

State of South Dakota

SPECIAL SESSION OF THE SEVENTY-EIGHTH LEGISLATIVE ASSEMBLY, 2003

184K0005

SENATE BILL NO. 3

Introduced by: Senators Kloucek, Dennert, Koetzle, Moore, and Reedy and Representatives Lange, Bradford, Gassman, and Sigdestad

1 FOR AN ACT ENTITLED, An Act to establish a comprehensive health association to provide
2 health insurance coverage to eligible persons, to provide an appropriation therefor, and to
3 declare an emergency.

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

5 Section 1. Terms used in this Act mean:

- 6 (1) "Association," the comprehensive health association established by section 2 of this
7 Act;
- 8 (2) "Association policy," any individual or group policy issued by the association that
9 provides the coverage specified in this Act;
- 10 (3) "Carrier," any person that provides health insurance in the state, including an
11 insurance company, a prepaid hospital or medical service plan, a health maintenance
12 organization, a multiple employer welfare arrangement, a carrier providing excess or
13 stop loss coverage to a self funded employer, and any other entity providing a plan of
14 health insurance or health benefits subject to state insurance regulation. The term,
15 carrier, does not include health insurance for coverages that are not health benefit



1 plans issued by insurance companies, prepaid hospital or medical service plans, or
2 health maintenance organizations. The term, carrier, includes any health benefit plan
3 issued through an association or trust. The term, health benefit plan, as used in this
4 Act is as defined in subdivision 58-17-66(9);

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

6 (5) "Health care facility," any health care facility licensed pursuant to chapter 34-12;

7 (6) "Health insurance," as defined in § 58-9-3;

8 (7) "Insured," any individual who is provided qualified comprehensive health insurance
9 under an association policy, which may include dependents and other covered
10 persons;

11 (8) "Medicaid," the federal-state assistance program established under Title XIX of the
12 Social Security Act;

13 (9) "Medicare," the federal government health insurance program established under Title
14 XVIII of the Social Security Act;

15 (10) "Policy," any contract, policy, or plan of health insurance;

16 (11) "Policy year," any consecutive twelve-month period during which a policy provides
17 or obligates the carrier to provide health insurance.

18 Section 2. There is established a nonprofit corporation known as the Comprehensive Health
19 Insurance Association, which shall assure that health insurance, as provided for in this Act, is
20 made available to each eligible South Dakota resident who applies to the association for
21 coverage. Any carrier providing health insurance or health care services in South Dakota shall
22 be a member of the association. The association shall operate under a plan of operation
23 established and approved pursuant to this Act and shall exercise its powers through a board of
24 directors established pursuant to this Act.

1 Section 3. The board of directors of the association shall consist of nine individuals who are
2 representative of categories of members of the association, health care providers, consumers who
3 have purchased or are likely to purchase coverage from the association, insurance producers,
4 small employers, and the director, who shall be a nonvoting ex-officio member. In the initial and
5 in each successor board, three members shall be representative of and elected by qualified writers
6 of group health insurance, two members shall be representative of and elected by qualified
7 writers of individual health insurance, one member shall be representative of the health care
8 provider community and shall be appointed by the director, one member shall be representative
9 of consumers covered through the high risk pool and shall be appointed by the director, one
10 member shall be a representative of insurance producers and shall be appointed by the director,
11 and one member shall be a representative of small employers and shall be appointed by the
12 director. There shall be no more than one member representing any one qualified writer or its
13 affiliate.

14 Members of the board may be reimbursed from the moneys of the association for expenses
15 incurred by them as members, but may not be otherwise compensated by the association for their
16 services.

