

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

193C0010

SENATE STATE AFFAIRS COMMITTEE

ENGROSSED NO. **HB1012** - 2/10/99

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 establish criteria for the use of utilization review by
2 health carriers, utilization review organizations, and other contracted entities.

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

4 Section 1. Terms used in this Act mean:

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

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

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

15 (4) "Certification," a determination by a health carrier or its designee utilization review

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

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

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

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

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

14 (11) "Facility," an institution providing health care services or a health care setting,
15 including hospitals and other licensed inpatient centers, ambulatory surgical or
16 treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
17 laboratory, and imaging centers, and rehabilitation, and other therapeutic health
18 settings;

19 (12) "Health benefit plan," a policy, contract, certificate, or agreement entered into,
20 offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or
21 reimburse any of the costs of health care services;

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

24 (14) "Health care provider" or "provider," a health care professional or a facility;

25 (15) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief

- 1 of a health condition, illness, injury, or disease;
- 2 (15A) "Health carrier," an entity subject to the insurance laws and regulations of this state,
3 or subject to the jurisdiction of the director, that contracts or offers to contract to
4 provide, deliver, arrange for, pay for, or reimburse any of the costs of health care
5 services, including a sickness and accident insurance company, a health maintenance
6 organization, a nonprofit hospital and health service corporation, or any other entity
7 providing a plan of health insurance, health benefits, or health services;
- 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 health carrier;
- 25 (21) "Participating provider," a provider who, under a contract with the health carrier or

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

4 (22) "Prospective review," utilization review conducted prior to an admission or a course
5 of treatment;

6 (23) "Retrospective review," utilization review of medical necessity that is conducted after
7 services have been provided to a patient, but does not include the review of a claim
8 that is limited to an evaluation of reimbursement levels, veracity of documentation,
9 accuracy of coding, or adjudication for payment;

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

14 (25) "Utilization review," an activity as defined in subdivisions 58-17-91(4) and 58-18-
15 64(4); and

16 (26) "Utilization review organization," an entity that conducts utilization review.

17 Section 2. This Act applies to any health carrier that provides or performs utilization review
18 services. The requirements of this Act also apply to any designee of the health carrier or
19 utilization review organization that performs utilization review functions on the carrier's behalf.

20 Section 3. A health carrier is responsible for monitoring all utilization review activities carried
21 out by, or on behalf of, the health carrier and for ensuring that all requirements of this Act and
22 applicable rules are met. The health carrier shall also ensure that appropriate personnel have
23 operational responsibility for the conduct of the health carrier's utilization review program.

24 Section 4. If a health carrier contracts to have a utilization review organization or other entity
25 perform the utilization review functions required by this Act or applicable rules, the director shall

1 hold the health carrier responsible for monitoring the activities of the utilization review
2 organization or entity with which the health carrier contracts and for ensuring that the
3 requirements of this Act and applicable rules are met.

4 Section 5. A health carrier that conducts utilization review shall implement a written
5 utilization review program that describes all review activities, both delegated and nondelegated,
6 for covered services provided. The program document shall describe the following:

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

19 A health carrier shall prepare an annual summary report of its utilization review program
20 activities and file the report, if requested, with the director and the secretary of the Department
21 of Health.

22 Section 6. A utilization review program shall use documented clinical review criteria that are
23 based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A
24 health carrier may develop its own clinical review criteria, or it may purchase or license clinical
25 review criteria from qualified vendors. A health carrier shall make available its clinical review

1 criteria upon request to authorized government agencies including the Division of Insurance and
2 the Department of Health.

3 Section 7. Qualified licensed health care professionals shall administer the utilization review
4 program and oversee review decisions. Any adverse determination shall be evaluated by an
5 appropriately licensed and clinically qualified health care provider.

6 Section 8. A health carrier shall issue utilization review decisions in a timely manner pursuant
7 to the requirements of this Act. A health carrier shall obtain all information required to make a
8 utilization review decision, including pertinent clinical information. A health carrier shall have
9 a process to ensure that utilization reviewers apply clinical review criteria consistently.

10 Section 9. A health carrier shall routinely assess the effectiveness and efficiency of its
11 utilization review program.

12 Section 10. A health carrier's data system shall be sufficient to support utilization review
13 program activities and to generate management reports to enable the health carrier to monitor
14 and manage health care services effectively.

15 Section 11. If a health carrier delegates any utilization review activities to a utilization review
16 organization, the health carrier shall maintain adequate oversight, which shall include:

- 17 (1) A written description of the utilization review organization's activities and
18 responsibilities, including reporting requirements;
- 19 (2) Evidence of formal approval of the utilization review organization program by the
20 health carrier; and
- 21 (3) A process by which the health carrier evaluates the performance of the utilization
22 review organization.

23 Section 12. A health carrier shall coordinate the utilization review program with other
24 medical management activity conducted by the carrier, such as quality assurance, credentialing,
25 provider contracting data reporting, grievance procedures, processes for assessing member

1 satisfaction, and risk management.

2 Section 13. A health carrier shall provide covered persons and participating providers with
3 access to its review staff by a toll-free number or collect call telephone line.

4 Section 14. When conducting utilization review, the health carrier shall collect only the
5 information necessary to certify the admission, procedure or treatment, length of stay, frequency,
6 and duration of services.

7 Section 15. Compensation to persons providing utilization review services for a health carrier
8 may not contain incentives, direct or indirect, for these persons to make inappropriate review
9 decisions. Compensation to any such persons may not be based, directly or indirectly, on the
10 quantity or type of adverse determinations rendered.

11 Section 16. A health carrier shall maintain written procedures for making utilization review
12 decisions and for notifying covered persons and providers acting on behalf of covered persons
13 of its decisions.

14 Section 17. For initial determinations, a health carrier shall make the determination within
15 two working days of obtaining all necessary information regarding a proposed admission,
16 procedure, or service requiring a review determination:

17 (1) In the case of a determination to certify an admission, procedure, or service, the
18 health carrier shall notify the provider rendering the service by telephone within
19 twenty-four hours of making the initial certification; and shall provide written or
20 electronic confirmation of the telephone notification to the covered person and the
21 provider within two working days of making the initial certification.

22 (2) In the case of an adverse determination, the health carrier shall notify the provider
23 rendering the service by telephone within twenty-four hours of making the adverse
24 determination; and shall provide written or electronic confirmation of the telephone
25 notification to the covered person and the provider within one working day of making

1 the adverse determination.

2 Section 18. For concurrent review determinations, a health carrier shall make the
3 determination within one working day of obtaining all necessary information:

4 (1) In the case of a determination to certify an extended stay or additional services, the
5 health carrier shall notify by telephone the provider rendering the service within one
6 working day of making the certification; and the health carrier shall provide written
7 or electronic confirmation to the covered person and the provider within one working
8 day after the telephone notification. The written notification shall include the number
9 of extended days or next review date, the new total number of days or services
10 approved, and the date of admission or initiation of services.

11 (2) In the case of an adverse determination, the health carrier shall notify by telephone the
12 provider rendering the service within twenty-four hours of making the adverse
13 determination; and the health carrier shall provide written or electronic notification
14 to the covered person and the provider within one working day of the telephone
15 notification. The service shall be continued without liability to the covered person
16 until the covered person has been notified of the determination.

