HUMAN SERVICES  
COMMITTEE ENGROSSED NO. **HB1009** -  
2/3/99

Introduced by: Representatives Hunt, Cerny, Fiegen, Hagen, and Peterson and Senators  
Lawler, Brosz, and Kloucek at the request of the Interim Health and Human  
Services Committee

1 FOR AN ACT ENTITLED, An Act to require a managed care plan to have a medical director  
2 or director.

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

4 Section 1. Terms used in this Act mean:

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

9 (2) "Managed care entity," a licensed insurance company, hospital or medical service  
10 plan, health maintenance organization, an employer or employee organization, or a  
11 managed care contractor that operates a managed care plan;

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

- 1           (a) Arrangements with selected providers to furnish health care services;
- 2           (b) Explicit standards for the selection of participating providers; or
- 3           (c) Financial incentives for persons enrolled in the plan to use the participating
- 4                 providers and procedures provided for by the plan.

5           Section 2. A managed care plan shall appoint a medical director who has an unrestricted  
6 license to practice medicine. However, a managed care plan that specializes in a specific healing  
7 art shall appoint a director, who has an unrestricted license to practice in that healing art. The  
8 director is responsible for oversight of treatment policies, protocols, quality assurance activities,  
9 and utilization management decisions of the managed care plan.

10          Section 3. Nothing in this Act applies to dental only, vision only, accident only, school  
11 accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed  
12 occurrence, or fixed per procedure benefit without regard to expenses incurred.

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Health and Human Services. H.J. 33

3 1/27/99 Scheduled for Committee hearing on this date.

4 1/27/99 Scheduled for Committee hearing on this date.

5 1/29/99 Scheduled for Committee hearing on this date.

6 1/29/99 Health and Human Services Do Pass Amended, Passed, AYES 12, NAYS 0. H.J. 306

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

463C0192

HOUSE HEALTH AND HUMAN SERVICES  
COMMITTEE ENGROSSED NO. **HB1010** -  
2/3/99

Introduced by: Representatives Hunt, Cerny, Duenwald, Fiegen, Hagen, Koskan, and Peterson  
and Senators Kloucek, Brosz, Ham, and Lawler at the request of the Interim  
Health and Human Services Committee

1 FOR AN ACT ENTITLED, An Act to provide certain protections for persons enrolled in  
2 managed care plans.

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

4 Section 1. Terms used in this Act mean:

5 (1) "Capitation," a prefixed, per member, monthly payment to a provider that covers  
6 contracted services and is paid in advance of its delivery;

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

11 (3) "Managed care entity," a licensed insurance company, hospital or medical service  
12 plan, health maintenance organization, an employer or employee organization, or a  
13 managed care contractor that operates a managed care plan;

14 (4) "Managed care plan," a plan operated by a managed care entity that provides for the

1 financing or delivery of health care services, or both, to persons enrolled in the plan  
2 through any of the following:

- 3 (a) Arrangements with selected providers to furnish health care services;
- 4 (b) Explicit standards for the selection of participating providers; or
- 5 (c) Financial incentives for persons enrolled in the plan to use the participating  
6 providers and procedures provided for by the plan;

7 (5) "Provider," any person who furnishes health services and is licensed or otherwise  
8 authorized to render such services in the state;

9 (6) "Withhold," a percentage of the negotiated provider payment that is withheld  
10 periodically by the managed care entity and used, as necessary, to cover annual  
11 overruns in anticipated health services costs.

12 Section 2. If a covered person's health care provider leaves or is terminated by the managed  
13 care plan without cause, the managed care plan shall permit the covered person to continue an  
14 ongoing course of treatment with the covered person's current health care provider for a  
15 transitional period of up to ninety days from the date of notice to the covered person of the  
16 provider's disaffiliation from the managed care plan's network; or if the covered person has  
17 entered a second trimester of pregnancy at the time of the provider's disaffiliation, for a  
18 transitional period that includes the provision of post-partum care directly related to the delivery.

19 Notwithstanding the provisions of this section, such care shall be authorized by the managed  
20 care plan during the transitional period only if the health care provider agrees:

21 (1) To continue to accept reimbursement from the managed care plan at the rates  
22 applicable prior to the start of the transitional period as payment in full;

23 (2) To adhere to the plan's quality assurance requirements and to provide to the  
24 organization necessary medical information related to such care; and

25 (3) To otherwise adhere to the plan's policies and procedures, including procedures

1            regarding referrals and obtaining pre-authorization and a treatment plan approved by  
2            the plan.

3            Section 3. No managed care plan may, by contract, written policy or procedure, or informal  
4 policy or procedure, prohibit or restrict any provider from disclosing to any covered person any  
5 information that the provider deems appropriate regarding:

- 6            (1)    A condition or a course of treatment with an enrollee including the availability of  
7            other therapies, consultations, or tests; or
- 8            (2)    The provisions, terms, or requirements of the managed care plan's products as they  
9            relate to the covered person, if applicable.

10           Section 4. No managed care plan may, by contract, written policy or procedure, or informal  
11 policy or procedure, prohibit or restrict any health care provider from filing a complaint, making  
12 a report, or commenting to an appropriate governmental body regarding the policies or practices  
13 of the managed care plan that the provider believes may negatively impact upon the quality of,  
14 or access to, patient care.

15           Section 5. Any contract between a managed care plan and a participating provider of health  
16 care services shall be in writing and shall set forth that if the managed care plan fails to pay for  
17 covered health care services as set forth in the contract, the covered person is not liable to the  
18 provider for any sums owed by the managed care plan.

19           Section 6. No participating provider, or agent, trustee, or assignee thereof, may maintain any  
20 action at law against a covered person to collect sums owed by the managed care plan, except  
21 in cases of subrogation.

22           Section 7. A managed care plan shall provide to covered persons and prospective covered  
23 persons written information describing the terms and conditions of the plan. All written plan  
24 descriptions shall be readable, easily understood, truthful, and in an objective format. The  
25 following specific information shall be included in the format:

- 1 (1) Coverage provisions, benefits, and any exclusions by category of service, provider,  
2 and if applicable, by specific service;
- 3 (2) Any authorization review requirements, including preauthorization review, concurrent  
4 review, post-service review, post-payment review, and any procedures that may lead  
5 the patient to be denied coverage for or not be provided with a particular service;
- 6 (3) The general methodology of any financial incentives to limit utilization of health  
7 services;
- 8 (4) An explanation of how plan limitations impact enrollees, including information on  
9 enrollee financial responsibility for payment of coinsurance or other noncovered or  
10 out-of-plan services;
- 11 (5) A description of the accessibility and availability of services, including a list of the  
12 providers participating in the managed care plan and of the providers who are  
13 accepting new patients, the addresses of primary care physicians and participating  
14 hospitals, and the specialty of each physician and category of the other participating  
15 providers. The information required by this subdivision may be contained in a separate  
16 document and incorporated in the contract by reference and shall be amended from  
17 time to time as necessary to provide covered persons with the most current  
18 information;
- 19 (6) A statement as to whether the plan includes a limited drug formulary, a statement that  
20 the formulary will be made available to any covered person on request, and  
21 instructions on how to request that an exception be made to the formulary. If a  
22 managed care plan uses a drug formulary, it shall make allowance for exceptions to  
23 the formulary if a nonformulary alternative is more appropriate due to medical  
24 necessity or to maximize the effectiveness of a plan of treatment; and
- 25 (7) A statement that a covered person is not, under any circumstances, liable, assessable,

1           or in any way subject to payments for debts, liabilities, insolvency, impairment, or any  
2           other financial obligations of the managed care entity.

3           Section 8. No managed care entity may offer a provider, and no contract between a managed  
4           care entity and a provider may contain, any incentive plan that includes a specific payment made,  
5           in any type or form, to the provider as an inducement to deny, reduce, limit, or delay specific,  
6           medically necessary, and appropriate services covered by the health care contract and provided  
7           with respect to a specific member or group of members with similar medical conditions. Nothing  
8           in this section prohibits contracts that contain incentive plans that involve general payments such  
9           as capitation payments, withholds, or any other shared risk agreements that are not tied to  
10          specific medical decisions involving specific members or groups of members with similar medical  
11          conditions.

12          Section 9. If the director of the Division of Insurance and the secretary of the Department  
13          of Health find that the requirements of any private accrediting body meet the requirements of  
14          this Act, the managed care plan may, at the discretion of the director and secretary, be deemed  
15          to have met the applicable requirements.

16          Section 10. Nothing in this Act applies to dental only, vision only, accident only, school  
17          accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed  
18          occurrence, or fixed per procedure benefit without regard to expenses incurred. The provisions  
19          of this Act only apply to oral or written communications specifically designed to elicit an  
20          application for insurance.

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Health and Human Services. H.J. 33

3 1/27/99 Scheduled for Committee hearing on this date.

4 1/27/99 Scheduled for Committee hearing on this date.

5 1/29/99 Scheduled for Committee hearing on this date.

6 1/29/99 Health and Human Services Do Pass Amended, Passed, AYES 11, NAYS 1. H.J. 307

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

166C0012

HOUSE HEALTH AND HUMAN SERVICES  
COMMITTEE ENGROSSED NO. **HB1011** -  
2/3/99

Introduced by: Representatives Hunt, Cerny, Duenwald, and Hagen and Senators Kloucek and Lawler at the request of the Interim Health and Human Services Committee

1 FOR AN ACT ENTITLED, An Act to provide covered persons in managed care plans with  
2 reasonable access to providers.

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

4 Section 1. Terms used in this Act mean:

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

9 (2) "Managed care entity," a licensed insurance company, hospital or medical service  
10 plan, health maintenance organization, an employer or employee organization, or a  
11 managed care contractor that operates a managed care plan;

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

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

- 1 (b) Explicit standards for the selection of participating providers; or
- 2 (c) Financial incentives for persons enrolled in the plan to use the participating
- 3 providers and procedures provided for by the plan;
- 4 (4) "Provider," any person who furnishes health services and is licensed or otherwise
- 5 authorized to render such services in the state.

6 Section 2. A managed care plan shall maintain a network that is sufficient in numbers and  
7 types of providers to assure that all services to covered persons are accessible within a  
8 reasonable distance or travel time. Sufficiency shall be determined in accordance with the  
9 requirements of this section. The director shall establish sufficiency standards, in rules  
10 promulgated pursuant to chapter 1-26, by reference to any reasonable criteria, including:  
11 provider-covered person ratios by specialty; primary care provider-covered person ratios;  
12 geographic accessibility; waiting times for appointments with participating providers; hours of  
13 operation; and the volume of technological and specialty services available to serve the needs of  
14 covered persons requiring technologically advanced or specialty care. In determining whether  
15 a plan has complied with this provision, the director shall give due consideration to the relative  
16 availability of health care providers in the service area under consideration. If the managed care  
17 plan has an insufficient number or type of participating providers to provide a covered benefit  
18 within a reasonable distance or travel time, the managed care plan shall ensure that the covered  
19 person obtains the covered benefit at no greater cost than if the benefit were obtained from  
20 participating providers.

21 Section 3. If the director of the Division of Insurance and the secretary of the Department  
22 of Health find that the requirements of any private accrediting body meet the requirements of  
23 network adequacy as set forth in this Act, the managed care plan may, at the discretion of the  
24 director and secretary, be deemed to have met the applicable requirements.

25 Section 4. Nothing in this Act applies to dental only, vision only, accident only, school

- 1 accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed
- 2 occurrence, or fixed per procedure benefit without regard to expenses incurred.

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Health and Human Services. H.J. 33

3 1/27/99 Scheduled for Committee hearing on this date.

4 1/27/99 Scheduled for Committee hearing on this date.

5 1/29/99 Scheduled for Committee hearing on this date.