17 Section 4. The board shall submit to the director a proposed plan of operation for the
18 association and any amendments necessary or suitable to assure the fair, reasonable, and
19 equitable administration of the association. If the board fails to submit a proposed plan of
20 operation within one hundred eighty days after the appointment of the board of directors, or if
21 at any later time the board fails to submit suitable amendments to the plan, the director shall
22 proceed with the rule-making process as required by this section. The plan of operation, whether
23 based upon a proposal from the board or the director, shall be established by rules promulgated
24 pursuant to chapter 1-26 and shall consider whether the proposed plan of operation is suitable

1 to assure the fair, reasonable, and equitable administration of the association, and provides for
2 the sharing of association losses, if any, on an equitable and proportionate basis among the
3 member carriers. In addition to other requirements, the plan of operation shall provide for all of
4 the following:

- 5 (1) The handling and accounting of assets and moneys of the association;
- 6 (2) The amount and method of reimbursing members of the board;
- 7 (3) Regular times and places for meetings of the board of directors;
- 8 (4) Records to be kept of all financial transactions, and the annual fiscal reporting to the
9 director;
- 10 (5) Procedures for selecting the board of directors and submitting the selections to the
11 director for approval;
- 12 (6) Procedures for assessing the members in proportion to the number of persons they
13 cover through primary, excess, and stop loss insurance in this state;
- 14 (7) The periodic advertising of the general availability of health insurance coverage from
15 the association;
- 16 (8) Additional provisions necessary or proper for the execution of the powers and duties
17 of the association.

18 Section 5. The plan of operation may provide that the powers and duties of the association
19 may be delegated. A delegation under this section takes effect only upon the approval of both
20 the board of directors and the director. The director may not approve a delegation unless the
21 protections afforded to the insureds are substantially equivalent to or greater than those provided
22 under this Act.

23 Section 6. The association has the general powers and authority enumerated by this Act and
24 executed in accordance with the plan of operation approved by the director. The association has

1 the general powers and authority granted under the laws of this state to carriers licensed to issue
2 health insurance. In addition, the association may do any of the following:

- 3 (1) Enter into contracts as necessary or proper to carry out this Act;
- 4 (2) Sue or be sued, including taking any legal action necessary or proper for recovery of
5 any assessments for, on behalf of, or against participating carriers;
- 6 (3) Borrow money to effectuate the purposes of this Act;
- 7 (4) Take legal action necessary to avoid the payment of improper claims against the
8 association or the coverage provided by or through the association;
- 9 (5) Establish or utilize a medical review committee to determine the reasonably
10 appropriate level and extent of health care services in each instance;
- 11 (6) Establish appropriate rates, scales of rates, rate classifications, and rating adjustments,
12 which rates may not be unreasonable in relation to the coverage provided and the
13 reasonable operations expenses of the association;
- 14 (7) Pool risks among members;
- 15 (8) Issue association policies on an indemnity, network, or provision of service basis and
16 may design, utilize, contract, or otherwise arrange for the delivery of cost effective
17 health care services, including establishing or contracting with preferred provider
18 organizations, health maintenance organizations, and other limited network provider
19 arrangements in providing the coverage required by this Act;
- 20 (9) Administer separate pools, separate accounts, or other plans or arrangements
21 considered appropriate for separate members or groups of members;
- 22 (10) Operate and administer any combination of plans, pools, or other mechanisms
23 considered appropriate to best accomplish the fair and equitable operation of the
24 association;

1 (11) Appoint from among members appropriate legal, actuarial, and other committees as
2 necessary to provide technical assistance in the operation of the association, policy,
3 and other contract design, and any other functions within the authority of the
4 association;

5 (12) Hire independent consultants as necessary;

6 (13) Include in its policies a provision providing for subrogation rights by the association
7 in a case in which the association pays expenses on behalf of an individual who is
8 injured or suffers a disease under circumstances creating a liability upon another
9 person to pay damages to the extent of the expenses paid by the association, but only
10 to the extent the damages exceed the policy deductible and coinsurance amounts paid
11 by the insured. The association may waive its subrogation rights if it determines that
12 the exercise of the rights would be impractical, uneconomical, or would create a
13 hardship on the insured.