17 Section 19. For retrospective review determinations, a health carrier shall make the
18 determination within thirty working days of receiving all necessary information:

19 (1) In the case of a certification, the health carrier may notify in writing the covered
20 person and the provider rendering the service.

21 (2) In the case of an adverse determination, the health carrier shall notify in writing the
22 provider rendering the service and the covered person within five working days of
23 making the adverse determination.

24 Section 20. Any written notification of an adverse determination shall include the principal
25 reason or reasons for the determination, the instructions for initiating an appeal, grievance, or

1 reconsideration of the determination, and the instructions for requesting a written statement of
2 the clinical rationale used to make the determination. A health carrier shall provide the clinical
3 rationale in writing for an adverse determination to any party who received notice of the adverse
4 determination and who follows the procedures for a request. The clinical rationale shall contain
5 sufficient specificity to allow the covered person to understand the basis of the adverse
6 determination.

7 Section 21. A health carrier shall have written procedures to address the failure or inability
8 of a provider or a covered person to provide all necessary information for review. If the provider
9 or a covered person will not release necessary information, the health carrier may deny
10 certification.

11 Section 22. In the certificate of coverage or member handbook provided to covered persons,
12 a health carrier shall include a clear and comprehensive description of its utilization review
13 procedures, including the procedures for obtaining review of adverse determinations, and a
14 statement of rights and responsibilities of covered persons with respect to those procedures. A
15 health carrier shall include a summary of its utilization review procedures in materials intended
16 for prospective covered persons. A health carrier shall print on its membership cards a toll-free
17 telephone number to call for utilization review decisions.

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

21 Section 24. 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 utilization review as set forth in this Act, the health carrier may, at the discretion of the director
24 and secretary, be deemed to have met the applicable requirements.

25 Section 25. The director may, after consultation with the secretary of the Department of

1 Health, promulgate rules pursuant to chapter 1-26 to carry out the provisions of the Act. The
2 rules shall be designed to afford the public timely administration of utilization review and to
3 assure that utilization review decisions are made in a fair and clinically acceptable manner. The
4 rules may include the following:

- 5 (1) Definition of terms;
- 6 (2) Timing, form, and content of reports;
- 7 (3) Application of clinical criteria as it relates to utilization review;
- 8 (4) Written determinations; and
- 9 (5) Utilization review procedures.

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

7 2/4/99 House of Representatives Do Pass Amended, Passed, AYES 52, NAYS 11. H.J. 376

8 2/5/99 First read in Senate and referred to State Affairs. S.J. 346

9 2/8/99 Scheduled for Committee hearing on this date.

10 2/8/99 Scheduled for Committee hearing on this date.

11 2/8/99 State Affairs Do Pass Amended, Passed, AYES 8, NAYS 0. S.J. 392

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

346C0266

SENATE STATE AFFAIRS COMMITTEE

ENGROSSED NO. **HB1013** - 2/10/99

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.

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 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 (3A) "Health carrier," an entity subject to the insurance laws and regulations of this state,
15 or subject to the jurisdiction of the director, that contracts or offers to contract, or

1 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of
2 the costs of health care services, including a sickness and accident insurance company,
3 a health maintenance organization, a nonprofit hospital and health service corporation,
4 or any other entity providing a plan of health insurance, health benefits, or health
5 services;

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

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

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

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

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

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

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

24 (8) "Stabilized," with respect to an emergency medical condition, that no material
25 deterioration of the condition is likely, with reasonable medical probability, to result

1 or occur before an individual can be transferred.

2 Section 2. A health carrier shall cover emergency services necessary to screen and stabilize
3 a covered person and may not require prior authorization of such services if a prudent lay person
4 acting reasonably would have believed that an emergency medical condition existed. With respect
5 to care obtained from a noncontracting provider within the service area of a managed care plan,
6 a health carrier shall cover emergency services necessary to screen and stabilize a covered person
7 and may not require prior authorization of such services if a prudent layperson would have
8 reasonably believed that use of a contracting provider would result in a delay that would worsen
9 the emergency, or if a provision of federal, state, or local law requires the use of a specific
10 provider. The coverage shall be at the same benefit level as if the service or treatment had been
11 rendered by a participating provider.

12 A health carrier shall cover emergency services if the plan, acting through a participating
13 provider or other authorized representative, has authorized the provision of emergency services.

14 Section 3. If a participating provider or other authorized representative of a health carrier
15 authorizes emergency services, the health carrier may not retroactively deny its authorization
16 after the emergency services have been provided, or reduce payment for a covered expense
17 furnished in reliance on approval, unless the approval was based on a material misrepresentation
18 about the covered person's health condition made by the provider of emergency services.

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

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

25 Section 6. A covered person shall have access to emergency services twenty-four hours a

1 day, seven days a week to treat emergency medical conditions that require immediate medical
2 attention.

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

6 Section 8. If the director of the Division of Insurance and the secretary of the Department
7 of Health find that the requirements of any private accrediting body meet the requirements of
8 coverage of emergency medical services as set forth in this Act, the health carrier may, at the
9 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

7 2/4/99 House of Representatives Do Pass Amended, Passed, AYES 53, NAYS 6. H.J. 377

8 2/5/99 First read in Senate and referred to State Affairs. S.J. 346

9 2/8/99 Scheduled for Committee hearing on this date.

10 2/8/99 Scheduled for Committee hearing on this date.

11 2/8/99 State Affairs Do Pass Amended, Passed, AYES 8, NAYS 0. S.J. 396

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

159C0269

HOUSE ENGROSSED NO. **HB1015** - 2/5/99

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 § 6-16-2 be amended to read as follows:

1 6-16-2. The application for organization shall be a petition verified by one or more
2 circulators by affidavit stating that each affiant personally witnessed the signatures on the petition
3 and believe the signatures to be genuine. The petition shall be signed by at least twenty-five
4 percent of the landowners within the proposed district who are also registered voters within the
5 district. If the proposed district is in two or more counties, a petition shall be filed in each county
6 and each petition shall be signed by at least ~~twenty~~ twenty-five percent of the landowners within
7 the proposed district who are also registered voters within the proposed district in that county.
8 The petition shall be accompanied by a deposit covering the estimated costs as determined by
9 the county auditor of the public notices and the conduct of the election for the formation of the
10 district.

11 Section 3. That § 6-16-4 be amended to read as follows:

12 6-16-4. The county auditor shall publish the notice of the voter registration deadline at least
13 once each week for two consecutive weeks, the last publication to be not less than twenty- five
14 nor more than thirty days prior to the election. The auditor shall publish notices of election at
15 least once each week for two consecutive weeks, the last publication to be not less than four nor
16 more than ten days before the election in a legal newspaper or newspapers of general circulation
17 in the proposed district.

18 Section 4. That § 34-11A-28 be amended to read as follows:

19 34-11A-28. The boundaries of any ambulance district organized under the provisions of this
20 chapter may be changed in the manner prescribed by §§ 34-11A-4 to ~~34-11A-10~~ 34-11A-8,
21 inclusive, ~~but.~~ However, the ~~changes~~ change of boundaries of ~~any such a~~ any such a district may not impair
22 or affect ~~its~~ the district's organization or ~~its~~ the district's right in or to property; nor may ~~it~~ the change of
23 boundaries impair, affect, or discharge any contract, obligation, lien, or change for or upon which
24 ~~it might~~ the district may be liable had ~~such~~ the change of boundaries not been made.