6 1/29/99 Health and Human Services Do Pass Amended, Passed, AYES 11, NAYS 1. H.J. 307

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

193C0010

HOUSE HEALTH AND HUMAN SERVICES  
COMMITTEE ENGROSSED NO. **HB1012** -  
2/3/99

Introduced by: Representatives Fiegen, Cerny, Duenwald, Hagen, Hunt, Koskan, and Peterson  
and Senators Brosz, Ham, Kloucek, and Lawler at the request of the Interim  
Health and Human Services Committee

1 FOR AN ACT ENTITLED, An Act to provide utilization review of managed care plans.

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

3 Section 1. Terms used in this Act mean:

4 (1) "Adverse determination," a determination by a managed care plan or its designee  
5 utilization review organization that an admission, availability of care, continued stay,  
6 or other health care service has been reviewed and, based upon the information  
7 provided, does not meet the managed care plan's requirements for medical necessity,  
8 appropriateness, health care setting, level of care or effectiveness, and the requested  
9 service is therefore denied, reduced, or terminated;

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

12 (3) "Case management," a coordinated set of activities conducted for individual patient  
13 management of serious, complicated, protracted, or other health conditions;

14 (4) "Certification," a determination by a managed care plan or its designee utilization

1 review organization that an admission, availability of care, continued stay, or other  
2 health care service has been reviewed and, based on the information provided, satisfies  
3 the managed care plan's requirements for medical necessity, appropriateness, health  
4 care setting, level of care, and effectiveness;

5 (5) "Clinical peer," a physician or other health care professional who holds a nonrestricted  
6 license in the same or similar speciality as typically manages the medical condition,  
7 procedure, or treatment under review;

8 (6) "Clinical review criteria," the written screening procedures, decision abstracts, clinical  
9 protocols, and practice guidelines used by the managed care plan to determine the  
10 necessity and appropriateness of health care services;

11 (7) "Concurrent review," utilization review conducted during a patient's hospital stay or  
12 course of treatment;

13 (8) "Covered benefits" or "benefits," those health care services to which a covered person  
14 is entitled under the terms of a health benefit plan;

15 (9) "Covered person," a policyholder, subscriber, enrollee, or other individual  
16 participating in a health benefit plan;

17 (10) "Discharge planning," the formal process for determining, prior to discharge from a  
18 facility, the coordination and management of the care that a patient receives following  
19 discharge from a facility;

20 (11) "Facility," an institution providing health care services or a health care setting,  
21 including hospitals and other licensed inpatient centers, ambulatory surgical or  
22 treatment centers, skilled nursing centers, residential treatment centers, diagnostic,  
23 laboratory, and imaging centers, and rehabilitation, and other therapeutic health  
24 settings;

25 (12) "Health benefit plan," a policy, contract, certificate, or agreement entered into,

- 1 offered, or issued by a managed care plan to provide, deliver, arrange for, pay for, or  
2 reimburse any of the costs of health care services;
- 3 (13) "Health care professional," a physician or other health care practitioner licensed,  
4 accredited, or certified to perform specified health services consistent with state law;
- 5 (14) "Health care provider" or "provider," a health care professional or a facility;
- 6 (15) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief  
7 of a health condition, illness, injury, or disease;
- 8 (16) "Managed care contractor," a person who establishes, operates, or maintains a  
9 network of participating providers; or contracts with an insurance company, a hospital  
10 or medical service plan, an employer, an employee organization, or any other entity  
11 providing coverage for health care services to operate a managed care plan;
- 12 (17) "Managed care entity," a licensed insurance company, hospital or medical service  
13 plan, health maintenance organization, an employer or employee organization, or a  
14 managed care contractor that operates a managed care plan;
- 15 (18) "Managed care plan," a plan operated by a managed care entity that provides for the  
16 financing or delivery of health care services, or both, to persons enrolled in the plan  
17 through any of the following:
- 18 (a) Arrangements with selected providers to furnish health care services;  
19 (b) Explicit standards for the selection of participating providers; or  
20 (c) Financial incentives for persons enrolled in the plan to use the participating  
21 providers and procedures provided for by the plan;
- 22 (19) "Necessary information," includes the results of any face-to-face clinical evaluation  
23 or second opinion that may be required;
- 24 (20) "Network," the group of participating providers providing services to a managed care  
25 plan;

- 1       (21) "Participating provider," a provider who, under a contract with the managed care plan  
2             or with its contractor or subcontractor, has agreed to provide health care services to  
3             covered persons with an expectation of receiving payment, other than coinsurance,  
4             copayments, or deductibles, directly or indirectly, from the managed care plan;
- 5       (22) "Prospective review," utilization review conducted prior to an admission or a course  
6             of treatment;
- 7       (23) "Retrospective review," utilization review of medical necessity that is conducted after  
8             services have been provided to a patient, but does not include the review of a claim  
9             that is limited to an evaluation of reimbursement levels, veracity of documentation,  
10            accuracy of coding, or adjudication for payment;
- 11      (24) "Second opinion," an opportunity or requirement to obtain a clinical evaluation by a  
12            provider other than the one originally making a recommendation for a proposed health  
13            service to assess the clinical necessity and appropriateness of the initial proposed  
14            health service;
- 15      (25) "Utilization review," a set of formal techniques designed to monitor the use of, or  
16            evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care  
17            services, procedures, or settings. Techniques may include ambulatory review,  
18            prospective review, second opinion, certification, concurrent review, case  
19            management, discharge planning, and retrospective review; and
- 20      (26) "Utilization review organization," an entity that conducts utilization review.

21       Section 2. This Act applies to any managed care plan that provides or performs utilization  
22       review services. The requirements of this Act also apply to any designee of the managed care  
23       plan or utilization review organization that performs utilization review functions on the plan's  
24       behalf.

25       Section 3. A managed care plan is responsible for monitoring all utilization review activities

1 carried out by, or on behalf of, the managed care plan and for ensuring that all requirements of  
2 this Act and applicable rules are met. The managed care plan shall also ensure that appropriate  
3 personnel have operational responsibility for the conduct of the managed care plan's utilization  
4 review program.

5 Section 4. If a managed care plan contracts to have a utilization review organization or other  
6 entity perform the utilization review functions required by this Act or applicable rules, the  
7 director shall hold the managed care plan responsible for monitoring the activities of the  
8 utilization review organization or entity with which the managed care plan contracts and for  
9 ensuring that the requirements of this Act and applicable rules are met.

10 Section 5. A managed care plan that conducts utilization review shall implement a written  
11 utilization review program that describes all review activities, both delegated and nondelegated,  
12 for covered services provided. The program document shall describe the following:

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

25 A managed care plan shall file an annual summary report of its utilization review program

1 activities with the director and the secretary of the Department of Health.

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

8 Section 7. Qualified licensed health care professionals shall administer the utilization review  
9 program and oversee review decisions. A clinical peer shall evaluate the clinical appropriateness  
10 of adverse determinations.

11 Section 8. A managed care plan shall issue utilization review decisions in a timely manner  
12 pursuant to the requirements of this Act. A managed care plan shall obtain all information  
13 required to make a utilization review decision, including pertinent clinical information. A  
14 managed care plan shall have a process to ensure that utilization reviewers apply clinical review  
15 criteria consistently.

16 Section 9. A managed care plan shall routinely assess the effectiveness and efficiency of its  
17 utilization review program.

18 Section 10. A managed care plan's data system shall be sufficient to support utilization review  
19 program activities and to generate management reports to enable the managed care plan to  
20 monitor and manage health care services effectively.

21 Section 11. If a managed care plan delegates any utilization review activities to a utilization  
22 review organization, the managed care plan shall maintain adequate oversight, which shall  
23 include:

24 (1) A written description of the utilization review organization's activities and  
25 responsibilities, including reporting requirements;

1 (2) Evidence of formal approval of the utilization review organization program by the  
2 managed care plan; and

3 (3) A process by which the managed care plan evaluates the performance of the  
4 utilization review organization.

5 Section 12. A managed care plan shall coordinate the utilization review program with other  
6 medical management activity conducted by the plan, such as quality assurance, credentialing,  
7 provider contracting data reporting, grievance procedures, processes for assessing member  
8 satisfaction, and risk management.

9 Section 13. A managed care plan shall provide covered persons and participating providers  
10 with access to its review staff by a toll-free number or collect call telephone line.

11 Section 14. When conducting utilization review, the managed care plan shall collect only the  
12 information necessary to certify the admission, procedure or treatment, length of stay, frequency,  
13 and duration of services.

14 Section 15. Compensation to persons providing utilization review services for a managed  
15 care plan may not contain incentives, direct or indirect, for these persons to make inappropriate  
16 review decisions. Compensation to any such persons may not be based, directly or indirectly, on  
17 the quantity or type of adverse determinations rendered.

18 Section 16. A managed care plan shall maintain written procedures for making utilization  
19 review decisions and for notifying covered persons and providers acting on behalf of covered  
20 persons of its decisions.

21 Section 17. For initial determinations, a managed care plan shall make the determination  
22 within two working days of obtaining all necessary information regarding a proposed admission,  
23 procedure, or service requiring a review determination:

24 (1) In the case of a determination to certify an admission, procedure, or service, the  
25 managed care plan shall notify the provider rendering the service by telephone within

1 twenty-four hours of making the initial certification; and shall provide written or  
2 electronic confirmation of the telephone notification to the covered person and the  
3 provider within two working days of making the initial certification.

4 (2) In the case of an adverse determination, the managed care plan shall notify the  
5 provider rendering the service by telephone within twenty-four hours of making the  
6 adverse determination; and shall provide written or electronic confirmation of the  
7 telephone notification to the covered person and the provider within one working day  
8 of making the adverse determination.

9 Section 18. For concurrent review determinations, a managed care plan shall make the  
10 determination within one working day of obtaining all necessary information:

11 (1) In the case of a determination to certify an extended stay or additional services, the  
12 managed care plan shall notify by telephone the provider rendering the service within  
13 one working day of making the certification; and the managed care plan shall provide  
14 written or electronic confirmation to the covered person and the provider within one  
15 working day after the telephone notification. The written notification shall include the  
16 number of extended days or next review date, the new total number of days or  
17 services approved, and the date of admission or initiation of services.

18 (2) In the case of an adverse determination, the managed care plan shall notify by  
19 telephone the provider rendering the service within twenty-four hours of making the  
20 adverse determination; and the managed care plan shall provide written or electronic  
21 notification to the covered person and the provider within one working day of the  
22 telephone notification. The service shall be continued without liability to the covered  
23 person until the covered person has been notified of the determination.

24 Section 19. For retrospective review determinations, a managed care plan shall make the  
25 determination within thirty working days of receiving all necessary information:

1       (1)    In the case of a certification, the managed care plan may notify in writing the covered  
2                    person and the provider rendering the service.

3       (2)    In the case of an adverse determination, the managed care plan shall notify in writing  
4                    the provider rendering the service and the covered person within five working days  
5                    of making the adverse determination.

6       Section 20. A written notification of an adverse determination shall include the principal  
7   reason or reasons for the determination, the instructions for initiating an appeal or  
8   reconsideration of the determination, and the instructions for requesting a written statement of  
9   the clinical rationale, including the clinical review criteria used to make the determination. A  
10  managed care plan shall provide the clinical rationale in writing for an adverse determination,  
11  including the clinical review criteria used to make that determination, to any party who received  
12  notice of the adverse determination and who follows the procedures for a request.

13       Section 21. A managed care plan shall have written procedures to address the failure or  
14  inability of a provider or a covered person to provide all necessary information for review. If the  
15  provider or a covered person will not release necessary information, the managed care plan may  
16  deny certification.

17       Section 22. In a case involving an initial determination or a concurrent review determination,  
18  a managed care plan shall give the provider rendering the service an opportunity to request on  
19  behalf of the covered person a reconsideration of an adverse determination by the reviewer  
20  making the adverse determination.

21       Section 23. The reconsideration shall occur within one working day of the receipt of the  
22  request and shall be conducted between the provider rendering the service and the reviewer who  
23  made the adverse determination or a clinical peer designated by the reviewer if the reviewer who  
24  made the adverse determination cannot be available within one working day.

25       Section 24. If the reconsideration process does not resolve the difference of opinion, the

1 adverse determination may be appealed by the covered person or the provider on behalf of the  
2 covered person. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal  
3 of an adverse determination.

4 Section 25. A managed care plan shall establish written procedures for a standard appeal of  
5 an adverse determination. An appeal procedure shall be available to the covered person and to  
6 the provider acting on behalf of the covered person.

7 Section 26. Each appeal shall be evaluated by an appropriate clinical peer in the same or  
8 similar speciality as would typically manage the case being reviewed. The clinical peer may not  
9 have been involved in the initial adverse determination.

10 Section 27. For any standard appeal, the managed care plan shall notify in writing both the  
11 covered person and the attending or ordering provider of the decision within twenty working  
12 days following the request for an appeal. The written decision shall contain:

- 13 (1) The names, titles, and qualifying credentials of the person evaluating the appeal;
- 14 (2) A statement of the reviewers' understanding of the reason for the covered person's  
15 request for an appeal;
- 16 (3) The reviewers' decision in clear terms and the medical rationale in sufficient detail for  
17 the covered person to respond further to the managed care plan's position;
- 18 (4) A reference to the evidence or documentation used as the basis for the decision,  
19 including the clinical review criteria used to make the determination, and instructions  
20 for requesting the clinical review criteria; and
- 21 (5) A description of the process for submitting a grievance in writing requesting a further  
22 review of the case.

23 Section 28. A managed care plan shall annually provide a written certification to the director  
24 that the utilization review program of the managed care plan or its designee complies with all  
25 applicable state and federal laws establishing confidentiality and reporting requirements.

1 Section 29. In the certificate of coverage or member handbook provided to covered persons,  
2 a managed care plan shall include a clear and comprehensive description of its utilization review  
3 procedures, including the procedures for obtaining review of adverse determinations, and a  
4 statement of rights and responsibilities of covered persons with respect to those procedures. A  
5 managed care plan shall include a summary of its utilization review procedures in materials  
6 intended for prospective covered persons. A managed care plan shall print on its membership  
7 cards a toll-free telephone number to call for utilization review decisions.

8 Section 30. Nothing in this Act applies to dental only, vision only, accident only, school  
9 accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed  
10 occurrence, or fixed per procedure benefit without regard to expenses incurred.

11 Section 31. If the director of the Division of Insurance and the secretary of the Department  
12 of Health find that the requirements of any private accrediting body meet the requirements of  
13 utilization review as set forth in this Act, the managed care plan may, at the discretion of the  
14 director and secretary, be deemed to have met the applicable requirements.

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Health and Human Services. H.J. 34

3 1/27/99 Scheduled for Committee hearing on this date.

4 1/27/99 Scheduled for Committee hearing on this date.

5 1/29/99 Scheduled for Committee hearing on this date.

6 1/29/99 Health and Human Services Do Pass Amended, Passed, AYES 11, NAYS 1. H.J. 308

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

346C0266

HOUSE HEALTH AND HUMAN SERVICES  
COMMITTEE ENGROSSED NO. **HB1013** -  
2/3/99

Introduced by: Representatives Hunt, Duenwald, Fiegen, Hagen, Koskan, and Peterson and  
Senators Lawler, Brosz, Ham, and Kloucek at the request of the Interim Health  
and Human Services Committee

1 FOR AN ACT ENTITLED, An Act to establish certain requirements regarding coverage of  
2 emergency medical services in managed care plans.