14 Section 7. The board of directors shall select a plan administrator based on criteria
15 established by the board which shall include:

16 (1) The plan administrator's proven ability to handle health insurance coverage to
17 individuals;

18 (2) The efficiency and timeliness of the plan administrator's claim processing procedures;

19 (3) An estimate of total charges for administering the plan;

20 (4) The plan administrator's ability to apply effective cost containment programs and
21 procedures and to administer the plan in a cost efficient manner; and

22 (5) The financial condition and stability of the plan administrator.

23 Section 8. The plan administrator shall serve for a period specified in the contract between
24 the plan and the plan administrator subject to removal for cause and subject to any terms,

1 conditions, and limitations of the contract between the plan and the plan administrator. At least
2 one year prior to the expiration of each period of service by a plan administrator, the board shall
3 invite eligible entities, including the current plan administrator to submit bids to serve as the plan
4 administrator. Selection of the plan administrator for the succeeding period shall be made at least
5 six months prior to the end of the current period. The plan administrator shall perform such
6 functions relating to the plan as may be assigned to it, including:

- 7 (1) Determination of eligibility;
- 8 (2) Payment of claims;
- 9 (3) Establishment of a premium billing procedure for collection of premium from persons
10 covered under the plan; and
- 11 (4) Other necessary functions to assure timely payment of benefits to covered persons
12 under the plan.

13 The plan administrator shall submit regular reports to the board regarding the operation of
14 the plan. The frequency, content, and form of the report shall be specified in the contract
15 between the board and the plan administrator. Following the close of each calendar year, the plan
16 administrator shall determine net written and earned premiums, the expense of administration,
17 and the paid and incurred losses for the year and report this information to the board and the
18 division on a form prescribed by the director. The plan administrator shall be paid as provided
19 in the contract between the plan and the plan administrator.

20 Section 9. Rates for coverages issued by the association may not be unreasonable in relation
21 to the benefits provided, the risk experience, and the reasonable expenses of providing coverage.
22 Case characteristics as allowed pursuant to § 58-17-74 may be used in establishing rates for
23 those insured through the association. Rates shall take into consideration the extra morbidity and
24 administration expenses, if any, for risks insured in the association. The rates for a given

1 classification for those that qualify for coverage pursuant to § 58-17-85 or whose coverage
2 immediately prior to coverage through the association was a policy issued pursuant to § 58-17-
3 85 may not be more than one hundred fifty percent of the average in-force premium or payment
4 rate for that classification charged by the three carriers with the largest individual health
5 insurance premium or payment volume in the state during the preceding calendar year. In
6 determining the average rate of the three largest individual health carriers, the rates or payments
7 charged by the carriers shall be actuarially adjusted to determine the rate or payment that would
8 have been charged for benefits similar to those issued by the association.

9 Section 10. Following the close of each calendar year, the board shall determine the net
10 premiums and payments, the expenses of administration, and the incurred losses of the
11 association for the year. The board shall certify the amount of any net loss for the preceding
12 calendar year. In sharing losses, the board may abate or defer in any part the assessment of a
13 member, if, in the opinion of the board, payment of the assessment would endanger the ability
14 of the member to fulfill its contractual obligations. The board may also provide for an initial or
15 interim assessment against members of the association if necessary to assure the financial
16 capability of the association to meet the incurred or estimated claims expenses or operating
17 expenses of the association until the next calendar year is completed. Net gains shall be held at
18 interest to offset future losses or allocated to reduce future premiums.