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

1 34A-5-18. The board of trustees shall give notice of the election provided for in § 34A-5-17
 2 pursuant to ~~§ 34A-5-8~~ § 6-16-4, and the question shall be submitted to the voters on a separate
 3 ballot and be so stated as to enable each voter to vote for or against the proposed question.

4 Section 6. That § 46A-14-8 be amended to read as follows:

5 46A-14-8. The initiating petition shall contain the following:

- 6 (1) The name of the proposed district;
- 7 (2) That there is need in the interest of the public health, safety, and welfare for creation
 8 of a district to accomplish improvements in the watershed;
- 9 (3) A statement in general terms setting forth the purposes of the contemplated
 10 improvements, the territory to be included in the district; and all proposed
 11 subdivisions thereof, if any, of the district;
- 12 (4) The number ~~and names~~ of managers, ~~which~~ shall be three or five members, ~~to be~~
 13 ~~appointed as first managers of the proposed district, and who shall act for a period of~~
 14 ~~one year or until the first annual meeting. They.~~ Each manager shall be owners of own
 15 land located in the proposed district but ~~none shall~~ may not be a public officer of the
 16 state or federal government;
- 17 (5) A list of landowners and the total acreage of land owned by each within the proposed
 18 district;
- 19 (6) A map of the proposed district and the ownership of all land in the proposed district,
 20 except the outline only of the jurisdiction of the authorized officials of municipalities
 21 included need be shown; and
- 22 (7) The location of the official place of business of the proposed district;
- 23 ~~(8) A request for the organization of the district as proposed and appointment of the first~~
 24 ~~managers.~~

25 Section 7. That § 46A-18-4 be amended to read as follows:

1 46A-18-4. The petition established pursuant to § 46A-18-2 shall contain:

2 (1) The name of the proposed district;

3 (2) The object and purpose of the water project and works proposed to be constructed
4 or acquired, together with a general description of the nature, location, and method
5 of operation of the proposed works or program of activities;

6 (3) A legal description of the lands constituting the proposed district and the ~~names~~ name
7 of any ~~municipalities~~ municipality included partly or wholly within the boundaries of
8 the proposed district;

9 (4) The location of the principal place of business of the proposed district; and

10 (5) The number of members of the board of directors of the proposed district, which
11 number may not be less than three nor more than seven, and a statement as to ~~whether~~
12 if the directors shall be elected at large or shall be elected by director divisions, ~~the~~
13 ~~names and addresses of the members who shall serve as directors until their~~
14 ~~successors are elected and qualified as provided in this chapter, and, if director~~
15 ~~divisions are provided for, the respective divisions that the directors are to represent.~~
16 The persons named in the petition as directors. Each director shall be a qualified
17 ~~voters~~ voter of the district and, if director divisions are provided for, shall be a
18 qualified voters voter of the respective ~~divisions~~ division ~~the directors are~~ director is
19 to represent.

20 Section 8. That § 46A-18-21 be amended to read as follows:

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

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

5 1/21/99 House of Representatives Deferred to another day. H.J. 116

6 1/28/99 Intent to reconsider. H.J. 250

7 1/29/99 House of Representatives Deferred to another day. H.J. 265

8 1/29/99 House of Representatives Reconsidered, AYES 62, NAYS 3. H.J. 264

9 2/3/99 Motion to Amend, Passed. H.J. 350

10 2/3/99 House of Representatives Deferred to another day. H.J. 351

11 2/4/99 House of Representatives Do Pass Amended, Passed, AYES 61, NAYS 4. H.J. 373

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

400C0406

SENATE TRANSPORTATION COMMITTEE

ENGROSSED NO. **HB1053** - 2/10/99

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

1 FOR AN ACT ENTITLED, An Act to revise the open container law.

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

3 Section 1. That § 35-1-9.1 be amended to read as follows:

4 35-1-9.1. It is a Class 2 misdemeanor for any person to consume any alcoholic beverage, or
5 have a package or any receptacle containing an alcoholic beverage in ~~his~~ the person's possession
6 in a motor vehicle unless the seal of the original package remains unbroken or the alcoholic
7 beverage is so removed from the passenger area of the motor vehicle that no occupant of the
8 motor vehicle ~~shall have~~ has access to it while the vehicle is ~~in motion~~ located on a public
9 highway or the right-of-way of a public highway.

10 Section 2. Terms used in § 35-1-9.1 mean:

11 (1) "Alcoholic beverage," any distilled spirits, wine, and malt beverage as defined in this
12 section;

13 (2) "Distilled spirits," ethyl alcohol, hydrated oxide of ethyl, spirits of wine, whiskey, rum,
14 brandy, gin, and other distilled spirits, including all dilutions and mixtures thereof, for
15 nonindustrial use containing any amount of alcohol;

16 (3) "Malt beverage," beer, ale, porter, stout, and other similar beverages of any name or

1 description made by the alcoholic fermentation of an infusion or decoction, or
2 combination of both, in potable brewing water, of malted barley with hops, or their
3 parts, or their products, or from any substitute therefor, and with or without other
4 malted cereals, and with or without the addition of unmalted or prepared cereals,
5 other carbohydrates or products prepared therefrom, and with or without the addition
6 of carbon dioxide, and with or without other wholesome products suitable for human
7 consumption containing not less than one-half of one percent of alcohol by volume;
8 and

9 (4) "Wine," any liquid either commonly used, or reasonably adapted to use, for beverage
10 purposes, and obtained by the fermentation of the natural sugar content of fruits or
11 other agricultural products containing sugar and containing not less than one-half of
12 one percent of alcohol by weight but not more than twenty-four percent of alcohol by
13 volume.

14 Section 3. It is not a violation of section 1 of this Act if an alcoholic beverage is located in
15 a locked glove compartment of the motor vehicle.

16 Section 4. It is not a violation of section 1 of this Act if an open alcoholic beverage is behind
17 the last upright seat of a motor vehicle that is not equipped with a trunk or in an area not
18 normally occupied by the driver or passengers.

19 Section 5. It is not a violation of section 1 of this Act if a carrier defined in subdivision 35-1-
20 1(3) is licensed pursuant to subdivision 35-4-2(9).

21 Section 6. It is not a violation of section 1 of this Act if any passenger possesses or consumes
22 an alcoholic beverage in the living quarters of a motor home, house coach, or house trailer while
23 the vehicle is not in motion.

1 **BILL HISTORY**

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

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

4 1/16/99 Transportation Deferred to another day, AYES 8, NAYS 5.

5 1/25/99 Scheduled for Committee hearing on this date.

6 1/25/99 Transportation Do Pass Amended, Passed, AYES 13, NAYS 0. H.J. 169

7 1/27/99 Motion to Amend, Passed. H.J. 219

8 1/27/99 House of Representatives Do Pass Amended, Passed, AYES 57, NAYS 12. H.J. 220

9 1/28/99 First read in Senate and referred to Transportation. S.J. 243

10 2/9/99 Scheduled for Committee hearing on this date.