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

4 Section 1. Terms used in this Act mean:

5 (1) "Covered person," a policyholder, subscriber, enrollee, or other individual  
6 participating in a managed care plan;

7 (2) "Emergency medical condition," the sudden and, at the time, unexpected onset of a  
8 health condition that requires immediate medical attention, if failure to provide  
9 medical attention would result in serious impairment to bodily functions or serious  
10 dysfunction of a bodily organ or part, or would place the person's health in serious  
11 jeopardy;

12 (3) "Emergency service," health care items and services furnished or required to evaluate  
13 and treat an emergency medical condition;

14 (4) "Managed care contractor," a person who establishes, operates, or maintains a

1 network of participating providers; or contracts with an insurance company, a hospital  
2 or medical service plan, an employer, an employee organization, or any other entity  
3 providing coverage for health care services to operate a managed care plan;

4 (5) "Managed care entity," a licensed insurance company, hospital or medical service  
5 plan, health maintenance organization, an employer or employee organization, or a  
6 managed care contractor that operates a managed care plan;

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

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

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

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

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

18 (8) "Stabilized," with respect to an emergency medical condition, that no material  
19 deterioration of the condition is likely, with reasonable medical probability, to result  
20 or occur before an individual can be transferred.

21 Section 2. A managed care plan shall cover emergency services necessary to screen and  
22 stabilize a covered person and may not require prior authorization of such services if a prudent  
23 lay person acting reasonably would have believed that an emergency medical condition existed.

24 With respect to care obtained from a non-contracting provider within the service area of a  
25 managed care plan, a plan shall cover emergency services necessary to screen and stabilize a

1 covered person and may not require prior authorization of such services if a prudent layperson  
2 would have reasonably believed that use of a contracting provider would result in a delay that  
3 would worsen the emergency, or if a provision of federal, state, or local law requires the use of  
4 a specific provider. The coverage shall be at the same benefit level as if the service or treatment  
5 had been rendered by a participating provider.

6 A managed care plan shall cover emergency services if the plan, acting through a  
7 participating provider or other authorized representative, has authorized the provision of  
8 emergency services.

9 Section 3. If a participating provider or other authorized representative of a managed care  
10 plan authorizes emergency services, the plan may not retroactively deny its authorization after  
11 the emergency services have been provided, or reduce payment for a covered expense furnished  
12 in reliance on approval, unless the approval was based on a material misrepresentation about the  
13 covered person's health condition made by the provider of emergency services.

14 Section 4. Coverage of emergency services is subject to any contract coverage limits,  
15 applicable copayments, coinsurance, and deductibles.

16 Section 5. For immediately required post-evaluation or post-stabilization services, a health  
17 carrier shall provide access to an authorized representative twenty-four hours a day, seven days  
18 a week, to facilitate review, or otherwise provide coverage with no financial penalty to the  
19 covered person.

20 Section 6. A covered person shall have access to emergency services twenty-four hours a  
21 day, seven days a week to treat emergency medical conditions that require immediate medical  
22 attention.

23 Section 7. Nothing in this Act applies to dental only, vision only, accident only, school  
24 accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed  
25 occurrence, or fixed per procedure benefit without regard to expenses incurred.

1           Section 8. If the director of the Division of Insurance and the secretary of the Department  
2 of Health find that the requirements of any private accrediting body meet the requirements of  
3 coverage of emergency medical services as set forth in this Act, the managed care plan may, at  
4 the discretion of the director and secretary, be deemed to have met the applicable requirements.

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Health and Human Services. H.J. 34

3 1/27/99 Scheduled for Committee hearing on this date.

4 1/27/99 Scheduled for Committee hearing on this date.

5 1/29/99 Scheduled for Committee hearing on this date.

6 1/29/99 Health and Human Services Do Pass Amended, Passed, AYES 12, NAYS 0. H.J. 309

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

159C0269

HOUSE LOCAL GOVERNMENT COMMITTEE

ENGROSSED NO. **HB1015** - 1/20/99

Introduced by: The Committee on Local Government at the request of the State Board of Elections

1 FOR AN ACT ENTITLED, An Act to revise certain election procedures for the formation of  
2 certain special districts and the election of directors, managers, or trustees.

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

4 Section 1. That chapter 6-16 be amended by adding thereto a NEW SECTION to read as  
5 follows:

6 A landowner for the purposes of chapter 6-16 means any person who owns property, as  
7 defined pursuant to § 10-4-2 or 10-9-1, within the special district and is listed as an owner of the  
8 property by the register of deeds. A partnership, association, cooperative, trust, limited liability  
9 company, or corporation may by resolution appoint one person to vote in a special district  
10 election on behalf of the partnership, association, cooperative, trust, limited liability company,  
11 or corporation. A person who has purchased property under a contract for deed which is of  
12 record in the office of the register of deeds in the county where the real property is situated is  
13 entitled to vote in the special district election and the seller of the property under a recorded  
14 contract for deed may not vote. No person, partnership, association, cooperative, trust, limited  
15 liability company, or corporation may vote more than once in any special district election.

16 Section 2. That chapter 6-16 be amended by adding thereto a NEW SECTION to read as

1 follows:

2 Sections 3 to 6, inclusive, of this Act apply to elections of the board of directors, managers,  
3 or trustees for certain special districts. The special districts covered are county road, ambulance,  
4 rural fire protection, watershed, and water project districts.

5 Section 3. That chapter 6-16 be amended by adding thereto a NEW SECTION to read as  
6 follows:

7 Each special district shall conduct an election during the annual meeting to replace any  
8 director, manager, or trustee whose term has expired. The district clerk or secretary is designated  
9 as the person in charge of the election and shall conduct the election on behalf of the district. The  
10 notice of election shall be published pursuant to the time frames established in § 6-16-4.  
11 However, the notice for a water project district shall include information on any project reserve  
12 fund established by the water project district pursuant to § 46A-18-57.1.

13 Section 4. That chapter 6-16 be amended by adding thereto a NEW SECTION to read as  
14 follows:

15 The district president or chair shall call the landowners present at the annual meeting to  
16 order. The person in charge of the election shall select and appoint three landowners of the  
17 district to serve as election deputies, who shall be duly sworn and shall conduct the district's  
18 election. The voters in attendance at the annual meeting shall nominate each person to be elected.

19 Section 5. That chapter 6-16 be amended by adding thereto a NEW SECTION to read as  
20 follows:

21 An election deputy shall keep a poll list by entering the name of each person who votes. A  
22 single ballot shall be distributed to each voter upon which votes may be cast for each office to  
23 be elected. Each voter shall fold the ballot to conceal the contents and deliver the ballot to an  
24 election deputy. The election deputy shall deposit the ballot in a box provided for that purpose.

25 Section 6. That chapter 6-16 be amended by adding thereto a NEW SECTION to read as

1 follows:

2 At the close of the election, the election deputies shall publicly count the votes. After the  
3 counting is commenced, the counting shall continue without adjournment or interruption until  
4 completed. The count shall be conducted according to the procedures for the tabulation of paper  
5 ballots as provided in the general election procedures in chapter 12-20. The person who has the  
6 highest number of votes for any office is elected. If two or more persons have an equal and the  
7 highest number of votes for any office, the election deputies shall at once publicly determine by  
8 lot which person is elected. After the count has been completed, the secretary shall enter a  
9 statement of the result in the minutes and publicly read the results at the meeting. The reading  
10 shall be deemed notice of the result of the election.

11 Section 7. That § 6-16-2 be amended to read as follows:

12 6-16-2. The application for organization shall be a petition verified by one or more  
13 circulators by affidavit stating that each affiant personally witnessed the signatures on the petition  
14 and believe the signatures to be genuine. The petition shall be signed by at least twenty-five  
15 percent of the landowners within the proposed district ~~who are also registered voters within the~~  
16 ~~district~~. If the proposed district is in two or more counties, a petition shall be filed in each county  
17 and each petition shall be signed by at least ~~twenty~~ twenty-five percent of the landowners within  
18 the proposed district ~~who are also registered voters within the proposed district~~ in that county.  
19 The petition shall be accompanied by a deposit covering the estimated costs as determined by  
20 the county auditor of the public notices and the conduct of the election for the formation of the  
21 district.

22 Section 8. That § 6-16-4 be amended to read as follows:

23 6-16-4. The county auditor shall publish the notice ~~of the voter registration deadline at least~~  
24 ~~once each week for two consecutive weeks, the last publication to be not less than twenty-five~~  
25 ~~nor more than thirty days prior to the election. The auditor shall publish notices of election at~~

1 least once each week for two consecutive weeks, the last publication to be not less than four nor  
2 more than ten days before the election in a legal newspaper or newspapers of general circulation  
3 in the proposed district.

4 Section 9. That § 6-16-6 be amended to read as follows:

5 6-16-6. A person who is a landowner in the proposed district ~~and is registered to vote in the~~  
6 ~~proposed district~~ may vote in the elections provided for in § 6-16-5. However, the qualifications  
7 of a voter for irrigation district elections are provided in chapter 46A-4. ~~Absentee voting is~~  
8 ~~allowed~~ A person who is a landowner in the proposed district may vote absentee pursuant to  
9 chapter 12-19 for the election on the question of formation of the special district.

10 Section 10. That § 6-16-7 be amended to read as follows:

11 6-16-7. If there is a conflict regarding who has a right to vote in the election pursuant to §§  
12 6-16-4 to 6-16-6 and sections 1 to 6, inclusive, of this Act, the judges of election shall settle the  
13 conflict by referring to the official records of the register of deeds ~~and county auditor~~ in each  
14 county where these official records are held.

15 Section 11. That § 31-12A-3 be amended to read as follows:

16 31-12A-3. Any landowner who owns land lying within the limits of the territory proposed  
17 to be organized into a district may file a petition with the board of county commissioners asking  
18 that a road district be organized to function in the territory described in the petition. The petition  
19 shall set forth:

- 20 (1) The proposed name of the district;
- 21 (2) That there is need for road work in the territory described in the petition;
- 22 (3) A description of the territory proposed to be organized as a district; and
- 23 (4) A request ~~that the board of county commissioners define the boundaries for the~~  
24 ~~district~~; that a referendum be held within the territory ~~so defined~~ on the question of  
25 the creation of a road district in the territory; ~~and that the board determine that such~~

1 a district be created.

2 Section 12. That § 31-12A-13 be repealed.

3 ~~31-12A-13. The board of county commissioners is authorized to expend funds of the county,~~  
4 ~~in the manner and to the extent permitted by law for other county expenditures, in the payment~~  
5 ~~of necessary costs of preparation of petitions, surveys, maps, and applications submitted under~~  
6 ~~the provisions of this chapter, and of the holding of elections on the incorporation of road~~  
7 ~~districts hereunder. The county board is also authorized to accept and expend any funds~~  
8 ~~appropriated to the State Department of Transportation and allocated by that department to the~~  
9 ~~county for these purposes.~~

10 Section 13. That § 31-12A-15 be amended to read as follows:

11 31-12A-15. ~~In every~~ Each road district shall hold an annual election of officers ~~shall be held~~  
12 meeting on the first Tuesday after the anniversary date of the first election ~~at such place in the~~  
13 ~~district as the board of trustees shall designate. Such election shall be conducted according to~~  
14 ~~chapter 9-13.~~

15 Section 14. That § 31-12A-17 be amended to read as follows:

16 31-12A-17. ~~The trustees~~ Each trustee to be elected at the initial election; shall be nominated  
17 by the voters in attendance at the meeting in which the organizational election is held. ~~Any~~  
18 ~~trustee to be elected at subsequent elections, shall be nominated by filing with the district clerk~~  
19 ~~not less than fifteen days before any subsequent election, certificates of nomination for the offices~~  
20 ~~of trustee. The certificates shall be in writing and shall contain the name of the candidate,~~  
21 ~~residence, business address, and the office for which the candidate is named, and shall be signed~~  
22 ~~by at least five percent of the qualified voters.~~

23 Section 15. That § 34-11A-28 be amended to read as follows:

24 34-11A-28. The boundaries of any ambulance district organized under the provisions of this  
25 chapter may be changed in the manner prescribed by §§ 34-11A-4 to ~~34-11A-10~~ 34-11A-8,

1 inclusive, ~~but. However,~~ the ~~changes~~ change of boundaries of ~~any such a~~ district may not impair  
2 or affect ~~its~~ the district's organization or ~~its~~ right in or to property; nor may it the change of  
3 boundaries impair, affect, or discharge any contract, obligation, lien, or change for or upon which  
4 ~~it might~~ the district may be liable had ~~such~~ the change of boundaries not been made.

5 Section 16. That § 34-11A-29 be amended to read as follows:

6 34-11A-29. A regular meeting of the ~~registered voters who are residing within the boundaries~~  
7 landowners of a district shall be held in the first quarter of each calendar year and special  
8 meetings may be called by the board of directors at any time. ~~Notice thereof shall be given by the~~  
9 The secretary-treasurer shall give notice of a special meeting by one publication in a legal  
10 newspaper of general circulation in each county in which ~~such~~ the district is situated. The  
11 meeting shall be held not less than seven days nor more than fourteen days after the date of  
12 publication of ~~such~~ the notice.