19 Assessment of health carriers and excess or stop loss carriers shall be based upon the number
20 of persons they cover through primary, excess, and stop loss insurance in this state and shall be
21 as follows:

22 (1) For the purposes of this section, the term, participating carrier, includes all carriers
23 as defined in section 1 of this Act;

24 (2) In addition to the powers enumerated in this Act, the board, on behalf and under the

1 direction of the director may assess participating carriers in accordance with the
2 provisions of this section, and make advance interim assessments as may be
3 reasonable and necessary for the association's organizational and interim operating
4 expenses;

5 (3) Following the close of each fiscal year, the administrator shall determine the net
6 premiums (premiums less reasonable administrative expense allowances), the expenses
7 of administration, and the incurred losses for the year, taking into account investment
8 income and other appropriate gains and losses. The deficit incurred by the association
9 shall be recouped by assessments apportioned under this section by the board among
10 participating carriers and from other sources as may be allowed under law;

11 (4) Each participating carrier's assessment shall be determined by multiplying the total
12 assessment of all participating carriers as determined in subdivision (2) by a fraction,
13 the numerator of which equals the number of individuals in this state covered under
14 health insurance policies, including by way of excess or stop loss coverage, by each
15 participating carrier, and the denominator of which equals the total number of all
16 individuals in this state covered under health insurance policies, including by way of
17 excess or stop loss coverage, by all participating carriers, all determined as of the end
18 of the prior calendar year;

19 (5) The board shall make reasonable efforts designed to ensure that each insured
20 individual is counted only once with respect to any assessment. For that purpose, the
21 board shall require each participating carrier that obtains excess or stop loss insurance
22 to include in its count of insured individuals all individuals whose coverage is
23 reinsured, including by way of excess or stop loss coverage, in whole or part. The
24 board shall allow a participating carrier who is an excess or stop loss carrier to

1 exclude from its number of insured individuals those who have been counted by the
2 primary carrier or by the primary reinsurer or primary excess or stop loss carrier for
3 the purpose of determining its assessment under this section;

4 (6) Each participating carrier's assessment shall be determined by the board based on
5 annual statements and other reports deemed to be necessary by the board and filed by
6 the participating carrier with the board. The board may use any reasonable method of
7 estimating the number of insureds of a participating carrier if the specific number is
8 unknown. With respect to participating carriers that are excess or stop loss carriers,
9 the board may use any reasonable method of estimating the number of persons insured
10 by each reinsurer or excess or stop loss carrier;

11 (7) A participating carrier may petition the director for an abatement or deferment of all
12 or part of an assessment imposed by the board. The director may abate or defer, in
13 whole or in part, the assessment if, in the opinion of the director, payment of the
14 assessment would endanger the ability of the participating carrier to fulfill its
15 contractual obligations. If an assessment against a participating carrier is abated or
16 deferred in whole or in part, the amount by which the assessment is abated or deferred
17 may be assessed against the other participating carriers in a manner consistent with
18 the basis for assessments set forth in this section. The participating carrier receiving
19 such abatement or deferment shall remain liable to the association for the deficiency
20 for four years.

21 The amount appropriated in section 33 of this Act shall be used for the establishment and
22 operation of the association prior to making any assessment of participating carriers and any
23 available federal funding for the establishment or operation of the association shall be used to the
24 extent possible prior to making any assessment of participating carriers. Assessments made of

1 any carrier shall be allowed as a credit on the premium tax return of that carrier.

2 Section 11. The association shall conduct periodic audits to assure the general accuracy of
3 the financial data submitted to the association, and the association shall have an annual audit of
4 its operations made by an independent certified public accountant.

5 Section 12. The association and the board are subject to examination by the director. Not
6 later than April thirtieth of each year, the board of directors shall submit to the director a
7 financial report for the preceding calendar year in a form approved by the director.

8 Section 13. Any policy form issued by the association shall be filed with and approved by the
9 director before its use.

10 Section 14. The association is exempt from payment of all fees and all taxes levied by this
11 state or any of its political subdivisions.

12 Section 15. If the association policy contains a network feature, the negotiated fee will be
13 the limit of the amount paid and the provider shall be subject to subdivision 58-17C-14(2) for
14 any amounts due from the individual insured. The benefits to be contained in the association
15 policy shall be established by the board and be subject to the approval of the director. The
16 association policy shall be designed to provide comprehensive coverage consistent with major
17 medical coverage currently being offered in the individual health insurance market. The coverage
18 and benefits for association policies may not be altered by any other state law without specific
19 reference to this Act indicating a legislative intent to add or delete from the coverage provided
20 pursuant to this Act. Any association policy shall cover biologically-based mental illnesses on the
21 same basis as other covered illnesses.