11 2/9/99 Transportation Do Pass Amended, Passed, AYES 5, NAYS 2. S.J. 398

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

660C0391

SENATE EDUCATION COMMITTEE ENGROSSED NO. **HB1084** - 2/10/99

Introduced by: Representatives Hunt, Brooks, and Crisp and Senator Munson (David)

1 FOR AN ACT ENTITLED, An Act to establish deadlines for action by school districts on
2 certain reorganization petitions and plans and to declare an emergency.

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

4 Section 1. That § 13-6-10 be amended to read as follows:

5 13-6-10. ~~Whenever~~ If the school board or the voters of two or more districts or parts of
6 districts express a desire to consolidate their respective districts to create a new entity; or the
7 school board or the voters of an existing district express a desire to divide the district to create
8 one or more new entities; or the school board or the voters of an existing district express a desire
9 to dissolve and be annexed to an existing district, the school board may by resolution, or shall,
10 ~~when~~ if presented by a petition signed by fifteen percent of the registered voters residing in the
11 district, based upon the total number of registered voters at the last preceding general election,
12 develop a plan to accomplish the desire expressed in the resolution or contained in the petition.
13 If more than one district is involved, their respective school boards shall act jointly in the
14 preparation of ~~such~~ the plan. Within fifteen days after a petition is filed as provided in this
15 section, the school district shall acknowledge the receipt of the petition in writing to the person
16 who filed the petition. Within one hundred eighty days after the petition was filed, the school

1 board shall develop the plan required in this section and shall file the plan as required in § 13-6-
2 17. The Department of Education and Cultural Affairs may grant two extensions of the filing
3 deadline, not to exceed ninety days each.

4 The school board shall call conferences and hold hearings to develop the plan. The school
5 board may employ a consultant.

6 Section 2. Whereas, this Act is necessary for the support of the state government and its
7 existing public institutions, an emergency is hereby declared to exist, and this Act shall be in full
8 force and effect from and after its passage and approval.

1 **BILL HISTORY**

2 1/20/99 First read in House and referred to Education. H.J. 94

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

4 1/26/99 Education Do Pass Amended, Passed, AYES 13, NAYS 0. H.J. 189

5 1/28/99 House of Representatives Do Pass Amended, Passed, AYES 68, NAYS 1. H.J. 252

6 1/29/99 First read in Senate and referred to Education. S.J. 265

7 2/9/99 Scheduled for Committee hearing on this date.

8 2/9/99 Education Do Pass Amended, Passed, AYES 4, NAYS 3. S.J. 397

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

228C0305

HOUSE LOCAL GOVERNMENT COMMITTEE

ENGROSSED NO. **HB1108** - 1/29/99

Introduced by: Representatives Davis, Chicoine, Crisp, Fitzgerald, Kooistra, Lockner,
McNenny, Michels, and Nachtigal and Senators Hainje and Moore

1 FOR AN ACT ENTITLED, An Act to authorize public utilities or electric utilities to remove
2 certain obstructions that may impair its operations.

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

4 Section 1. Any public utility or electric utility as defined in § 49-34A-1 and any utility
5 operated by any political subdivision of the state may remove or alter any vegetation or other
6 material if the utility determines that such removal or alteration is reasonably necessary for the
7 safe repair, use, operation, or maintenance of the utility's electric or gas transmission or
8 distribution lines.

1 **BILL HISTORY**

2 1/22/99 First read in House and referred to Local Government. H.J. 125

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

4 1/28/99 Local Government Do Pass Amended, Passed, AYES 10, NAYS 1. H.J. 236

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

517C0452

HOUSE JUDICIARY COMMITTEE ENGROSSED NO. **HB1137** - 2/2/99

Introduced by: Representatives Fischer-Clemens, Derby, Diedrich (Larry), Duniphan, Fitzgerald, Hennies, Koehn, McIntyre, McNenny, Peterson, Sebert, Slaughter, and Young and Senators Olson, Flowers, Hainje, Munson (David), Shoener, and Whiting

1 FOR AN ACT ENTITLED, An Act to revise the definition of outdoor recreation purpose for
2 political subdivisions.

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

4 Section 1. That § 20-9-19 be amended to read as follows:

5 20-9-19. Terms used in §§ 20-9-19 to 20-9-23, inclusive, mean:

6 (1) "Land," all land, trails, water, watercourses, lakes, ponds, reservoirs, or improvements
7 to real property, except for machinery and equipment on or attached to the realty,
8 when located on lands owned, leased, or managed by any political subdivision of
9 South Dakota, all areas designated as snowmobile, equestrian, hiking, or other
10 recreational trails by any political subdivision of South Dakota, all private lands leased
11 by any political subdivision of South Dakota, for public hunting, and all lands owned,
12 leased, or operated by any political subdivision of South Dakota and operated as a
13 park; and

14 (2) "Outdoor recreational purpose," includes any of the following activities or any
15 combination thereof: hunting, fishing, swimming other than in a swimming pool,

1 boating, canoeing, kayaking, camping, picnicking, hiking, biking, skateboarding, in-
2 line skating, sledding, horseback riding, off-road driving, nature study, water skiing,
3 team sports, snowmobiling, skiing, climbing, spelunking, para-sailing, hang gliding,
4 shooting, observing wildlife, viewing or enjoying historical, archaeological, scenic, or
5 scientific sites, or engaging in any other form of outdoor sport or recreational activity
6 of any sort.

1 **BILL HISTORY**

2 1/25/99 First read in House and referred to Judiciary. H.J. 172

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

4 2/1/99 Judiciary Do Pass Amended, Passed, AYES 9, NAYS 3. H.J. 276

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

834C0468

SENATE COMMERCE COMMITTEE

ENGROSSED NO. **SB161** - 2/2/99

Introduced by: Senators Daugaard, Brosz, Duxbury, Flowers, Halverson, Hutmacher, Paisley, Shoener, and Symens and Representatives Cutler, Apa, Brown (Richard), Duenwald, Fiegen, Haley, Jaspers, Koskan, McNenny, Napoli, Peterson, Waltman, and Wilson

1 FOR AN ACT ENTITLED, An Act to classify certain manufactured homes as real property for
2 property tax purposes, to establish a procedure for bringing taxes current and issuing certain
3 permits, and to establish certain penalties.

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

5 Section 1. That § 10-4-2.4 be amended to read as follows:

6 10-4-2.4. Real property, for the purposes of ad valorem taxation, includes manufactured
7 homes as defined in subdivision 32-3-1(6) with a model year of ~~1997~~ 1994 or newer. This section
8 does not apply to any manufactured home in the inventory of any dealer as defined in subdivision
9 32-7A-1(1).

10 Section 2. That § 10-4-2.6 be amended to read as follows:

11 10-4-2.6. If a manufactured home with a model year of ~~1997~~ 1994 or newer, is sold by a
12 licensed manufactured home dealer, the dealer shall complete the manufactured home listing
13 form, as prescribed by the secretary of revenue, and send the completed form to the director of
14 equalization of the county in which the manufactured home was delivered. The form shall be sent
15 within thirty days after the delivery of the manufactured home.

1 Section 3. That § 10-4-2.4 be amended to read as follows:

2 10-4-2.4. Real property, for the purposes of ad valorem taxation, includes manufactured
3 homes as defined in subdivision 32-3-1(6) with a model year of ~~1997~~ 1990 or newer. This section
4 does not apply to any manufactured home in the inventory of any dealer as defined in subdivision
5 32-7A-1(1).