13 Section 17. That § 34-31A-43 be amended to read as follows:

14 34-31A-43. A regular meeting of the ~~electors who are owners of any interest in real property~~  
15 ~~assessed for taxation~~ landowners in the district ~~and who are residing within the boundaries of a~~  
16 ~~district~~ shall be held in the first quarter of each calendar year and special meetings may be called  
17 by the board of directors at any time. ~~Notice thereof shall be given by the~~ The secretary-treasurer  
18 shall give notice of a special meeting by one publication in a legal newspaper of general  
19 circulation in each county in which ~~such~~ the district is situated. The meeting shall be held not less  
20 than seven days nor more than fourteen days after the date of publication of ~~such~~ the notice.

21 Section 18. That § 34A-5-18 be amended to read as follows:

22 34A-5-18. The board of trustees shall give notice of the election provided for in § 34A-5-17  
23 pursuant to ~~§ 34A-5-8~~ § 6-16-4, and the question shall be submitted to the voters on a separate  
24 ballot and be so stated as to enable each voter to vote for or against the proposed question.

25 Section 19. That § 46A-14-8 be amended to read as follows:

1 46A-14-8. The initiating petition shall contain the following:

2 (1) The name of the proposed district;

3 (2) That there is need in the interest of the public health, safety, and welfare for creation  
4 of a district to accomplish improvements in the watershed;

5 (3) A statement in general terms setting forth the purposes of the contemplated  
6 improvements, the territory to be included in the district; and all proposed  
7 subdivisions thereof, if any, of the district;

8 (4) The number ~~and names~~ of managers, ~~which~~ shall be three or five members, ~~to be~~  
9 ~~appointed as first managers of the proposed district, and who shall act for a period of~~  
10 ~~one year or until the first annual meeting. They.~~ Each manager shall be owners of own  
11 land located in the proposed district but none shall may not be a public officer of the  
12 state or federal government;

13 (5) A list of landowners and the total acreage of land owned by each within the proposed  
14 district;

15 (6) A map of the proposed district and the ownership of all land in the proposed district,  
16 except the outline only of the jurisdiction of the authorized officials of municipalities  
17 included need be shown; and

18 (7) The location of the official place of business of the proposed district;

19 ~~(8) A request for the organization of the district as proposed and appointment of the first~~  
20 ~~managers.~~

21 Section 20. That § 46A-14-38 be amended to read as follows:

22 46A-14-38. ~~Candidates shall file their written applications with the secretary of the board of~~  
23 ~~managers, at least thirty days before elections. All managers and candidates~~ Each manager and  
24 candidate shall be landowners of own land in the district. Landowners residing within or outside  
25 ~~the district may vote in person, or by absentee ballot.~~

1 Section 21. That § 46A-18-4 be amended to read as follows:

2 46A-18-4. The petition established pursuant to § 46A-18-2 shall contain:

- 3 (1) The name of the proposed district;
- 4 (2) The object and purpose of the water project and works proposed to be constructed  
5 or acquired, together with a general description of the nature, location, and method  
6 of operation of the proposed works or program of activities;
- 7 (3) A legal description of the lands constituting the proposed district and the ~~names~~ name  
8 of any ~~municipalities~~ municipality included partly or wholly within the boundaries of  
9 the proposed district;
- 10 (4) The location of the principal place of business of the proposed district; and
- 11 (5) The number of members of the board of directors of the proposed district, which  
12 number may not be less than three nor more than seven, and a statement as to ~~whether~~  
13 if the directors shall be elected at large or shall be elected by director divisions; ~~the~~  
14 ~~names and addresses of the members who shall serve as directors until their~~  
15 ~~successors are elected and qualified as provided in this chapter, and, if director~~  
16 ~~divisions are provided for, the respective divisions that the directors are to represent.~~  
17 ~~The persons named in the petition as directors.~~ Each director shall be a qualified  
18 ~~voters~~ voter of the district and, if director divisions are provided for, shall be a  
19 qualified ~~voters~~ voter of the respective ~~divisions~~ division the ~~directors are~~ director is  
20 to represent.

21 Section 22. That § 46A-18-21 be amended to read as follows:

22 46A-18-21. The initial district directors ~~named in the petition for formation, upon~~  
23 ~~establishment of the district by the Board of Water and Natural Resources;~~ shall assume the  
24 duties of ~~their offices~~ office and serve until ~~their~~ successors are duly elected and qualified.

25 Section 23. That § 46A-18-23 be amended to read as follows:

1       46A-18-23. Prior to May first of each year, on dates established by the directors, an annual  
2 meeting of the district shall be held during which the ~~voters~~ landowners shall elect, ~~by ballot,~~  
3 ~~under the direction of the secretary of the district,~~ directors to replace those the directors whose  
4 terms have expired. Each director shall own land in the district. Newly elected directors shall  
5 assume office at the time of ~~their~~ election.

6       Section 24. That § 46A-18-24 be repealed.

7       ~~46A-18-24. The water project district directors shall publish a notice once each week for~~  
8 ~~three consecutive weeks immediately prior to the annual election and meeting stating the time,~~  
9 ~~place and purpose of the election and meeting, the names of the director candidates and the~~  
10 ~~director division that each candidate is to represent in a legal newspaper of general circulation~~  
11 ~~in each county that has land situated within the district. The notice shall also include information~~  
12 ~~on any project reserve fund established by the district, as provided in § 46A-18-57.1.~~

13       Section 25. That § 46A-18-25 be repealed.

14       ~~46A-18-25. Nominations of director candidates to be elected at the annual election shall be~~  
15 ~~by nominating petition signed by at least twenty-five qualified voters or ten percent of the~~  
16 ~~qualified voters, whichever is less, in the district, if the directors are elected at large, or signed~~  
17 ~~by at least ten qualified voters or ten percent of the qualified voters, whichever is less, in the~~  
18 ~~director division if the directors are elected by division. The petitions shall be in a form~~  
19 ~~prescribed by the state board of elections and shall be filed with the secretary of the district at~~  
20 ~~least thirty days prior to the election.~~

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Local Government. H.J. 34

3 1/19/99 Scheduled for Committee hearing on this date.

4 1/19/99 Local Government Do Pass Amended, Passed, AYES 12, NAYS 1. H.J. 80

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

400C0220

## HOUSE COMMERCE COMMITTEE ENGROSSED NO. **HB1056** - 2/3/99

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

1 FOR AN ACT ENTITLED, An Act to revise certain requirements for coordination of benefits  
2 of group health plans.

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

4 Section 1. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
5 as follows:

6 For the purposes of this chapter, the term, allowable expense, means a health care service or  
7 expense including deductibles, coinsurance, or copayments, that is covered in full or in part by  
8 any of the plans covering the person, except as provided in this section. If a plan provides  
9 benefits in the form of services, the reasonable cash value of each service is considered an  
10 allowable expense and a benefit paid. An expense or service or a portion of an expense or service  
11 that is not covered by any of the plans is not an allowable expense. Expenses that are not  
12 allowable include the following:

13 (1) If a covered person is confined in a private hospital room, the difference between the  
14 cost of a semi-private room in the hospital and the private room, (unless the patient's  
15 stay in the private hospital room is medically necessary in terms of generally accepted  
16 medical practice, or one of the plans routinely provides coverage for private hospital

1 rooms) is not an allowable expense;

2 (2) If a person is covered by two or more plans that compute the benefit payments on the  
3 basis of usual and customary fees, any amount in excess of the highest of the usual  
4 and customary fee for a specified benefit is not an allowable expense;

5 (3) If a person is covered by two or more plans that provide benefits or services on the  
6 basis of negotiated fees, any amount in excess of the highest of the negotiated fees is  
7 not an allowable expense; or

8 (4) If a person is covered by one plan that calculates its benefits or services on the basis  
9 of usual and customary fees and another plan that provides its benefits or services on  
10 the basis of negotiated fees, the primary plan's payment arrangement shall be the  
11 allowable expense for all plans.

12 Section 2. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
13 as follows:

14 For the purposes of this chapter, the term, claim, means a request that benefits of a plan be  
15 provided or paid. The benefits claimed may be in the form of:

- 16 (1) Services (including supplies);
- 17 (2) Payment for all or a portion of the expenses incurred;
- 18 (3) A combination of subdivisions (1) and (2) of this section; or
- 19 (4) An indemnification.

20 Section 3. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
21 as follows:

22 For the purposes of this chapter, the term, closed panel plan, means a health maintenance  
23 organization (HMO), preferred provider organization (PPO), exclusive provider organization  
24 (EPO), or other plan that provides health benefits to covered persons primarily in the form of  
25 services through a panel of providers that have contracted with or are employed by the plan, and

1 that excludes benefits for services provided by other providers, except in cases of emergency or  
2 referral by a panel provider.

3 Section 4. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
4 as follows:

5 For the purposes of this chapter, the term, coordination of benefits or COB, means a  
6 provision establishing an order in which plans pay their claims, and permitting secondary plans  
7 to reduce their benefits so that the combined benefits of all plans do not exceed total allowable  
8 expenses.

9 Section 5. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
10 as follows:

11 For the purposes of this chapter, the term, custodial parent, means the parent awarded  
12 custody of a child by a court decree. In the absence of a court decree, the parent with whom the  
13 child resides more than one-half of the calendar year without regard to any temporary visitation  
14 is the custodial parent.

15 Section 6. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
16 as follows:

17 For the purposes of this chapter, the term, hospital indemnity benefits, means benefits not  
18 related to expenses incurred. The term does not include reimbursement-type benefits even if  
19 designed or administered to give the insured the right to elect indemnity-type benefits at the time  
20 of claim.

21 Section 7. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
22 as follows:

23 For the purposes of this chapter, the term, plan, means a form of coverage with which  
24 coordination is allowed. The definition of plan in the group contract shall state the types of  
25 coverage that will be considered in applying the COB provision of that contract. The right to

1 include a type of coverage is limited by the rest of this definition. Separate parts of a plan for  
2 members of a group that are provided through alternative contracts that are intended to be part  
3 of a coordinated package of benefits are considered one plan and there is no COB among the  
4 separate parts of the plan.

5 Section 8. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
6 as follows:

7 A plan may include:

- 8 (1) Group insurance contracts and group subscriber contracts;
- 9 (2) Uninsured arrangements of group or group-type coverage;
- 10 (3) Group or group-type coverage through closed panel plans;
- 11 (4) Group-type contracts. Group-type contracts are contracts which are not available to  
12 the general public and can be obtained and maintained only because of membership  
13 in or connection with a particular organization or group, including franchise or  
14 blanket coverage. Individually underwritten and issued guaranteed renewable policies  
15 are not group-type even if purchased through payroll deduction at a premium savings  
16 to the insured since the insured would have the right to maintain or renew the policy  
17 independently of continued employment with the employer;
- 18 (5) The amount by which group or group-type hospital indemnity benefits exceed two  
19 hundred dollars per day;
- 20 (6) The medical care components of group long-term care contracts, such as skilled  
21 nursing care;
- 22 (7) The medical benefits coverage in group, group-type and individual automobile, no  
23 fault, and traditional automobile fault-type contracts; and
- 24 (8) Medicare or other governmental benefits, as permitted by law, except as provided in  
25 section 10 of this Act. That part of the definition of plan may be limited to the

1 hospital, medical and surgical benefits of the governmental program.

2 Section 9. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
3 as follows:

4 No plan may include:

- 5 (1) Individual or family insurance contracts;
- 6 (2) Individual or family subscriber contracts;
- 7 (3) Individual or family coverage through closed panel plans;
- 8 (4) Individual or family coverage under other prepayment, group practice and individual  
9 practice plans;
- 10 (5) Group or group-type hospital indemnity benefits of two hundred dollars per day or  
11 less;
- 12 (6) School accident-type coverages. These contracts cover students for accidents only,  
13 including athletic injuries, either on a twenty-four-hour basis or on a to-and-from  
14 school basis;
- 15 (7) Benefits provided in group long-term care insurance policies for nonmedical services,  
16 for example, personal care, adult day care, homemaker services, assistance with  
17 activities of daily living, respite care, and custodial care or for contracts that pay a  
18 fixed daily benefit without regard to expenses incurred or the receipt of services;
- 19 (8) Medicare supplement policies;
- 20 (9) A state plan under medicaid; or
- 21 (10) A governmental plan which, by law, provides benefits that are in excess of those of  
22 any private insurance plan or other nongovernmental plan.

23 Section 10. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
24 as follows:

25 For the purposes of this chapter, the term, primary plan, means a plan whose benefits for a

1 person's health care coverage shall be determined without taking the existence of any other plan  
2 into consideration. A plan is a primary plan if either of the following is true:

3 (1) The plan either has no order of benefit determination rules, or its rules differ from  
4 those permitted by this chapter; or

5 (2) All plans that cover the person use the order of benefit determination rules required  
6 by this chapter, and under those rules the plan determines its benefits first.

7 Section 11. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
8 as follows:

9 For the purposes of this chapter, the term, secondary plan, means a plan that is not a primary  
10 plan. If a person is covered by more than one secondary plan, the order of benefit determination  
11 rules of this chapter decide the order in which secondary plans benefits are determined in relation  
12 to each other. Each secondary plan shall take into consideration the benefits of the primary plan  
13 or plans and the benefits of any other plan which, under the rules of this chapter, has its benefits  
14 determined before those of that secondary plan.

15 Section 12. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
16 as follows:

17 For the purposes of this chapter, the term, this plan, means, in a COB provision, the part of  
18 the group contract providing the health care benefits to which the COB provision applies and  
19 which may be reduced because of the benefits of other plans. Any other part of the group  
20 contract providing health care benefits is separate from this plan. A group contract may apply  
21 one COB provision to certain of its benefits (such as dental benefits), coordinating only with  
22 similar benefits, and may apply another COB provision to coordinate with other benefits.