22 Section 16. The association policy shall include disease management programs that contain
23 cost containment mechanisms. If the insured does not enroll and participate in the applicable cost
24 containment activities, the insured is responsible for fifty percent of the eligible expenses for

1 related services after the deductible is met, and there is no maximum out-of-pocket coinsurance
2 amount.

3 Section 17. The association policy shall provide pharmacy benefits. In addition to any other
4 deductibles and coinsurance amounts, the insured shall pay a twenty-five percent coinsurance for
5 each prescription up to the maximum out-of-pocket coinsurance amount of fifteen hundred
6 dollars. If an intervention or cost containment mechanism is refused without a verifiable medical
7 reason, the insured shall pay a fifty percent coinsurance amount and only twenty-five percent of
8 the coinsurance applies toward the maximum out-of-pocket coinsurance amount for pharmacy
9 benefits.

10 Section 18. Each association policy shall offer the following plan-year benefit maximums:

- 11 (1) Thirty days coverage for inpatient alcoholism and substance abuse treatment;
- 12 (2) Two thousand dollars for outpatient alcoholism and substance abuse treatment; and
- 13 (3) Nine hundred dollars for up to thirty outpatient mental health visits for qualified
14 conditions that are not biologically-based.

15 Section 19. Except as otherwise provided in this Act, a person is not eligible for an
16 association policy if the person, on the effective date of coverage, has or will have coverage as
17 an insured or covered dependent under any insurance plan that has coverage equivalent to an
18 association policy; is eligible for benefits under chapter 28-6 at the time of application; has
19 terminated coverage provided by the association within the past twelve months; is an inmate of
20 any public institution or is eligible for public programs for which medical care is provided; or has
21 his or her premiums paid for or reimbursed under any government sponsored program or by any
22 government agency or health care provider, except as an otherwise qualifying full-time employee,
23 or dependent thereof, of a government agency or health care provider. Coverage under an
24 association policy is in excess of, and may not duplicate, coverage under any other form of health

1 insurance, employee/employer welfare plan, medical coverage under any homeowner's or
2 motorized vehicle insurance, no-fault automobile, service or payment received under the laws
3 of any national, state, or local government, or CHAMPUS. This section does not apply to those
4 persons meeting provisions pursuant to chapter 28-13.

5 Association coverage terminates for any person on the date that if such circumstance had
6 been present at the time of application, the person would have been ineligible for association
7 coverage. Association coverage may also be terminated for nonpayment of premiums.

8 Section 20. An association policy shall provide that coverage of a dependent unmarried
9 person terminates when the person becomes nineteen years of age or, if the person is enrolled
10 full time in an accredited educational institution, terminates at twenty-five years of age. The
11 policy shall also provide in substance that attainment of the limiting age does not operate to
12 terminate coverage when the person is and continues to be both of the following:

- 13 (1) Incapable of self-sustaining employment by reason of mental retardation or physical
14 disability; and
- 15 (2) Primarily dependent for support and maintenance upon the person in whose name the
16 contract is issued.

17 Proof of incapacity and dependency shall be furnished to the administrator within one
18 hundred twenty days of the person's attainment of the limiting age, and subsequently as may be
19 required by the association's procedures, but not more frequently than annually after the two-year
20 period following the person's attainment of the limiting age.

21 Section 21. The board may not change the rates for association policies except on a class
22 basis with a clear disclosure in the policy of the board's right to do so and upon approval of the
23 director.

24 Section 22. An association policy shall provide that upon the death of the individual in whose

1 name the policy is issued, every other individual then covered under the contract may elect,
2 within a period specified in the policy, to continue coverage under the same or a different policy
3 until such time as the person would have ceased to be entitled to coverage had the individual in
4 whose name the policy was issued lived.