6 Section 4. That § 10-4-2.6 be amended to read as follows:

7 10-4-2.6. If a manufactured home with a model year of ~~1997~~ 1990 or newer, is sold by a
8 licensed manufactured home dealer, the dealer shall complete the manufactured home listing
9 form, as prescribed by the secretary of revenue, and send the completed form to the director of
10 equalization of the county in which the manufactured home was delivered. The form shall be sent
11 within thirty days after the delivery of the manufactured home.

12 Section 5. The effective date of sections 3 and 4 of this Act is July 1, 2000.

13 Section 6. That § 10-4-2.4 be amended to read as follows:

14 10-4-2.4. Real property, for the purposes of ad valorem taxation, includes manufactured
15 homes as defined in subdivision 32-3-1(6) with a model year of ~~1997~~ 1985 or newer. This section
16 does not apply to any manufactured home in the inventory of any dealer as defined in subdivision
17 32-7A-1(1).

18 Section 7. That § 10-4-2.6 be amended to read as follows:

19 10-4-2.6. If a manufactured home with a model year of ~~1997~~ 1985 or newer, is sold by a
20 licensed manufactured home dealer, the dealer shall complete the manufactured home listing
21 form, as prescribed by the secretary of revenue, and send the completed form to the director of
22 equalization of the county in which the manufactured home was delivered. The form shall be sent
23 within thirty days after the delivery of the manufactured home.

24 Section 8. The effective date of sections 6 and 7 of this Act is July 1, 2001.

25 Section 9. That § 10-4-2.4 be amended to read as follows:

1 10-4-2.4. Real property, for the purposes of ad valorem taxation, includes manufactured
2 homes as defined in subdivision 32-3-1(6) with a model year of ~~1997~~ 1977 or newer. This section
3 does not apply to any manufactured home in the inventory of any dealer as defined in subdivision
4 32-7A-1(1).

5 Section 10. That § 10-4-2.6 be amended to read as follows:

6 10-4-2.6. If a manufactured home with a model year of ~~1997~~ 1977 or newer, is sold by a
7 licensed manufactured home dealer, the dealer shall complete the manufactured home listing
8 form, as prescribed by the secretary of revenue, and send the completed form to the director of
9 equalization of the county in which the manufactured home was delivered. The form shall be sent
10 within thirty days after the delivery of the manufactured home.

11 Section 11. The effective date of sections 9 and 10 of this Act is July 1, 2002.

12 Section 12. That chapter 10-6 be amended by adding thereto a NEW SECTION to read as
13 follows:

14 If a manufactured home is purchased or moved to a specific site after November first and the
15 manufactured home is moved, sold, transferred, or reassigned before November first in the
16 following year, no property taxes are due. The county treasurer shall issue an affidavit stating
17 that no taxes are due.

18 Section 13. That chapter 10-6 be amended by adding thereto a NEW SECTION to read as
19 follows:

20 If a manufactured home is purchased or moved to a specific site on or before November first
21 and the property has been assessed as real property and the owner of the manufactured home
22 plans to move, sell, transfer, or reassign the manufactured home before November first in the
23 following year, the county auditor shall levy a tax by applying the tax levy used for taxes payable
24 during the current year on other property in the same taxing district. The owner shall pay such
25 tax in full for the current year, not on a pro rata basis. If the taxes are paid in full, the county

1 treasurer shall issue an affidavit stating that the current year's taxes are paid.

2 Section 14. That chapter 10-6 be amended by adding thereto a NEW SECTION to read as
3 follows:

4 If a manufactured home has been assessed as real property and taxes are payable and the
5 owner of the manufactured home plans to move, sell, transfer, or reassign the manufactured
6 home before all the current taxes are paid, then the owner shall pay the current taxes in full, not
7 on a pro rata basis. If the taxes are paid in full, the county treasurer shall issue an affidavit stating
8 that the current year's taxes are paid.

9 Section 15. That § 32-5-16.3 be amended to read as follows:

10 32-5-16.3. Any person who moves a mobile home or manufactured home shall obtain a
11 permit, as prescribed by the secretary of revenue, from the county treasurer where the home is
12 located. The permit fee is valid for a single trip from the point of origin to a point of destination
13 within the state. Before the county treasurer may issue a permit, the owner of the mobile home
14 or manufactured home shall obtain an affidavit from the county treasurer stating that the current
15 year's taxes are paid as described in sections 12 to 14, inclusive, of this Act or § 10-9-3. The
16 permit fee for mobile homes and manufactured homes for use on the public highways is fifteen
17 dollars. ~~The permit is valid for a single trip from the point of origin to a point of destination~~
18 ~~within the state.~~ The fees collected shall be credited to the license plate special revenue fund. The
19 fee and permit imposed by this section does not apply to a new or used mobile home or
20 manufactured home ~~being delivered from the dealer to the purchaser~~ transported by a dealer
21 licensed under chapter 32-7A. A violation of this section is a Class 2 misdemeanor.

22 Section 16. That § 32-7A-17 be amended to read as follows:

23 32-7A-17. Any transfer or reassignment of a mobile home or manufactured home title shall
24 be accompanied by an affidavit issued by the county treasurer of the county in which the mobile
25 home or manufactured home is registered, stating that the current year's taxes are paid. The

1 county treasurer shall apply the requirements of section 12 to 14, inclusive, of this Act to
2 determine if the current year's taxes are paid. No title may be transferred until the taxes under
3 § 10-9-3 or 10-21-4 are paid. No transfer of title may be completed unless the mobile home or
4 manufactured home is registered as provided in § 10-9-3 or 10-4-2.6. In any event the title or
5 manufacturer's statement of origin shall be transferred within thirty days of delivery of the
6 manufactured home or mobile home. A violation of this section is a ~~Class 2~~ Class 1
7 misdemeanor.

8 Section 17. That § 32-7A-4.2 be amended by adding thereto a NEW SUBDIVISION to read
9 as follows:

10 Transporting a used mobile home or manufactured home without an affidavit, from the
11 county treasurer of the county in which the mobile home or manufactured home is registered,
12 stating that the current year's taxes are paid.

13 Section 18. That § 32-7A-11 be amended to read as follows:

14 32-7A-11. New and used mobile homes and manufactured homes owned by a dealer may be
15 transported upon the streets and highways to the dealer's place of business and to the purchaser
16 of such a home and between a dealer's place of business and a supplemental lot or a temporary
17 supplemental lot. Any transport of a mobile home or manufactured home by a dealer shall be
18 accompanied with a permit stating the point of origin and the point of destination. The dealer
19 shall provide a copy of the permit to the director of equalization in the county of origin and to
20 the director of equalization in the county of destination.

1 **BILL HISTORY**

2 1/27/99 First read in Senate and referred to Commerce. S.J. 213

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

4 2/2/99 Commerce Do Pass Amended, Passed, AYES 7, NAYS 0. S.J. 295

5 2/2/99 Commerce Place on Consent Calendar.