23 Section 13. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
24 as follows:

25 The plan definition of allowable expense may exclude certain types of coverage or benefits

1 such as dental care, vision care, prescription drug, or hearing aids. A plan that limits the  
2 application of COB to certain coverages or benefits may limit the definition of allowable  
3 expenses in its contract to services or expenses that are similar to the services or expenses that  
4 it provides. If COB is restricted to specific coverages or benefits in a contract, the definition of  
5 allowable expense shall include similar services or expenses to which COB applies.

6 Section 14. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
7 as follows:

8 The amount of the reduction may be excluded from allowable expense if a covered person's  
9 benefits are reduced under a primary plan:

- 10 (1) Because the covered person does not comply with the plan provisions concerning  
11 second surgical opinions or precertification of admissions or services; or
- 12 (2) Because the covered person has a lower benefit because the person did not use a  
13 panel provider.

14 Section 15. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
15 as follows:

16 If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan,  
17 the secondary plan shall pay or provide benefits as if it were primary when a covered person uses  
18 a nonpanel provider, except for emergency services or authorized referrals that are paid or  
19 provided by the primary plan.

20 Section 16. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
21 as follows:

22 The director shall, by rules promulgated pursuant to chapter 1-26, prescribe the format for  
23 the COB provision and a plain language explanation of the COB process for use in group  
24 contracts.

25 Section 17. That chapter 58-18A be amended by adding thereto a NEW SECTION to read

1 as follows:

2 A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

- 3 (1) Another plan exists and the covered person did not enroll in that plan;
- 4 (2) A person could have been covered under another plan, except with respect to Part B  
5 of medicare;
- 6 (3) A person is covered under another plan, except as allowed in this Act; or
- 7 (4) A person has elected an option under another plan providing a lower level of benefits  
8 than another option that could have been elected.

9 Nothing in this Act prohibits a plan from coordinating as a secondary payor with medicare  
10 to the extent allowed by federal law.

11 Section 18. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
12 as follows:

13 No plan may contain a provision that its benefits are always excess or always secondary  
14 unless that provision is in accord with the rules permitted by this chapter.

15 Section 19. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
16 as follows:

17 Under the terms of a closed panel plan, benefits are not payable if the covered person does  
18 not use the services of a closed panel provider. In most instances, COB does not occur if a  
19 covered person is enrolled in two or more closed panel plans and obtains services from a  
20 provider in one of the closed panel plans because the other closed panel plan (the one whose  
21 providers were not used) has no liability. However, COB may occur during the claim  
22 determination period if the covered person receives emergency services that would have been  
23 covered by both plans. Then the secondary plan shall use the benefit reserve to pay any unpaid  
24 allowable expense.

25 Section 20. That chapter 58-18A be amended by adding thereto a NEW SECTION to read

1 as follows:

2 If a person is covered by two or more plans, the rules for determining the order of benefit  
3 payments are as contained in sections 23 to 26, inclusive, of this Act.

4 Section 21. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
5 as follows:

6 The primary plan shall pay or provide its benefits as if the secondary plan or plans did not  
7 exist.

8 Section 22. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
9 as follows:

10 A plan that does not contain a coordination of benefits provision that is consistent with this  
11 chapter is always primary. However, coverage that is obtained by virtue of membership in a  
12 group and designed to supplement a part of a basic package of benefits may provide that the  
13 supplementary coverage shall be excess to any other parts of the plan provided by the contract  
14 holder. Examples of these types of situations are major medical coverages that are superimposed  
15 over base plan hospital and surgical benefits, and insurance type coverages that are written in  
16 connection with a closed panel plan to provide out-of-network benefits.

17 Section 23. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
18 as follows:

19 A plan may consider the benefits paid or provided by another plan only if it is secondary to  
20 that other plan.

21 Section 24. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
22 as follows:

23 The first of the following rules that describes which plan pays its benefits before another plan  
24 is the governing rule:

25 (1) The plan that covers the person other than as a dependent, for example as an

1 employee, member, subscriber, or retiree, is primary and the plan that covers the  
2 person as a dependent is secondary. However, if the person is a medicare beneficiary,  
3 and, as a result of the provisions of Title XVIII of the Social Security Act and  
4 implementing regulations, medicare is:

- 5 (a) Secondary to the plan covering the person as a dependent; and
- 6 (b) Primary to the plan covering the person as other than a dependent (e.g. a  
7 retired employee),

8 then the order of benefits is reversed so that the plan covering the person as an  
9 employee, member, subscriber or retiree is secondary and the other plan is primary;

10 (2) The primary plan is the plan of the parent whose birthday is earlier in the year if:

- 11 (a) The parents are married;
- 12 (b) The parents are not separated (whether or not they ever have been married);  
13 or
- 14 (c) A court decree awards joint custody without specifying that one parent has the  
15 responsibility to provide health care coverage;

16 (3) If both parents have the same birthday, the plan that has covered either of the parents  
17 longer is primary;

18 (4) If the specific terms of a court decree state that one of the parents is responsible for  
19 the child's health care expenses or health care coverage, that plan is primary. If the  
20 parent with financial responsibility has no coverage for the child's health care services  
21 or expenses, but that parent's spouse does, the spouse's plan is primary;

22 (5) If the parents are not married or are separated (whether or not they ever were  
23 married) or are divorced, and there is no court decree allocating responsibility for the  
24 child's health care services or expenses, the order of benefit determination among the  
25 plans of the parents and the parents' spouses is:

- 1 (a) The plan of the custodial parent; then
- 2 (b) The plan of the spouse of the custodial parent; then
- 3 (c) The plan of the noncustodial parent; and then
- 4 (d) The plan of the spouse of the noncustodial parent;
- 5 (6) The plan that covers a person as an employee who is neither laid off nor retired (or
- 6 as that employee's dependent) is primary. If the other plan does not have this rule; and
- 7 if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- 8 Coverage provided an individual as a retired worker and as a dependent of that
- 9 individual's spouse as an active worker will be determined under section 35 of this
- 10 Act;
- 11 (7) If a person whose coverage is provided under a right of continuation pursuant to
- 12 federal or state law also is covered under another plan, the plan covering the person
- 13 as an employee, member, subscriber or retiree (or as that person's dependent) is
- 14 primary and the continuation coverage is secondary. If the other plan does not have
- 15 this rule, and if, as a result, the plans do not agree on the order of benefits, this rule
- 16 does not apply.

17 Section 25. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
18 as follows:

19 If the provisions of sections 23 to 26, inclusive, of this Act do not determine the order of  
20 benefits, the plan that covered the person for the longer period of time is the primary plan.

21 Section 26. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
22 as follows:

23 To determine the length of time a person has been covered under a plan, two plans shall be  
24 treated as one if the covered person was eligible under the second within twenty-four hours after  
25 the first ended.

1 Section 27. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
2 as follows:

3 The start of a new plan does not include:

- 4 (1) A change in the amount or scope of a plan's benefits;
- 5 (2) A change in the entity that pays, provides or administers the plan's benefits; or
- 6 (3) A change from one type of plan to another (such as, from a single employer plan to  
7 that of a multiple employer plan).

8 Section 28. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
9 as follows:

10 The person's length of time covered under a plan is measured from the person's first date of  
11 coverage under that plan. If that date is not readily available for a group plan, the date the person  
12 first became a member of the group shall be used as the date from which to determine the length  
13 of time the person's coverage under the present plan has been in force.

14 Section 29. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
15 as follows:

16 If none of the provisions of sections 22 to 30, inclusive, of this Act determine the primary  
17 plan, the allowable expenses shall be shared equally between the plans.

18 Section 30. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
19 as follows:

20 If a plan is secondary, it shall reduce its benefits so that the total benefits paid or provided  
21 by all plans for any claim or claims are not more than one hundred percent of total allowable  
22 expenses. In determining the amount of a claim to be paid by the secondary plan should the plan  
23 wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid in  
24 the absence of other insurance and apply that calculated amount to any allowable expense under  
25 its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by any

1 amount that, when combined with the amount paid by the primary plan, exceeds the total  
2 allowable expense for that claim.

3 Section 31. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
4 as follows:

5 A plan shall, in its explanation of benefits provided to covered persons, include the following  
6 language: If you are covered by more than one health benefit plan, you should file all your claims  
7 with each plan.

8 Section 32. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
9 as follows:

10 A secondary plan that provides benefits in the form of services may recover the reasonable  
11 cash value of the services from the primary plan, to the extent that benefits for the services are  
12 covered by the primary plan and have not already been paid or provided by the primary plan.  
13 Nothing in this section may be interpreted to require a plan to reimburse a covered person in cash  
14 for the value of services provided by a plan that provides benefits in the form of services.

15 Section 33. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
16 as follows:

17 A plan with order of benefit determination rules that comply with this chapter (complying  
18 plan) may coordinate its benefits with a plan that is excess or always secondary or that uses order  
19 of benefit determination rules that are inconsistent with those contained in this chapter  
20 (noncomplying plan) on the following basis:

- 21 (1) If the complying plan is the primary plan, it shall pay or provide its benefits first;
- 22 (2) If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its  
23 benefits first, but the amount of the benefits payable shall be determined as if the  
24 complying plan were the secondary plan. In such a situation, the payment shall be the  
25 limit of the complying plan's liability; and

1 (3) If the noncomplying plan does not provide the information needed by the complying  
2 plan to determine its benefits within a reasonable time after it is requested to do so,  
3 the complying plan shall assume that the benefits of the noncomplying plan are  
4 identical to its own, and shall pay its benefits accordingly. If, within two years of  
5 payment, the complying plan receives information as to the actual benefits of the  
6 noncomplying plan, it shall adjust payments accordingly.

7 Section 34. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
8 as follows:

9 If the noncomplying plan reduces its benefits so that the covered person receives less in  
10 benefits than the person would have received had the complying plan paid or provided its benefits  
11 as the secondary plan and the noncomplying plan paid or provided its benefits as the primary  
12 plan, and governing state law allows the right of subrogation set forth below, then the complying  
13 plan shall advance to or on behalf of the covered person an amount equal to the difference.

14 Section 35. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
15 as follows:

16 In no event may the complying plan advance more than the complying plan would have paid  
17 had it been the primary plan less any amount it previously paid for the same expense or service.  
18 In consideration of the advance, the complying plan shall be subrogated to all rights of the  
19 covered person against the noncomplying plan. The advance by the complying plan shall also be  
20 without prejudice to any claim it may have against a noncomplying plan in the absence of  
21 subrogation.

22 Section 36. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
23 as follows:

24 COB differs from subrogation. Provisions for one may be included in health care benefits  
25 contracts without compelling the inclusion or exclusion of the other.

1 Section 37. That chapter 58-18A be amended by adding thereto a NEW SECTION to read  
2 as follows:

3 If the plans cannot agree on the order of benefits within thirty calendar days after the plans  
4 have received all of the information needed to pay the claim, the plans shall immediately pay the  
5 claim in equal shares and determine their relative liabilities following payment, except that no  
6 plan may be required to pay more than it would have paid had it been the primary plan.

7 Section 38. That § 58-18A-1 be repealed.

8 ~~58-18A-1. Terms used in this chapter mean:~~

9 ~~(1) "Allowable expense," the necessary, reasonable, and customary item of expense for~~  
10 ~~health care when the item of expense is covered, in full or in part, under one or more~~  
11 ~~plans covering the person for whom the claim is made. Allowable expense is restricted~~  
12 ~~by the following:~~

13 ~~(a) When a plan provides benefits in the form of services, the reasonable cash~~  
14 ~~value of each service will be considered as both an allowable expense and a~~  
15 ~~benefit paid;~~

16 ~~(b) When COB is restricted in its use to a specific coverage in a contract, the~~  
17 ~~definition of allowable expense must include the corresponding expenses or~~  
18 ~~services to which COB applies;~~

19 ~~(c) The difference between the cost of a private hospital room and the cost of the~~  
20 ~~semiprivate hospital room is not considered an allowable expense under the~~  
21 ~~above definition, unless the patient's stay in a private hospital room is medically~~  
22 ~~necessary in terms of generally accepted medical practice;~~

23 ~~(2) "Claim determination period," a period of time, not less than twelve consecutive~~  
24 ~~months over which allowable expenses are compared with total benefits payable in the~~  
25 ~~absence of COB to determine:~~

- 1 ~~———— (a) Whether overinsurance exists; and~~
- 2 ~~———— (b) How much each plan will pay or provide;~~
- 3 ~~———— (3) "Coordination of benefits" or "COB," a provision in a group health and accident~~  
4 ~~policy intended to avoid claims payment delays and duplication of benefits when a~~  
5 ~~person is covered by two or more plans of coverage providing benefits or service for~~  
6 ~~medical, dental or other care or treatment;~~
- 7 ~~———— (4) "Plan," a contract providing health care benefits to which a COB provision applies and~~  
8 ~~which may be reduced on account of benefits of other plans. A plan may include:~~
  - 9 ~~———— (a) Any group contract as defined in § 58-18-1 issued by any insurance company,~~  
10 ~~fraternal benefit society, health maintenance organization, nonprofit hospital~~  
11 ~~service plan, or medical service corporation;~~
  - 12 ~~———— (b) Medical benefits coverage in automobile insurance contracts;~~
  - 13 ~~———— (c) Medicare or other government benefits, limited to hospital, medical and~~  
14 ~~surgical benefits of the governmental program;~~
  - 15 ~~———— (d) Employee welfare benefit plans within the meaning of the Employee~~  
16 ~~Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., as of~~  
17 ~~January 1, 1987.~~
- 18 ~~———— A plan does not include an individual health and accident insurance~~  
19 ~~policy or individual subscriber contract; a blanket health insurance~~  
20 ~~policy as defined in § 58-18-12; a state plan under medicaid or any other~~  
21 ~~plan whose benefits, by law, are excess to those of any private insurance~~  
22 ~~plan or other nongovernmental plan; or group hospital indemnity~~  
23 ~~benefits of one hundred dollars per day or less;~~
- 24 ~~———— (5) "Primary plan," a plan whose benefits are required to be determined before those of~~  
25 ~~another plan and without considering the existence of another plan if:~~