5 Section 23. The director shall prescribe the format as prescribed by section 26 of this Act for
6 disclosure by carriers of the availability of insurance coverage from the association.

7 Section 24. None of the following may be the basis of any legal civil action, or criminal
8 liability against the board, association, or members of them, either jointly or separately: the
9 participation by carriers or members in the association, the establishment of rates, forms, or
10 procedures for coverage issued by the association, serving or carrying out the functions as a
11 member of the board, or any joint or collective action required by this Act. Any person aggrieved
12 by this Act may request a contested case hearing pursuant to chapter 1-26, which constitutes the
13 person's sole remedy.

14 Section 25. Any carrier authorized to provide health care insurance or coverage for health
15 care services in this state shall provide notice and application for coverage under the association
16 for those individuals eligible pursuant to § 58-17-85. An application for health insurance shall
17 be on forms prescribed by the board and made available to the carriers.

18 Section 26. That § 58-17-68 be amended to read as follows:

19 58-17-68. For purposes of §§ 58-17-66 to 58-17-87, inclusive, the term, professional
20 association plan, means a health benefit plan offered through a professional association that
21 covers members of a professional association and their dependents, and not others, in this state
22 regardless of the situs of delivery of the policy or contract and which meets all the following
23 criteria:

24 (1) Conforms with all the provisions of the rate requirements of §§ 58-17-66 to 58-17-87,

1 inclusive;

2 (2) Provides renewability of coverage for the members and dependents of members of the
3 professional association that meets the renewability requirements of §§ 58-17-66 to
4 58-17-87, inclusive;

5 (3) Provides availability of coverage for the members and dependents of members of the
6 professional association ~~in conformance with the provisions of § 58-17-85~~ without
7 regard to health status; and

8 (4) Is offered by a carrier that offers health benefit plan coverage to any professional
9 association seeking health benefit plan coverage from the carrier.

10 Section 27. That § 58-17-85 be amended to read as follows:

11 58-17-85. If a person has an aggregate of at least ~~twelve~~ eighteen months of creditable
12 coverage and, is a resident of this state, ~~the carrier shall accept such person for coverage under~~
13 ~~a health benefit plan, which contains benefits which are equal to or exceed the benefits contained~~
14 ~~in the basic plan that was approved and adopted by rule by the director pursuant to chapter 1-26~~
15 ~~and the maximum lifetime maximum benefit of the coverage is not less than one million dollars~~
16 ~~if the person applies within sixty-three days of the date of losing prior creditable coverage. In~~
17 ~~addition to the plan which equals or exceeds the basic coverage, the carrier shall also offer to the~~
18 ~~eligible person, the individual standard plan as approved and adopted by rule by the director or~~
19 ~~a plan with benefits that exceed the standard plan. No carrier is required to issue further~~
20 ~~individual health benefit coverage under §§ 58-17-68 to 58-17-87, inclusive, if the individual~~
21 ~~health benefit plans issued to high-risk individuals constitute two percent or more of that carrier's~~
22 ~~earned premium on an annual basis from individual health benefit plans covered by §§ 58-17-66~~
23 ~~to 58-17-87, inclusive. Each carrier who meets the two percent earned premium threshold shall~~
24 ~~report within thirty days to the director in a format prescribed by the director. If the director~~

1 ~~determines that all carriers in the individual market have met the two percent threshold, the~~
2 ~~threshold shall, upon order of the director, be expanded an additional two percent. The threshold~~
3 ~~shall be expanded in additional two percent increments if all carriers in the individual market~~
4 ~~meet the previous threshold. The director may promulgate rules pursuant to chapter 1-26 to~~
5 ~~determine which individual policies may be used to determine the two percent threshold, the~~
6 ~~procedures involved, and the applicable time frames. In making that determination, the director~~
7 ~~shall develop a method designed to limit the number of high-risk individuals to whom any one~~
8 ~~carrier may be required to issue coverage. No carrier is required to provide coverage pursuant~~
9 ~~to this section if and applies within sixty-three days of the date of losing prior creditable coverage~~
10 ~~and is no longer eligible for that creditable coverage, the person is eligible for coverage under~~
11 ~~the association policy as provided for in this Act if none of the following apply:~~