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

660C0733

SENATE HEALTH AND HUMAN SERVICES
COMMITTEE ENGROSSED NO. **SB198** -
2/9/99

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

Introduced by: Senators Reedy, Bogue, Dunn (Rebecca), and Lawler and Representatives Fitzgerald, Chicoine, Davis, Engbrecht, Koskan, Lockner, Patterson, and Solum

1 FOR AN ACT ENTITLED, An Act to limit the practice of psychotherapy to certain persons.

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

3 Section 1. No person may represent himself or herself as a psychotherapist, or engage in the
4 practice of, or attempt to practice, psychotherapy unless licensed as one of the following:

5 (1) A physician who is licensed pursuant to chapter 36-4;

6 (2) A psychologist who is licensed pursuant to chapter 36-27A;

7 (3) A licensed psychiatric nurse with a master's degree from an accredited education
8 program and has two years of supervised clinical experience in a mental health setting;

9 (4) A licensed social worker with a master's degree from an accredited training program
10 and has two years of supervised clinical experience in a mental health setting;

11 (5) A counselor who is licensed pursuant to chapter 36-32 as a licensed professional
12 counselor -- mental health;

13 (6) A marriage and family therapist who is licensed pursuant to chapter 36-33;

14 (7) A physician's assistant who is licensed pursuant to chapter 36-4A and has two years

1 of supervised clinical experience in a mental health setting;

2 (8) A nurse practitioner who is licensed pursuant to chapter 36-9A and has two years of

3 supervised clinical experience in a mental health setting.

4 A violation of this section is a Class 2 misdemeanor.

1 **BILL HISTORY**

2 1/28/99 First read in Senate and referred to Health and Human Services. S.J. 233

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

4 2/5/99 Scheduled for Committee hearing on this date.

5 2/8/99 Health and Human Services Hog Housed.

6 2/8/99 Scheduled for Committee hearing on this date.

7 2/8/99 Health and Human Services Do Pass Amended, Passed, AYES 5, NAYS 0. S.J. 367

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

400C0805

SENATE STATE AFFAIRS COMMITTEE ENGROSSED

NO. **SB235** - 2/10/99

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

1 FOR AN ACT ENTITLED, An Act to require the disclosure of information to prospective
2 enrollees of managed care plans.

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

4 Section 1. This Act applies to any health carrier who offers a managed care plan as defined
5 in §§ 58-17-91 and 58-18-64.

6 Section 2. Any health carrier shall provide to any prospective enrollee written information
7 describing the terms and conditions of the plan. If the plan is described orally, easily understood,
8 truthful, objective terms shall be used. All written plan descriptions shall be readable, easily
9 understood, truthful, and in an objective format. The format shall be standardized among each
10 plan that a health carrier offers so that comparison of the attributes of the plans is facilitated.

11 The following specific information shall be communicated:

12 (1) Coverage provisions, benefits, and any exclusions by category of service, provider,
13 and if applicable, by specific service;

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

- 1 (3) The existence of any financial arrangements or contractual provisions with review
2 companies or providers of health care services that would directly or indirectly limit
3 the services offered, restrict referral, or treatment options;
- 4 (4) Explanation of how plan limitations impact enrollees, including information on
5 enrollee financial responsibility for payment of coinsurance or other non-covered or
6 out-of-plan services;
- 7 (5) A description of the accessibility and availability of services, including a list of
8 providers participating in the managed care network and of the providers in the
9 network who are accepting new patients, the addresses of primary care physicians and
10 participating hospitals, and the specialty of each provider in the network; and
- 11 (6) A description of any drug formulary provisions in the plan and the process for
12 obtaining a copy of the current formulary upon request. There shall be a process for
13 requesting an exception to the formulary and instructions as to how to request an
14 exception to the formulary.

15 Section 3. Nothing in this Act applies to dental only, vision only, accident only, school
16 accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed
17 occurrence, or fixed per procedure benefit without regard to expenses incurred. The provisions
18 of this Act only apply to oral or written communications specifically designed to elicit an
19 application for insurance.

1 **BILL HISTORY**

2 2/1/99 First read in Senate and referred to State Affairs. S.J. 278

3 2/8/99 Scheduled for Committee hearing on this date.

4 2/8/99 Scheduled for Committee hearing on this date.

5 2/8/99 State Affairs Do Pass Amended, Passed, AYES 8, NAYS 0. S.J. 391

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

400C0808

SENATE STATE AFFAIRS COMMITTEE ENGROSSED

NO. **SB236** - 2/10/99

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

1 FOR AN ACT ENTITLED, An Act to establish standards for network adequacy and quality of
2 care in managed care plans and to require the registration of managed care entities.

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

4 Section 1. Terms used in this Act mean:

5 (1) "Closed plan," a managed care plan that requires covered persons to use participating
6 providers under the terms of the managed care plan and does not provide any benefits
7 for out-of-network services except for emergency services;

8 (2) "Consumer," someone in the general public who may or may not be a covered person
9 or a purchaser of health care, including employers;

10 (3) "Covered benefits" or "benefits," those health care services to which a covered person
11 is entitled under the terms of a plan;

12 (4) "Covered person," a policyholder, subscriber, enrollee, or other individual
13 participating in a plan;

14 (5) "Director," the director of the Division of Insurance;

15 (6) "Discounted fee for service," a contractual arrangement between a health carrier and
16 a provider or network of providers under which the provider is compensated in a

1 discounted fashion based upon each service performed and under which there is no
2 contractual responsibility on the part of the provider to manage care, to serve as a
3 gatekeeper or primary care provider, or to provide or assure quality of care. A
4 contract between a provider or network of providers and a health maintenance
5 organization is not a discounted fee for service arrangement;

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

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

13 (9) "Facility," an institution providing health care services or a health care setting,
14 including hospitals and other licensed inpatient centers, ambulatory surgical or
15 treatment centers, skilled nursing centers, residential treatment centers, diagnostic,
16 laboratory and imaging centers, and rehabilitation and other therapeutic health
17 settings;

18 (10) "Health benefit plan," a policy, contract, certificate, or agreement entered into, offered
19 or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any
20 of the costs of health care services;

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

23 (12) "Health care provider" or "provider," a health care professional or a facility;

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

- 1 (14) "Health carrier," an entity subject to the insurance laws and regulations of this state,
2 or subject to the jurisdiction of the director, that contracts or offers to contract, or
3 enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of
4 the costs of health care services, including a sickness and accident insurance company,
5 a health maintenance organization, a nonprofit hospital, and health service
6 corporation, or any other entity providing a plan of health insurance, health benefits,
7 or health services;
- 8 (15) "Health indemnity plan," a health benefit plan that is not a managed care plan;
- 9 (16) "Intermediary," a person authorized to negotiate and execute provider contracts with
10 health carriers on behalf of health care providers or on behalf of a network;
- 11 (17) "Managed care plan," a plan as defined in subdivisions 58-17-91(3) and 58-18-64(3);
- 12 (18) "Network," the group of participating providers providing services to a managed care
13 plan;
- 14 (19) "Open plan," a managed care plan other than a closed plan that provides incentives,
15 including financial incentives, for covered persons to use participating providers under
16 the terms of the managed care plan;
- 17 (20) "Participating provider," a provider who, under a contract with the health carrier or
18 with its contractor or subcontractor, has agreed to provide health care services to
19 covered persons with an expectation of receiving payment, other than coinsurance,
20 copayments or deductibles, directly or indirectly from the health carrier;
- 21 (21) "Quality assessment," the measurement and evaluation of the quality and outcomes
22 of medical care provided to individuals, groups, or populations;
- 23 (22) "Quality improvement," the effort to improve the processes and outcomes related to
24 the provision of care within the health plan;
- 25 (23) "Secretary," the secretary of the Department of Health.