1 ~~———— (a) The plan either has no order of benefit determination rules or it has rules that~~  
2 ~~differ from those permitted by this chapter; or~~

3 ~~———— (b) All plans covering a person use the order of benefit determination provision~~  
4 ~~required by this chapter, and under these provisions, the plan determines its~~  
5 ~~benefits first;~~

6 ~~—— (6) "Secondary plan," a plan whose benefits are determined after those of another plan~~  
7 ~~and which may be reduced on account of benefits provided under any primary plan;~~

8 ~~—— (7) "This plan," a term in a COB provision which refers to the part of the group contract~~  
9 ~~providing the health care benefits to which the COB provision applies and which may~~  
10 ~~be reduced on account of the benefits of other plans.~~

11       Section 39. That § 58-18A-2 be repealed.

12 ~~—— 58-18A-2. This chapter permits, but does not require, plans to include coordination of~~  
13 ~~benefits provisions.~~

14       Section 40. That § 58-18A-3 be repealed.

15 ~~—— 58-18A-3. A group contract that includes a COB provision shall be consistent with this~~  
16 ~~chapter. A plan that does not include a COB provision may not take the benefits of another plan~~  
17 ~~as defined in § 58-18A-1 into account when it determines its benefits. However, coverage that~~  
18 ~~is designed to supplement a part of a basic package of benefits may provide that the~~  
19 ~~supplementary coverage shall be excess to any other parts of plan coverage provided an insured.~~

20       Section 41. That § 58-18A-4 be repealed.

21 ~~—— 58-18A-4. A plan may apply one COB provision to certain of its benefits, coordinating only~~  
22 ~~with like benefits, and may apply other separate COB provisions to coordinate other benefits.~~

23 ~~Each contract or arrangement for coverage under subdivision 58-18A-1(4) is a separate plan.~~

24       Section 42. That § 58-18A-5 be repealed.

25 ~~—— 58-18A-5. If there is a basis for a claim under two or more plans, a plan which includes a~~

1 ~~COB provision that complies with this chapter is secondary to a plan which does not include~~  
2 ~~such a provision. If both plans contain COB provisions that comply with this chapter, the plan~~  
3 ~~which is determined to be primary according to the rules in § 58-18A-6 shall determine its~~  
4 ~~benefits before those of the other plan.~~

5 Section 43. That § 58-18A-6 be repealed.

6 ~~58-18A-6. The order of benefits shall be determined using the first of the following rules~~  
7 ~~which applies:~~

8 ~~(1) The benefits of the plan which covers the person as an employee, member or~~  
9 ~~subscriber are determined before those of the plan which covers the person as a~~  
10 ~~dependent;~~

11 ~~(2) Except as stated in subdivision (3) of this section, if two or more plans cover the same~~  
12 ~~child as a dependent of different persons:~~

13 ~~(a) The benefits of the plan of the parent whose birthday falls earlier in a year are~~  
14 ~~determined before those of the plan of the parent whose birthday falls later in~~  
15 ~~that year;~~

16 ~~(b) If both parents have the same birthday, the benefits of the plan which covered~~  
17 ~~the parent longer are determined before those of the plan which covered the~~  
18 ~~other parent for a shorter period of time;~~

19 ~~(c) If the other plan does not have the rule described in subdivision (2)(a) of this~~  
20 ~~section but has a rule based upon the gender of the parent and, as a result, the~~  
21 ~~plans do not agree on the order of benefits, the rule in the other plan will~~  
22 ~~determine the order of benefits;~~

23 ~~The term "birthday," as used in this section, means the month and day, rather than the~~  
24 ~~year, in which the person was born;~~

25 ~~(3) If two or more plans cover a person as a dependent child of divorced or separated~~

1 ~~parents, benefits for the child are determined in the following order:~~

2 ~~———— (a) First, the plan of the parent with custody of the child;~~

3 ~~———— (b) Second, the plan of the spouse of the parent with custody of the child; and~~

4 ~~———— (c) Third, the plan of the parent not having custody of the child.~~

5 ~~———— However, if the specific terms of a court decree state that one of the parents is~~  
6 ~~responsible for the health care expenses of the child, and the entity obligated to pay~~  
7 ~~or provide the benefits of the plan of that parent has actual knowledge of those terms,~~  
8 ~~the benefits of that plan are determined first. This paragraph does not apply with~~  
9 ~~respect to any claim determination period or plan year during which any benefits are~~  
10 ~~actually paid or provided before the entity has that actual knowledge.~~

11 ~~———— (4) The benefits of a plan which covers a person as an employee who is neither laid off~~  
12 ~~nor retired or as that employee's dependent are determined before those of a plan~~  
13 ~~which covers that person as a laid-off or retired employee or as that employee's~~  
14 ~~dependent. If the other plan does not have this rule, and if, as a result, the plans do~~  
15 ~~not agree on the order of benefits, this order of determination is ignored;~~

16 ~~———— (5) If subdivisions (1) to (4), inclusive, of this section do not determine the order of~~  
17 ~~benefits, the benefits of the plan which covered an employee, member or subscriber~~  
18 ~~for the longer period are determined before those of the plan which covered that~~  
19 ~~person for the shorter time. To determine the length of time a person has been~~  
20 ~~covered under a plan, two plans shall be treated as one if the claimant was eligible~~  
21 ~~under the second within twenty-four hours after the first ended.~~

22 Section 44. That § 58-18A-7 be repealed.

23 ~~———— 58-18A-7. If, according to the order of benefit determination provisions of this chapter, a~~  
24 ~~plan is secondary to one or more other plans, the secondary plan may reduce its benefits so that~~  
25 ~~they and the benefits payable under the other plans do not total more than one hundred percent~~

1 of allowable expenses. If the benefits of the secondary plan are reduced, each benefit is reduced  
2 in proportion.

3 Section 45. That § 58-18A-9 be repealed.

4 ~~58-18A-9. A payment made under another plan may include an amount which should have~~  
5 ~~been paid under this plan. In that event, the entity which should have made the payment may pay~~  
6 ~~that amount to the organization which made the payment. That amount shall then be treated as~~  
7 ~~though it were a benefit paid under this plan. The entity does not have to pay that amount again.~~  
8 ~~The term "payment made" includes providing benefits in the form of services, in which case~~  
9 ~~"payment made" means reasonable cash value of the benefits provided in the form of services.~~

10 Section 46. That § 58-18A-10 be repealed.

11 ~~58-18A-10. If the amount of the payments made by an entity is more than it should have paid~~  
12 ~~under this COB provision, it may recover the excess from one or more of the following:~~

13 ~~(1) Any person it has paid or for whom it has paid;~~

14 ~~(2) Any insurance company, fraternal benefit society, nonprofit hospital service plan,~~  
15 ~~medical service corporation or health maintenance organization; or~~

16 ~~(3) Any other organization.~~

17 ~~The "amount of the payments made" includes the reasonable cash value of any benefits~~  
18 ~~provided in the form of services.~~

19 Section 47. That § 58-18A-11 be repealed.

20 ~~58-18A-11. A group contract may not reduce benefits on the basis that:~~

21 ~~(1) Another plan exists;~~

22 ~~(2) A person is or could have been covered under another plan, except with respect to~~  
23 ~~part B of medicare; or~~

24 ~~(3) A person has elected an option under another plan providing a lower level of benefits~~  
25 ~~than another which could have been elected.~~

1 Section 48. That § 58-18A-12 be repealed.

2 ~~58-18A-12. Any plan with order of benefit determination rules which comply with this~~  
3 ~~chapter, herein referred to as a complying plan, may coordinate its benefits with a plan which is~~  
4 ~~"excess" or "always secondary" or which uses order of benefit determination rules which are~~  
5 ~~inconsistent with those contained in this chapter, herein referred to as a noncomplying plan, on~~  
6 ~~the following basis:~~

7 ~~(1) If the complying plan is the primary plan, it shall pay or provide its benefits on a~~  
8 ~~primary basis;~~

9 ~~(2) If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its~~  
10 ~~benefits first. However, the amount of the benefits payable shall be determined as if~~  
11 ~~the complying plan were the secondary plan. In such situation, the payment is the limit~~  
12 ~~of the complying plan's liability;~~

13 ~~(3) If the noncomplying plan does not provide the information needed by the complying~~  
14 ~~plan to determine its benefits within a reasonable time after it is requested to do so,~~  
15 ~~the complying plan shall assume that the benefits of the noncomplying plan are~~  
16 ~~identical to its own, and shall pay its benefits accordingly. However, the complying~~  
17 ~~plan shall adjust any payments it makes based on such assumption whenever~~  
18 ~~information becomes available as to the actual benefits of the noncomplying plan;~~

19 ~~(4) If the noncomplying plan reduces its benefits so that the employee, subscriber or~~  
20 ~~member receives less in benefits than he or she would have received had the~~  
21 ~~complying plan paid or provided its benefits as the secondary plan and the~~  
22 ~~noncomplying plan paid or provided its benefits as the primary plan, and governing~~  
23 ~~state law allows the right of subrogation set forth in § 58-18A-13, the complying plan~~  
24 ~~shall advance to or on behalf of the employee, subscriber or member an amount equal~~  
25 ~~to such difference. However, in no event may the complying plan advance more than~~

1           ~~the complying plan would have paid had it been the primary plan less any amount it~~  
2           ~~previously paid. In consideration of such advance, the complying plan shall be~~  
3           ~~subrogated to all rights of the employee, subscriber or member against the~~  
4           ~~noncomplying plan. Such advance by the complying plan shall also be without~~  
5           ~~prejudice to any claim it may have against the noncomplying plan in the absence of~~  
6           ~~such subrogation.~~

7           Section 49. That § 58-18A-13 be repealed.

8           ~~58-18A-13. The COB concept differs from the concept of subrogation and provisions~~  
9           ~~relating to one may be included in health care benefits contracts without requiring the inclusion~~  
10          ~~or exclusion of the other.~~

11          Section 50. That § 58-18A-14 be repealed.

12          ~~58-18A-14. A group contract which provides health care benefits and was issued before~~  
13          ~~July 1, 1987, shall be brought into compliance with this chapter by the later of:~~

14          ~~(1) The next anniversary date or renewal date of the group contract; or~~

15          ~~(2) The expiration of any applicable collectively bargained contract pursuant to which the~~  
16          ~~group contract was written.~~

17          Section 51. The provisions of this Act apply to group health plans that are issued or renewed  
18          on or after July 1, 2000.

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Commerce. H.J. 42

3 1/21/99 Scheduled for Committee hearing on this date.

4 2/2/99 Scheduled for Committee hearing on this date.

5 2/2/99 Commerce Do Pass Amended, Passed, AYES 13, NAYS 0. H.J. 312

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

336C0393

HOUSE LOCAL GOVERNMENT COMMITTEE

ENGROSSED NO. **HB1077** - 2/3/99

Introduced by: Representatives Hunt and Crisp and Senators Everist and Lange

1 FOR AN ACT ENTITLED, An Act to clarify voting eligibility and procedures for certain  
2 municipal incorporation elections.

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

4 Section 1. That chapter 9-3 be amended by adding thereto a NEW SECTION to read as  
5 follows:

6 In any election for the original incorporation of a municipality around all or a part of the  
7 shoreline of a lake, all owners of land as shown by the records of the county register of deeds  
8 within the proposed incorporated area, whether residents or not, and all resident voters in the  
9 proposed incorporated area, are entitled to vote.

10 Section 2. That chapter 9-3 be amended by adding thereto a NEW SECTION to read as  
11 follows:

12 The incorporation voting process after election of the inspectors shall be conducted pursuant  
13 to Title 12 and shall include the right to vote by absentee ballot.

14 Section 3. That § 9-3-3 be amended to read as follows:

15 9-3-3. Such persons shall cause an accurate census to be taken of the landowners and the  
16 resident population of the territory included in ~~said~~ the map as of a day not more than thirty days

1 previous to the time of presenting such application to the board of county commissioners as  
2 hereinafter provided. ~~Such~~ The census shall exhibit the name of every landowner and head of a  
3 family residing within ~~such~~ the territory on ~~such~~ that day and the number of persons belonging  
4 to every such family and shall also state the names of all persons residing within ~~such~~ the territory  
5 at ~~such~~ the time. ~~It~~ The census shall be verified by the affidavit of the person taking the ~~same~~  
6 census.

7 Section 4. That § 9-3-5 be amended to read as follows:

8 9-3-5. The application for incorporation shall be by a petition subscribed and verified by the  
9 applicants and subscribed by not less than fifteen percent of the landowners and registered voters  
10 residing within ~~such~~ the territory, based upon the total number of landowners and registered  
11 voters at the last preceding general election. It shall set forth the boundaries and area thereof  
12 according to the survey and the landowner and resident population thereof according to the  
13 census taken. It shall be presented at the time indicated in the notice of ~~such~~ the application or  
14 as soon thereafter as the board of county commissioners can receive and consider the ~~same~~  
15 application.