- 12 (1) The applicant is eligible for continuation of coverage under an employer plan;
- 13 (2) The applicant's creditable coverage is a conversion plan from an employer group plan;
- 14 or
- 15 (3) The person is covered or eligible to be covered under creditable coverage or lost
- 16 creditable coverage due to nonpayment of premiums; ~~or~~
- 17 ~~—(4)—The person loses coverage under a short term or limited duration plan.~~

18 Any person who has exhausted continuation rights and who is eligible for conversion or other

19 individual or association coverage has the option of obtaining coverage pursuant to this section

20 or the conversion plan or other coverage. A person who is otherwise eligible for the issuance of

21 coverage pursuant to this section may not be required to show proof that coverage was denied

22 by another carrier.

23 For purposes of this section, ~~a carrier may require~~ the association shall require reasonable

24 evidence that the prospective insured is a resident of this state. Factors that the ~~carrier~~

1 association may consider include a driver's license, voter registration, and where the prospective
2 insured resides.

3 Section 28. That § 58-17-86 be repealed.

4 ~~— 58-17-86. The director shall study and report on or before January 5, 1997, and on or before~~
5 ~~January fifth of each subsequent year to the Legislature and Governor on the effectiveness of~~
6 ~~§§ 58-17-66 to 58-17-87, inclusive. The report shall analyze the effectiveness of §§ 58-17-66~~
7 ~~to 58-17-87, inclusive, in promoting rate stability, product availability, and coverage~~
8 ~~affordability. The report may contain recommendations for actions to improve the overall~~
9 ~~effectiveness, efficiency, and fairness of the individual health insurance marketplace. The report~~
10 ~~may contain recommendations for market conduct or other regulatory standards or action.~~

11 Section 29. That § 58-17-80 be repealed.

12 ~~— 58-17-80. Each carrier shall file with the director annually, on or before March fifteenth, an~~
13 ~~actuarial certification certifying that the carrier is in compliance with §§ 58-17-66 to 58-17-87,~~
14 ~~inclusive, and that the rating methods of the carrier are actuarially sound. The certification shall~~
15 ~~be in a form and manner and shall contain such information as may be specified by the director~~
16 ~~in rules promulgated pursuant to chapter 1-26. A copy of the certification shall be retained by~~
17 ~~the carrier at its principal place of business.~~

18 Section 30. Effective July 1, 2003, carriers that have continuously and actively marketed
19 individual health benefit plans in this state since July 1, 1996, shall annually, on or before June
20 thirtieth, certify to the director, the earned premiums and paid claims during the preceding
21 calendar year on policies issued pursuant to § 58-17-85. The director shall determine the total
22 amount of losses for the carriers that exceed ninety percent of earned premiums on such policies
23 during the preceding year and shall certify this amount which shall be added to the losses to be
24 assessed against members of the association as prescribed by section 10 of this Act. The board

1 shall assess all member carriers of the association for the certified losses on the same basis as
2 assessments would be made for other losses incurred by the association for the same period.
3 Upon collection of these assessments from member carriers, the association shall reimburse each
4 individual carrier who qualified under the provisions of this section and who had losses in excess
5 of ninety percent of earned premiums certified by the director. The reimbursement for each
6 qualified carrier shall be in an amount equal to that carrier's actual losses in excess of ninety
7 percent of earned premiums for the reporting period.