1 Section 2. This Act applies to all health carriers that offer managed care plans.

2 Section 3. A health carrier providing a managed care plan shall maintain a network that is
3 sufficient in numbers and types of providers to assure that all services to covered persons will
4 be accessible without unreasonable delay. In the case of emergency services, covered persons
5 shall have access twenty-four hours per day, seven days per week. Sufficiency shall be
6 determined in accordance with the requirements of this section, and may be established by
7 reference to any reasonable criteria used by the carrier, including: provider-covered person ratios
8 by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times
9 for appointments with participating providers; hours of operation; and the volume of
10 technological and specialty services available to serve the needs of covered persons requiring
11 technologically advanced or specialty care.

12 Section 4. In any case where the health carrier has an insufficient number or type of
13 participating provider to provide a covered benefit, the health carrier shall ensure that the
14 covered person obtains the covered benefit at no greater cost to the covered person than if the
15 benefit were obtained from participating providers, or shall make other arrangements acceptable
16 to the director.

17 Section 5. The health carrier shall establish and maintain adequate arrangements to ensure
18 reasonable proximity of participating providers to the business or personal residence of covered
19 persons.

20 Section 6. A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity,
21 and legal authority of its providers to furnish all contracted benefits to covered persons. In the
22 case of capitated plans, the health carrier shall also monitor the financial capability of the
23 provider.

24 Section 7. In determining whether a health carrier has complied with any network adequacy
25 provision of this Act, the director shall give due consideration to the relative availability of health

1 care providers in the service area and to the willingness of providers to join a network.

2 Section 8. A health carrier shall file with the director, in a manner and form defined by rules
3 promulgated pursuant to chapter 1-26 by the director, an access plan meeting the requirements
4 of this Act for each of the managed care plans that the carrier offers in this state. The carrier shall
5 prepare an access plan prior to offering a new managed care plan, and shall annually update an
6 existing access plan. The access plan shall describe or contain at least the following:

- 7 (1) The health carrier's network;
- 8 (2) The health carrier's procedures for making referrals within and outside its network;
- 9 (3) The health carrier's process for monitoring and assuring on an ongoing basis the
10 sufficiency of the network to meet the health care needs of populations that enroll in
11 managed care plans;
- 12 (4) The health carrier's methods for assessing the health care needs of covered persons
13 and their satisfaction with services;
- 14 (5) The health carrier's method of informing covered persons of the plan's services and
15 features, including the plan's grievance procedures and its procedures for providing
16 and approving emergency and specialty care;
- 17 (6) The health carrier's system for ensuring the coordination and continuity of care for
18 covered persons referred to specialty physicians, for covered persons using ancillary
19 services, including social services and other community resources, and for ensuring
20 appropriate discharge planning;
- 21 (7) The health carrier's process for enabling covered persons to change primary care
22 professionals;
- 23 (8) The health carrier's proposed plan for providing continuity of care in the event of
24 contract termination between the health carrier and any of its participating providers,
25 or in the event of the health carrier's insolvency or other inability to continue

1 operations. The description shall explain how covered persons will be notified of the
2 contract termination, or the health carrier's insolvency or other cessation of
3 operations, and transferred to other providers in a timely manner; and

4 (9) Any other information required by the director to determine compliance with the
5 provisions of this Act.

6 The provisions of subdivisions (2), (4), (6), (7), and (8), of this section, and the provisions
7 regarding primary care provider-covered person ratios and hours of operation in section 3 of this
8 Act do not apply to discounted fee-for-service only networks.

9 Section 9. A health carrier offering a managed care plan shall satisfy all the following
10 requirements:

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

14 (2) In no event may a participating provider collect or attempt to collect from a covered
15 person any money owed to the provider by the health carrier nor may the provider
16 have any recourse against covered persons for any covered charges in excess of the
17 copayment, coinsurance, or deductible amounts specified in the coverage;

18 (3) The provisions of this Act do not require a health carrier, its intermediaries or the
19 provider networks with which they contract, to employ specific providers or types of
20 providers that may meet their selection criteria, or to contract with or retain more
21 providers or types of providers than are necessary to maintain an adequate network;

22 (4) A health carrier shall notify participating providers of the providers' responsibilities
23 with respect to the health carrier's applicable administrative policies and programs,
24 including payment terms, utilization review, quality assessment, and improvement
25 programs, grievance procedures, data reporting requirements, confidentiality

- 1 requirements, and any applicable federal or state programs;
- 2 (5) A health carrier may not prohibit or penalize a participating provider from discussing
3 treatment options with covered persons irrespective of the health carrier's position on
4 the treatment options, from advocating on behalf of covered persons within the
5 utilization review or grievance processes established by the carrier or a person
6 contracting with the carrier or from, in good faith, reporting to state or federal
7 authorities any act or practice by the health carrier that jeopardizes patient health or
8 welfare;
- 9 (6) A health carrier shall contractually require a provider to make health records available
10 to the carrier upon request but only those health records necessary to process claims,
11 perform necessary quality assurance or quality improvement programs, or to comply
12 with any lawful request for information from appropriate state authorities. Any person
13 that is provided records pursuant to this section shall maintain the confidentiality of
14 such records and may not make such records available to any other person who is not
15 legally entitled to the records;
- 16 (7) A health carrier and participating provider shall provide at least sixty days written
17 notice to each other before terminating the contract without cause. If a provider is
18 terminated without cause or chooses to leave the network, upon request by the
19 provider or the covered person and upon agreement by the provider to follow all
20 applicable network requirements, the carrier shall permit the covered person to
21 continue an ongoing course of treatment for ninety days following the effective date
22 of contract termination. In the event of a covered person that has entered a second
23 trimester of pregnancy at the time of contract termination as specified in this section,
24 the continuation of network coverage through that provider shall extend to the
25 provision of postpartum care directly related to the delivery;

- 1 (8) A health carrier shall notify the participating providers of their obligations, if any, to
2 collect applicable coinsurance, copayments, or deductibles from covered persons
3 pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify
4 covered persons of their personal financial obligations for noncovered services;
- 5 (9) A health carrier shall establish a mechanism by which the participating providers may
6 determine in a timely manner whether or not a person is covered by the carrier.

7 Section 10. In any contractual arrangement between a health carrier and an intermediary, the
8 following shall apply:

- 9 (1) A health carrier's ultimate statutory responsibility to monitor the offering of covered
10 benefits to covered persons shall be maintained whether or not any functions or duties
11 are contractually delegated or assigned to the intermediary;
- 12 (2) A health carrier shall have the right to approve or disapprove participation status of
13 a subcontracted provider in its own or a contracted network for the purpose of
14 delivering covered benefits to the carrier's covered persons;
- 15 (3) A health carrier shall maintain copies of all intermediary health care subcontracts at
16 its principal place of business in the state, or ensure that it has access to all
17 intermediary subcontracts, including the right to make copies to facilitate regulatory
18 review, upon twenty days prior written notice from the health carrier;
- 19 (4) If applicable, an intermediary shall transmit utilization documentation and claims paid
20 documentation to the health carrier. The carrier shall monitor the timeliness and
21 appropriateness of payments made to providers and health care services received by
22 covered persons;
- 23 (5) An intermediary shall maintain the books, records, financial information and
24 documentation of services provided to covered persons and preserve them for
25 examination pursuant to chapter 58-3;

1 (6) An intermediary shall allow the director access to the intermediary's books, records,
2 financial information, and any documentation of services provided to covered persons,
3 as necessary to determine compliance with this Act;

4 (7) A health carrier shall have the right, in the event of the intermediary's insolvency, to
5 require the assignment to the health carrier of the provisions of a provider's contract
6 addressing the provider's obligation to furnish covered services.