1 **BILL HISTORY**

2 1/19/99 First read in House and referred to Local Government. H.J. 85

3 1/28/99 Scheduled for Committee hearing on this date.

4 2/2/99 Scheduled for Committee hearing on this date.

5 2/2/99 Local Government Do Pass Amended, Passed, AYES 7, NAYS 6. H.J. 314

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

336C0400

HOUSE LOCAL GOVERNMENT COMMITTEE

ENGROSSED NO. **HB1096** - 2/3/99

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

Introduced by: Representatives Duenwald, Diedrich (Larry), Hagen, Jaspers, Koehn, Kooistra, Lintz, Monroe, Napoli, Wetz, and Young and Senators Vitter, Drake, Madden, Moore, and Staggers

1 FOR AN ACT ENTITLED, An Act to make the appointment of the county planning commission  
2 permissive.

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

4 Section 1. That § 11-2-2 be amended to read as follows:

5 11-2-2. ~~For the purpose of promoting health, safety, morals, and the general welfare of the~~  
6 ~~county, the~~ The board of county commissioners of each county in the state, ~~shall~~ may appoint  
7 a commission of five or more members, ~~the~~ to be known as the county planning commission. If  
8 a county proposes to enact or implement any purpose set forth in this chapter then the board of  
9 county commissioners shall appoint a county planning commission. The total membership of  
10 ~~which~~ the county planning commission shall always be an uneven number and at least one  
11 member of which shall be a member of the board, ~~to be known as the county planning~~  
12 ~~commission. Such~~ of county commissioners. The county planning commission shall also be is  
13 also the county zoning commission.

1 **BILL HISTORY**

2 1/21/99 First read in House and referred to Local Government. H.J. 108

3 1/26/99 Scheduled for Committee hearing on this date.

4 1/26/99 Local Government Deferred to another day.

5 1/28/99 Scheduled for Committee hearing on this date.

6 2/2/99 Scheduled for Committee hearing on this date.

7 2/2/99 Local Government Do Pass Amended, Passed, AYES 11, NAYS 2. H.J. 315

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

743C0467

## HOUSE COMMERCE COMMITTEE ENGROSSED NO. **HB1107** - 2/3/99

Introduced by: Representatives Cutler, Broderick, Chicoine, Fiegen, Fischer-Clemens,  
Peterson, and Wilson and Senators Olson, Munson (David), Reedy, Rounds,  
and Shoener

1 FOR AN ACT ENTITLED, An Act to revise certain provisions regarding mutually binding  
2 agreements between beer wholesalers and brewers, to revise a term relative to beer industry  
3 relationships, and to make provisions for malt beverage brand extensions.

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

5 Section 1. That § 35-8A-12 be amended to read as follows:

6 35-8A-12. Any waiver of the rights or remedies granted by this chapter is void. However,  
7 nothing in this chapter limits or prohibits suppliers and wholesalers from entering into mutually  
8 binding written agreements as defined in this chapter or to limit or prohibit good faith dispute  
9 settlements voluntarily entered into by the parties. However, no provision of any written  
10 agreement may purport to require the law of any state other than South Dakota to govern the  
11 relationship of the parties or to require wholesalers to waive the right to have disputes with their  
12 suppliers resolved in courts of competent jurisdiction in South Dakota or by a jury.

13 Section 2. That § 35-8A-9 be amended to read as follows:

14 35-8A-9. Any party to a distribution agreement aggrieved by a violation of any provision of  
15 this chapter may seek injunctive relief enjoining the violation and recovery of damages caused

1 by the violation. The prevailing party to any action charging a violation of this chapter is entitled  
2 to recover costs of suit and reasonable attorney's fees. Relief shall be sought in a civil action  
3 brought in the circuit court for the county in which the ~~wholesaler has his~~ wholesaler's principal  
4 place of business is located, ~~or in any other court of competent jurisdiction, whether state or~~  
5 ~~federal~~ or in a federal court of competent jurisdiction located in South Dakota.

6 After a dispute arises, arbitration shall proceed only if all parties agree, at that time, to submit  
7 the dispute to arbitration and that the decision of the arbitrators shall be final and binding. The  
8 dispute shall be submitted to a panel of three arbitrators. One arbitrator shall be selected by the  
9 supplier within thirty days after the parties have agreed to arbitrate. One arbitrator shall be  
10 selected by the wholesaler within thirty days after the parties have agreed to arbitrate. The third  
11 arbitrator shall be selected from a list of five candidates supplied by the American Arbitration  
12 Association at the request of the parties and made within ten days after the parties have agreed  
13 to submit the dispute to arbitration. Within ten days after receipt of the list, the wholesaler and  
14 the supplier may disqualify up to two candidates from the list. The American Arbitration  
15 Association shall select the third arbitrator from the candidates not disqualified by the parties.  
16 The arbitration shall proceed in accordance with the rules of the American Arbitration  
17 Association within thirty days after the selection of the arbitration panel has been completed. The  
18 cost of the arbitration shall be borne equally by the parties. The award of a majority of the  
19 arbitrators shall be final and binding on the parties.

20 Section 3. That chapter 35-8A be amended by adding thereto a NEW SECTION to read as  
21 follows:

22 For purposes of this chapter, the term, brand, means any word, name, group of letters,  
23 symbol, or combination thereof, that is adopted and used by a brewer or importer to identify a  
24 specific beer product, and to distinguish that beer product from another beer product.

25 Section 4. That chapter 35-8A be amended by adding thereto a NEW SECTION to read as

1 follows:

2 For purposes of this chapter, the term, brand extension, means any brand that incorporates  
3 all or a substantial part of the unique features of a preexisting brand of the same brewer or  
4 importer and that relies to a significant extent on the goodwill associated with that preexisting  
5 brand.

6 Section 5. That chapter 35-8A be amended by adding thereto a NEW SECTION to read as  
7 follows:

8 Any brewer or importer, who assigns a brand extension to a wholesaler, shall assign the  
9 brand extension to the wholesaler to whom the brewer or importer granted the exclusive sales  
10 territory for the brand from which the brand extension resulted. This requirement does not apply  
11 to any assignment of a brand extension to a wholesaler that was made by a brewer or importer  
12 before the effective date of this Act.

13 Section 6. That chapter 35-8A be amended by adding thereto a NEW SECTION to read as  
14 follows:

15 If prior to the effective date of this Act, a brewer or importer assigned a brand extension to  
16 a wholesaler who was not the appointed wholesaler for the brand from which the brand extension  
17 was made, then any additional brand extension shall be assigned to the wholesaler who first had  
18 the brand.

19 Section 7. That subdivision (6) of § 35-8A-2 be amended to read as follows:

20 (6) "Good faith," the duty of each party to any agreement to ~~act in a fair and equitable~~  
21 manner in carrying out the agreement deal with the other party in a fair, reasonable,  
22 and nondiscriminatory manner consistent with reasonable commercial standards of fair  
23 dealing;

24 Section 8. That § 35-8A-4 be amended to read as follows:

25 35-8A-4. No supplier may:

- 1 (1) Induce or coerce, or attempt to induce or coerce, a wholesaler to do any illegal act  
2 by threatening to amend, cancel, terminate, or refuse to renew any agreement existing  
3 between the supplier and wholesaler, or by any other means;
- 4 (2) Require a wholesaler by any means to participate in or contribute to any local or  
5 national advertising fund controlled directly or indirectly by a supplier, unless the cost  
6 is allocated fairly to each wholesaler in that market area according to sales to the  
7 wholesalers;
- 8 (3) Withhold delivery of malt beverages ordered by a wholesaler or change a wholesaler's  
9 quota of a brand or brands if the action is not made in good faith;
- 10 (4) Require a wholesaler to accept delivery of any malt beverages or other item or  
11 commodity which was not ordered by the wholesaler or which was ordered but  
12 properly canceled by the wholesaler in accordance with the procedures previously  
13 established by the supplier. However, a supplier may impose reasonable inventory  
14 requirements upon a wholesaler if the requirements are made in good faith and are  
15 generally applied to other similarly situated wholesalers of the supplier;
- 16 (5) Require a wholesaler to purchase one or more brands of malt beverages in order for  
17 the wholesaler to purchase another brand or brands of malt beverage for any reason;
- 18 (6) Prohibit a wholesaler from dealing in any product not supplied by the supplier,  
19 including any product of any other supplier of any other alcoholic beverage or any  
20 nonalcoholic product, or in any way attempt to regulate or control ancillary businesses  
21 of a wholesaler;
- 22 (7) Fix or maintain the price at which a wholesaler may resell malt beverages;
- 23 (8) Take any action not in good faith against a wholesaler for or because of the filing of  
24 a complaint regarding an alleged violation by the supplier of any state or federal law  
25 or administrative rule;

1       (9) ~~Require or prohibit without good cause any change in the manager or successor~~  
2       ~~manager of a wholesaler who has been approved by the supplier~~ Refuse to approve  
3       any proposed manager or successor manager without good cause or require or  
4       prohibit any change in the manager or successor manager of a wholesaler who has  
5       been previously approved by the supplier without good cause; or

6       (10) Withdraw from or discontinue supplying to a wholesaler one or more brands or  
7       packages of malt beverages. However, nothing in this subdivision prohibits a supplier  
8       from withdrawing or discontinuing any brand or package on a statewide or on a media  
9       coverage area basis at any time on reasonable notice or conducting test marketing of  
10      a new brand or of a brand of beer which is not currently being sold in this state.

11      Section 9. That chapter 35-8A be amended by adding thereto a NEW SECTION to read as  
12      follows:

13      The provisions of this Act apply to any agreement in existence as of July 1, 1999, as well as  
14      any agreement entered into after July 1, 1999. Any written agreement in existence on July 1,  
15      1999, which is continuous in nature or which has no specific duration or renewal provision, shall  
16      be considered, for the purpose of this Act, to have been renewed ninety days after July 1, 1999.

1 **BILL HISTORY**

2 1/21/99 First read in House and referred to Commerce. H.J. 111

3 2/2/99 Scheduled for Committee hearing on this date.

4 2/2/99 Commerce Do Pass Amended, Passed, AYES 11, NAYS 2. H.J. 313

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

562C0570

## HOUSE JUDICIARY COMMITTEE ENGROSSED NO. **HB1183** - 2/3/99

Introduced by: Representatives Solum and Broderick and Senators Munson (David), Lawler,  
and Shoener

1 FOR AN ACT ENTITLED, An Act to revise certain provisions regarding consumer installment  
2 sales contracts.

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

4 Section 1. That § 54-4-64 be amended to read as follows:

5 54-4-64. The provisions of §§ 54-4-36 to 54-4-63, inclusive, do not apply to any person  
6 selling goods or services, as defined in § 54-3A-1, and providing financing for such goods or  
7 services.

8 Section 2. That § 54-3A-1 be amended to read as follows:

9 54-3A-1. Terms used in this chapter, ~~unless the context otherwise requires~~, mean:

10 (1) "Cash sale price," the price for which the person making a sale pursuant to an  
11 installment sales contract would have sold the goods or services if the sale had been  
12 for cash. The cash sale price may include any taxes or license, title, and registration  
13 fees and the cash price of any accessories or services related to the sale, such as  
14 charges for delivery, installation, alterations, modifications, ~~and~~ improvements, and  
15 any other similar charges agreed upon between the parties. The cash price of a motor  
16 vehicle may also include a documentary fee or document administration fee for

1 services actually rendered to, for, or on behalf of, the retail buyer, in preparing,  
2 handling, and processing documents relating to the motor vehicle and the closing of  
3 the retail sale;

4 (2) "Consumer," a natural person who seeks or acquires, or is offered property, services,  
5 or credit for personal, family, household, or agricultural purposes;

6 (3) "Consumer transaction," a transaction involving the purchase or sale of goods or  
7 services for personal, family, household, or agricultural use from one, who in the  
8 ordinary course of business sells goods or services. The parties to a transaction, which  
9 involves the purchase or sale of goods or services but which is not a consumer  
10 transaction, may agree to be governed by all of the provisions of this chapter with  
11 respect to the transaction, and in such event the transaction shall be deemed to be a  
12 consumer transaction for all purposes of this chapter;

13 (4) "Finance charge," however denominated, ~~means~~ the amount which is paid or payable  
14 for the privilege of paying for goods or services in one or more installments. It does  
15 not include a delinquency charge as permitted in §§ 54-3A-11 and 54-3A-12,  
16 additional charges as permitted in § 54-3A-5, or any charge imposed by a creditor  
17 upon another person for purchasing or accepting an obligation of a consumer unless  
18 the consumer is required to pay any part of that charge in cash, as an addition to the  
19 obligation, or as a deduction from the proceeds of the obligation;

20 (5) "Goods," tangible personal chattels, whether or not in existence at the time the  
21 transaction is entered into, and including things which, at the time of sale or  
22 subsequently, are to be so affixed to real property as to become a part thereof,  
23 whether or not severable therefrom, but excluding money, chattel paper, documents  
24 of title and other instruments. "Goods" does not include motor vehicles which are sold  
25 in secured sales subject to chapter 54-7;

- 1 (6) "Installment sales contract," an arrangement other than a revolving charge account,  
2 entered into in this state evidencing any consumer transaction in which a consumer  
3 purchases goods or services from a creditor, under which arrangement a finance  
4 charge may be imposed and the consumer agrees to pay for the goods or services in  
5 one or more installments;
- 6 (7) "Official fees," the fees prescribed by law for filing, recording, or otherwise perfecting  
7 a security interest or the premium payable for any insurance in lieu of perfecting any  
8 security interest if the premium does not exceed the fees otherwise prescribed by law;
- 9 (8) "Services" includes:
- 10 (a) Work, labor, and other personal services;
- 11 (b) Privileges and contract rights with respect to accommodations or facilities,  
12 including ~~but not limited to~~ hotels and restaurants, transportation, education,  
13 entertainment, recreation, physical culture, hospital accommodations, funerals,  
14 and cemetery associations;
- 15 (c) Diagnostic work, maintenance, repair or improvement, other than as part of the  
16 manufacture or original construction, of properties; and
- 17 (d) Insurance;
- 18 (9) "Transaction," all of the agreements made between two or more persons to carry out  
19 an exchange of value, including the entire process of soliciting, negotiating, making,  
20 performing, and enforcing such agreements, whether or not any agreement is  
21 enforceable by action.