8 Section 31. Carriers who discontinued actively marketing individual health benefit plans in
9 this state after July 1, 1996, and have current policies issued pursuant to §§ 58-17-66 to 58-17-
10 87, inclusive, are eligible to receive reimbursement pursuant to section 30 of this Act if these
11 conditions are met:

- 12 (1) The carrier re-enters the individual health benefit plan market in this state no later than
13 July 1, 2005;
- 14 (2) The carrier has actively and continuously marketed individual health benefit plans for
15 a period of twenty-four months from the date of re-entry; and
- 16 (3) The carrier is actively marketing individual health benefit plans at the time the pooling
17 is calculated.

18 Section 32. That § 58-17-82 be amended to read as follows:

19 58-17-82. An individual health benefit plan subject to §§ 58-17-66 to 58-17-87, inclusive,
20 is renewable with respect to any person or dependent at the option of the person, except in any
21 of the following cases:

- 22 (1) The individual has failed to pay premiums or contributions in accordance with the
23 terms of the health insurance coverage or the insurer has not received timely premium
24 payments;

- 1 (2) Fraud or intentional misrepresentation of material fact by the person;
- 2 (3) In the case of a health insurance issuer that offers health insurance coverage in the
3 market through a network plan, there are no longer any enrollees in connection with
4 the plan who live, reside, or work in the service area of the issuer or in the area for
5 which the issuer is authorized to do business and the issuer would deny enrollment
6 with respect to the plan as provided for in § 58-18B-37;
- 7 (4) Election by the carrier not to renew all of its individual health benefit plans delivered
8 or issued for delivery to persons in the state. In such a case, the carrier shall provide
9 advance notice of its decision under this subdivision to the director in each state in
10 which it is licensed and provide notice of the decision not to renew coverage to all
11 affected individuals and to the director in each state in which an affected insured
12 individual is known to reside at least one hundred eighty days before the nonrenewal
13 of any individual health benefit plans by the carrier. Notice to the director under this
14 subdivision shall be provided at least three working days before the notice to the
15 affected individuals. In such instances, the director shall assist the affected persons in
16 finding replacement coverage;
- 17 (5) In the case of health insurance coverage that is made available only through one or
18 more bona fide associations, the membership of an employer in the association (on the
19 basis of which the coverage is provided) ceases but only if the coverage is terminated
20 uniformly without regard to any health status-related factor relating to any covered
21 individual; or
- 22 (6) The insured individual becomes eligible for medicare coverage under Title XVIII of
23 the Social Security Act, unless federal law requires that medicare coverage under Title
24 XVIII be excluded as a reason for renewability of coverage;

1 (7) If the issuer decides to discontinue offering a particular type of individual health
2 insurance offered in the individual market, coverage of such type may be discontinued
3 if:

4 (a) The issuer provides notice to each insured provided coverage of this type in
5 such market (and any participant and beneficiary covered under such coverage)
6 of the discontinuation at least ninety days prior to the date of the
7 discontinuation of the coverage;

8 (b) The issuer offers to each insured provided coverage of this type in such market,
9 the option to purchase ~~an~~ any other health insurance coverage currently being
10 offered by the issuer to an individual health plan in such market; or

11 (c) In exercising the option to discontinue coverage of this type and in offering the
12 option of coverage under subsection (b), the issuer acts uniformly without
13 regard to the claims experience of those insured or any health status-related
14 factor relating to any participant or beneficiary covered or any new participant
15 or beneficiary who may become eligible for such coverage.

16 Section 33. There is hereby appropriated from the budget reserve fund the sum of five million
17 dollars (\$5,000,000), or so much thereof as may be necessary, to the board of directors of the
18 comprehensive health association for the establishment and operation of the association.

19 Section 34. The chair of the board of directors shall approve vouchers and the state auditor
20 shall draw warrants to pay expenditures authorized by this Act.

21 Section 35. Whereas, this Act is necessary for the immediate preservation of the public
22 peace, health, or safety, an emergency is hereby declared to exist, and this Act shall be in full
23 force and effect from and after its passage and approval.