7 Section 11. A health carrier shall file with the director sample contract forms proposed for
8 use with its participating providers and intermediaries. A health carrier shall submit material
9 changes to a sample contract that would affect a provision required by this Act or any rules
10 promulgated pursuant to this Act to the director for approval thirty days prior to use. Changes
11 in provider payment rates, coinsurance, copayments, or deductibles, or other plan benefit
12 modifications are not considered material changes for the purpose of this section. If the director
13 takes no action within thirty days after submission of a material change to a contract by a health
14 carrier, the change is deemed approved. The health carrier shall maintain provider and
15 intermediary contracts and provide copies to the division or department upon request.

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

20 Section 13. In addition to any other remedies permitted by law, if the director determines that
21 a health carrier has not contracted with enough participating providers to assure that covered
22 persons have accessible health care services in a geographic area, or that a health carrier's access
23 plan does not assure reasonable access to covered benefits, or that a health carrier has entered
24 into a contract that does not comply with this Act, or that a health carrier has not complied with
25 a provision of this Act, the director may institute a corrective action that shall be followed by the

1 health carrier, or may use any of the director's other enforcement powers to obtain the health
2 carrier's compliance with this Act.

3 Section 14. The director may, after consultation with the secretary, promulgate pursuant to
4 chapter 1-26 reasonable rules to protect the public in its purchase of network health insurance
5 products, achieve the goals of this Act by ensuring adequate networks and by assuring quality
6 of health care to the public that purchases network products. The rules may include:

- 7 (1) Definition of terms;
- 8 (2) Provider/covered person ratios;
- 9 (3) Geographic access requirements;
- 10 (4) Accessibility of care;
- 11 (5) Contents of reports and filings;
- 12 (6) Notification requirements;
- 13 (7) Selection criteria;
- 14 (8) Recordkeeping;
- 15 (9) Setting of quality criteria based upon type of network; and
- 16 (10) Quality assurance/quality improvement plans.

17 Section 15. Each managed care entity, as defined in §§ 58-18-64 and 58-17-91, shall register
18 with the director prior to engaging in any managed care business in this state. The registration
19 shall be subject to the provisions of §§ 58-18-71 to 58-18-75, inclusive, and any applicable rules
20 promulgated pursuant to those sections.

21 Section 16. A health carrier that provides managed care plans shall develop and maintain the
22 infrastructure and disclosure systems necessary to measure the quality of health care services
23 provided to covered persons on a regular basis and appropriate to the types of plans offered by
24 the health carrier. A health carrier shall:

- 25 (1) Utilize a system designed to assess the quality of health care provided to covered

1 persons and appropriate to the types of plans offered by the health carrier. The system
2 shall include systematic collection, analysis, and reporting of relevant data in
3 accordance with statutory and regulatory requirements. The level of quality
4 assessment activities undertaken by a health plan may vary based on the plan's
5 structure with the least amount of quality assessment activities required being those
6 plans which are open and the provider network is simply a discounted fee for service
7 preferred provider organization;

8 (2) File a written description of the quality assessment program with the director in the
9 prescribed general format, which shall include a signed certification by a corporate
10 officer of the health carrier that the filing meets the requirements of this Act.

11 Section 17. A health carrier that issues a closed plan, or a combination plan having a closed
12 component, shall, in addition to complying with the requirements of section 16 of this Act,
13 develop and maintain the internal structures and activities necessary to improve the quality of
14 care being provided. Quality improvement activities for a health carrier subject to the
15 requirements of this section should, at a minimum, involve:

16 (1) Developing a written quality improvement plan designed to analyze both the
17 processes and outcomes of the health care delivered to covered persons;

18 (2) Establishing an internal system to implement the quality improvement plan and to
19 specifically identify opportunities to improve care and using the findings of the system
20 to improve the health care delivered to covered persons; and

21 (3) Assuring that participating providers have the opportunity to participate in
22 developing, implementing, and evaluating the quality improvement system.

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

25 Section 18. Nothing in this Act applies to health carrier's plans that do not contain provider

1 networks or to dental only, vision only, accident only, school accident, travel, or specified
2 disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per
3 procedure benefit without regard to expenses incurred.

4 Section 19. If the director and secretary find that the requirements of any private accrediting
5 body meet the requirements of network adequacy, quality assurance, or quality improvement as
6 set forth in this Act, the carrier may, at the discretion of the director and secretary, be deemed
7 to have met the applicable requirements.

8 Section 20. That § 58-41-12 be amended to read as follows:

9 58-41-12. Upon receipt of an application for issuance of a certificate of authority, the
10 director shall forthwith transmit copies of such application and accompanying documents to the
11 secretary. The secretary shall determine whether the applicant for a certificate of authority has:

12 (1) Demonstrated the willingness and potential ability to assure that health care services
13 will be provided in a manner to assure both the availability and accessibility of
14 adequate personnel and facilities ~~and in a manner enhancing availability, accessibility~~
15 ~~and continuity of service~~ consistent with the requirements of this Act;

16 (2) Arrangements, established in accordance with regulations promulgated by the
17 secretary for an ongoing quality of health care assurance program consistent with the
18 requirements of this Act concerning health care processes and outcomes;

19 (3) A procedure, established in accordance with regulations promulgated by the secretary,
20 to develop, compile, evaluate, and report statistics relating to the cost of its
21 operations, the pattern of utilization of its services, the availability and accessibility
22 of its services, and such other matters as may be reasonably required by the secretary;
23 and

24 (4) Reasonable provisions for emergency and out-of-area health care services.

25 Section 21. That § 58-41-53 be repealed.

1 ~~58-41-53. No health maintenance organization or representative may allow providers under~~
2 ~~agreement with a health maintenance organization to have recourse against enrollees for amounts~~
3 ~~above those specified in the evidence of coverage as the periodic prepayment, or copayment, for~~
4 ~~health care services. Violation of this section is a Class 2 misdemeanor.~~

5 Section 22. Nothing in this Act applies to health carriers that only offer individual policies
6 if:

7 (1) The policy does not use an individual or group to determine where or when services
8 will be rendered, the course of treatment, or who will provide the services;

9 (2) The policy does not require pre-authorization for services provided under the policy;
10 and

11 (3) The difference in policy benefits does not exceed ten percent whether an insured used
12 a participating provider or nonparticipating provider.

13 Section 23. The Division of Insurance shall separately monitor complaints regarding managed
14 care for any policy that is exempt pursuant to section 22 of this Act.

1 **BILL HISTORY**

2 2/1/99 First read in Senate and referred to State Affairs. S.J. 278

3 2/8/99 Scheduled for Committee hearing on this date.

4 2/8/99 Scheduled for Committee hearing on this date.

5 2/8/99 State Affairs Do Pass Amended, Passed, AYES 8, NAYS 0. S.J. 392