22 Section 3. That § 54-3A-5 be amended to read as follows:

23 54-3A-5. In addition to the finance charge, a creditor may contract for, and receive the  
24 following additional charges in connection with an installment sales contract if such charges are  
25 itemized and disclosed to the buyer:

1 (1) Official fees and taxes; and

2 (2) Charges for credit life, accident, health, loss of income, ~~property~~ or liability insurance;  
3 ~~provided, that. However,~~ any such insurance ~~shall be~~ is optional, and the consumer  
4 ~~must~~ shall be informed that any such insurance is optional.

5 Any such charges must be disclosed and explained to the consumer prior to signing any  
6 agreement to repay a consumer credit obligation. Any such charges must be separately agreed  
7 to in writing and separately signed by the consumer.

8 Section 4. That chapter 54-3A be amended by adding thereto a NEW SECTION to read as  
9 follows:

10 A creditor may require property insurance on the collateral securing the installment sales  
11 contract. The amount of the insurance required shall be reasonable and appropriate considering  
12 the nature of the property, the amount of the contract, the term of the contract, and any other  
13 circumstances. The insurance policy shall show the creditor as the loss payee, unless waived by  
14 the creditor.

15 Section 5. That chapter 54-3A be amended by adding thereto a NEW SECTION to read as  
16 follows:

17 The holder of a contract authorized by this chapter may, if the contract so provides, collect  
18 a charge not to exceed thirty dollars for each check, draft, order of withdrawal, or similar  
19 payment device that is received by the holder in connection with the contract and that is returned  
20 for nonpayment for any reason.

1 **BILL HISTORY**

2 1/26/99 First read in House and referred to Judiciary. H.J. 195

3 2/1/99 Scheduled for Committee hearing on this date.

4 2/1/99 Judiciary Do Pass Amended, Passed, AYES 7, NAYS 5. H.J. 310

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

709C0706

## HOUSE JUDICIARY COMMITTEE ENGROSSED NO. **HB1186** - 2/3/99

Introduced by: Representatives Hunt and Cerny and Senators Frederick and Lange

1 FOR AN ACT ENTITLED, An Act to ensure that minors do not gain access to obscene  
2 materials on certain public access computers and to limit liability for certain related actions.

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

4 Section 1. Any public library or public school that provides a public access computer shall  
5 do one or both of the following:

6 (1) Equip the computer with software that will limit minor's ability to gain access to  
7 obscene materials or purchase internet connectivity from an internet service provider  
8 that provides filter services to limit access to obscene materials;

9 (2) Develop and implement by January 1, 2001, a policy that establishes measures to  
10 ensure that minors do not gain computer access to obscene materials.

11 Section 2. Any public school that complies with section 1 of this Act or any public library  
12 that complies with section 1 of this Act may not be held liable for any damages that may arise  
13 from a minor gaining access to obscene materials through the use of a public access computer  
14 that is owned or controlled by the public school or public library.

15 Section 3. For the purposes of this Act, obscene material is defined pursuant to subdivision  
16 22-24-27(11).

- 1 Section 4. For the purposes of this Act, a public access computer is any computer that:
- 2 (1) Is located in a public school or public library;
- 3 (2) Is frequently or regularly used directly by a minor; and
- 4 (3) Is connected to any computer communication system.

1 **BILL HISTORY**

2 1/27/99 First read in House and referred to Judiciary. H.J. 209

3 2/1/99 Scheduled for Committee hearing on this date.

4 2/1/99 Judiciary Do Pass Amended, Passed, AYES 11, NAYS 1. H.J. 310

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

637C0768

## HOUSE EDUCATION COMMITTEE ENGROSSED NO. **HB1203** - 2/3/99

Introduced by: Representatives Brooks, Koskan, and Sebert and Senators Staggers, Bogue, Halverson, Lange, and Rounds

1 FOR AN ACT ENTITLED, An Act to clarify certain provisions relating to the maintenance of  
2 the child's birth certificate with the child's academic record.

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

4 Section 1. That § 13-27-3.1 be amended to read as follows:

5 13-27-3.1. Any person who is required pursuant to § 13-27-1 to cause any child to attend  
6 any public or nonpublic school or alternative instruction program pursuant to § 13-27-3 in this  
7 state shall, either at the time of enrollment in any school in this state or upon being excused from  
8 school attendance pursuant to § 13-27-3 or within thirty days of initial enrollment or excuse,  
9 provide the public school and alternative instruction program with a certified copy of such child's  
10 birth certificate or affidavit in lieu of birth certificate as issued by the department of health in such  
11 cases where the original birth certificate is deemed unattainable. A violation of this section is a  
12 Class 2 misdemeanor.

13 Section 2. That § 13-27-3.2 be amended to read as follows:

14 13-27-3.2. Any copy of any certified birth certificate provided pursuant to § 13-27-3.1 shall  
15 be maintained by the public and nonpublic school or alternative instruction program and shall  
16 become a part of the child's permanent ~~school~~ academic record.

1 Section 3. That § 13-27-3.3 be amended to read as follows:

2 13-27-3.3. The superintendent of any public or nonpublic school or alternative instruction  
3 program in this state shall regularly report to the state's attorney the name and address of any  
4 child for whom the public or nonpublic school or alternative instruction program does not have  
5 a copy of a certified birth certificate in violation of § 13-27-3.1.

1 **BILL HISTORY**

2 1/27/99 First read in House and referred to committee assignment waived. H.J. 213

3 1/28/99 Referred to Education. H.J. 240

4 2/2/99 Scheduled for Committee hearing on this date.

5 2/2/99 Education Do Pass Amended, Passed, AYES 9, NAYS 4. H.J. 314

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

447C0744

## HOUSE JUDICIARY COMMITTEE ENGROSSED NO. **HB1217** - 2/3/99

Introduced by: Representatives Hennies, Apa, Broderick, Koehn, Kooistra, Lintz, and McIntyre and Senators Ham, Albers, Bogue, Drake, Dunn (Rebecca), Kleven, Lawler, and Vitter

1 FOR AN ACT ENTITLED, An Act to revise the procedure for determining the period of time  
2 that has elapsed for a person who was previously convicted of driving under the influence.  
3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:  
4 Section 1. That § 32-23-4.1 be amended to read as follows:  
5 32-23-4.1. No previous conviction for, or plea of guilty to, a violation of § 32-23-1 occurring  
6 more than five years prior to the date of the violation being charged may be used to determine  
7 that the violation being charged is a second, third, or subsequent offense. However, any period  
8 of time during which the defendant was incarcerated for a previous violation may not be included  
9 when calculating if the time period provided in this section has elapsed.

1 **BILL HISTORY**

2 1/27/99 First read in House and referred to committee assignment waived. H.J. 215

3 1/28/99 Referred to Judiciary. H.J. 240

4 2/1/99 Scheduled for Committee hearing on this date.

5 2/1/99 Judiciary Do Pass Amended, Passed, AYES 11, NAYS 0. H.J. 311

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

400C0325

SENATE HEALTH AND HUMAN SERVICES  
COMMITTEE ENGROSSED NO. **SB22** -  
1/19/99

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

1 FOR AN ACT ENTITLED, An Act to revise certain provisions relating to vital records.

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

3 Section 1. That § 34-25-15 be amended to read as follows:

4 34-25-15. In cases of legitimation, the department, upon receipt of proof of the marriage of  
5 the parents after the birth of the child together with an affidavit of paternity signed by both  
6 parents of the child, shall prepare a new certificate of birth in the new name of the legitimated  
7 child.

8 Within ten days after the filing of an affidavit of acknowledgment of paternity, signed by both  
9 putative parents who are not married, the department shall add the name of the father to the  
10 certificate of birth if paternity is not shown on the record. Upon request of the parents, the  
11 surname of the child may be changed to that of the father or a combination of mother's and  
12 father's surnames, in which case the department shall prepare a new birth certificate. A change  
13 in paternity, which is already shown on a birth certificate, may be made only upon receipt of a  
14 court order determining paternity.

15 Upon receipt of a court order or affidavits determining the paternity of a child pursuant to

1 § 34- 25-13.1, the department shall prepare a new certificate of birth. Each applicant for a new  
2 birth record shall submit a five dollar fee to the department for the preparation and filing of the  
3 record.

4 Section 2. That § 34-25-36 be amended to read as follows:

5 34-25-36. A funeral director, embalmer, or other person who removes from the place of  
6 death or transports or finally disposes of a dead body or fetus, in addition to filing any certificate  
7 or other form required by this chapter, shall keep a record which shall identify the body, and shall  
8 on or before the fifth day of each month report to the ~~state department of health~~ all human bodies  
9 handled during the preceding month on a form provided for that purpose. If no death occurs in  
10 any given month which requires a funeral director to keep a record pursuant to this section, the  
11 funeral director shall report that fact on a form provided for that purpose.

12 Section 3. That § 34-25-43 be amended to read as follows:

13 34-25-43. The ~~state department of health~~ shall prepare, print, and supply to all registrars, all  
14 blanks and forms used in registering, recording, and preserving the reports and returns, or in  
15 otherwise carrying out the purposes of this chapter. No blanks or forms ~~shall~~ may be used other  
16 than those supplied by the ~~state department of health~~ or exact electronic replicas approved by  
17 the department.

18 Section 4. That § 34-25-46 be amended to read as follows:

19 34-25-46. The local registrar shall sign, date, and number consecutively the certificates of  
20 ~~birth, death, and burial or removal permits filed in his office, and sign thereon his name as~~  
21 ~~registrar, together with the date of filing in his office. He shall make a copy of each birth and~~  
22 ~~death certificate filed by him, in the form prescribed by the state department of health. He~~ at the  
23 county office. The local registrar shall transmit weekly to the state department monthly or more  
24 frequently when directed to do so, the original certificates of birth and death and shall maintain  
25 a copy of all death certificates filed in the county. If no vital event occurred death certificates

- 1 were filed in any ~~month, he~~ week, the local registrar shall report that fact on a form provided for
- 2 that purpose.

1 **BILL HISTORY**

2 1/12/99 First read in Senate and referred to Health and Human Services. S.J. 19

3 1/16/99 Scheduled for Committee hearing on this date.

4 1/16/99 Health and Human Services Do Pass Amended, Passed, AYES 7, NAYS 0. S.J. 61

# State of South Dakota

SEVENTY-FOURTH SESSION  
LEGISLATIVE ASSEMBLY, 1999

400C0211

SENATE TRANSPORTATION COMMITTEE

ENGROSSED NO. **SB40** - 1/22/99

Introduced by: The Committee on Transportation at the request of the Department of Game,  
Fish, and Parks

1 FOR AN ACT ENTITLED, An Act to establish certain prohibitions on use of temporary thirty-  
2 day snowmobile and boat license permits and to provide for a penalty thereof.

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

4 Section 1. That § 32-6C-10 be amended to read as follows:

5 32-6C-10. If a snowmobile is sold by a licensed dealer, the dealer may provide a temporary  
6 thirty-day license permit which is a permit to operate the snowmobile in this state for a period  
7 of thirty days after the date of sale or until the time the purchaser receives the regular license  
8 decals from the county treasurer, whichever occurs first. No dealer may use the permit upon any  
9 snowmobile owned by the dealer or for any purpose other than for snowmobiles sold by the  
10 dealer. No person may renew the temporary thirty-day license permit nor change or alter the date  
11 or other information thereon. A violation of this section is a Class 1 misdemeanor.

12 Section 2. That § 32-3A-10 be amended to read as follows:

13 32-3A-10. If a new or used boat is sold by a boat manufacturer or boat dealer, the boat  
14 manufacturer or boat dealer may provide a temporary tag permit to operate the boat in this state  
15 for thirty days after the date of sale of the boat or until the time the purchaser receives the  
16 licenses from the county treasurer, whichever occurs first. The temporary boat license tags shall

1 be displayed as required by § 32-3A-5 and rules promulgated, pursuant to chapter 1-26, by the  
2 department. No dealer may use the permit upon any boat owned by the dealer or for any purpose  
3 other than for boats sold by the manufacturer or dealer. No person may renew the temporary  
4 thirty-day license permit nor change or alter the date or other information thereon. A violation  
5 of this section is a Class 1 misdemeanor.

1 **BILL HISTORY**

2 1/12/99 First read in Senate and referred to Transportation. S.J. 22

3 1/19/99 Scheduled for Committee hearing on this date.

4 1/21/99 Scheduled for Committee hearing on this date.

5 1/21/99 Transportation Do Pass Amended, Passed, AYES 7, NAYS 0. S.J. 141