**South Carolina General Assembly**

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**H. 3738**

**STATUS INFORMATION**

General Bill

Sponsors: Reps. Mitchell, Cobb‑Hunter, Butler Garrick, J.H. Neal, Dillard, Alexander, Rutherford, King, Anderson, Govan, Mack, Whipper and R.L. Brown

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Introduced in the House on February 24, 2011

Currently residing in the House Committee on **Ways and Means**

Summary: Health Benefit Exchange Act

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

2/24/2011 House Introduced and read first time ([House Journal‑page 7](file:///h:\hj%20archive\2011\02-24-11.docx))

2/24/2011 House Referred to Committee on **Ways and Means** ([House Journal‑page 7](file:///h:\hj%20archive\2011\02-24-11.docx))

2/24/2011 House Member(s) request name added as sponsor: Butler Garrick, J.H.Neal, Dillard, Alexander, Rutherford

3/1/2011 House Member(s) request name added as sponsor: King, Anderson

3/9/2011 House Member(s) request name added as sponsor: Cooper, Brannon, Pitts, Allison, Lucas, Parker, Huggins, Loftis, Owens, Barfield, Govan, Hardwick, Horne, Mack, Herbkersman

3/16/2011 House Member(s) request name removed as sponsor: Horne, Herbkersman, Allison

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3/30/2011 House Member(s) request name removed as sponsor: Pitts, Loftis

5/24/2011 House Member(s) request name added as sponsor: Whipper, R.L.Brown

**VERSIONS OF THIS BILL**

[2/24/2011](file:///p:\pprever\2011-12\3738_20110224.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING CHAPTER 96 TO TITLE 38 TO ENACT THE “SOUTH CAROLINA HEALTH BENEFIT EXCHANGE ACT” SO AS TO ESTABLISH THE HEALTH BENEFIT EXCHANGE WITHIN THE OFFICE OF THE GOVERNOR FOR THE PURPOSE OF FACILITATING THE PURCHASE AND SALE OF QUALIFIED HEALTH PLANS AS PROVIDED FOR IN THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT; TO PROVIDE THAT THE GOVERNOR SHALL APPOINT THE DIRECTOR OF THE EXCHANGE WHO SHALL SERVE AS THE CHIEF EXECUTIVE OFFICER OF THE EXCHANGE AND TO PROVIDE THAT THE EXCHANGE MUST BE GOVERNED BY A BOARD OF DIRECTORS APPOINTED BY THE GOVERNOR; AND TO PROVIDE FOR THE POWERS AND DUTIES OF THE EXCHANGE, INCLUDING, AMONG OTHER THINGS, THE ESTABLISHMENT OF THE SMALL EMPLOYER EXCHANGE TO ASSIST QUALIFIED SMALL EMPLOYERS IN THIS STATE IN FACILITATING THE ENROLLMENT OF THEIR EMPLOYEES IN QUALIFIED HEALTH PLANS.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Title 38 of the 1976 Code is amended by adding:

“CHAPTER 96

South Carolina Health Benefit Exchange

“Section 38-96-10. This act may be cited as the ‘South Carolina Health Benefit Exchange Act’.

Section 38-96-20. The purpose of this act is to provide for the establishment of the South Carolina Health Benefit Exchange pursuant to the federal health care act in order to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Employer Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured, provide a transparent consumer driven marketplace, increase competition, reduce health care costs, establish portability and simplicity in accessing health coverage, and assist individuals with access to programs, premium assistance tax credits, and cost-sharing reductions.

Section 38-96-30. As used in this chapter:

(1) ‘Board’ means the South Carolina Health Benefit Exchange Board of Directors.

(2) ‘Exchange’ means the South Carolina Health Benefit Exchange established pursuant to Section 38-96-40.

(3) ‘Federal health care act’ means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to either, or regulations or guidance issued under those acts.

(4) ‘Health benefit plan’ means a policy, contract, certificate, or agreement offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(a) ‘Health benefit plan’ does not include:

(i) coverage only for accident or disability income insurance or any combination of these;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers’ compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(b) ‘Health benefit plan’ does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan;

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these; or

(iii) other similar, limited benefits specified in federal regulations issued pursuant to Public Law 104-191.

(c) ‘Health benefit plan’ does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provisions of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance.

(d) ‘Health benefit plan’ does not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(iii) similar supplemental coverage provided to the coverage under a group health plan.

(5) ‘Health insurance carrier’ or ‘carrier’ means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Department of Insurance, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a health and accident insurance company, a health maintenance organization, a nonprofit hospital, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(6) ‘Qualified dental plan’ means a limited scope dental plan that has been certified in accordance with regulations promulgated pursuant to this chapter.

(7) ‘Qualified employer’ means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the small employer exchange, and at the option of the employer, some or all of its part-time employees if the employer:

(a) has its principal place of business in this State and elects to provide coverage through the small employer exchange to all of its eligible employees, wherever employed; or

(b) elects to provide coverage through the small employer exchange to all of its eligible employees who are principally employed in this State.

(8) ‘Qualified health plan’ means a health benefit plan that has in effect a certification that the plan meets the criteria for certification as provided for in regulation.

(9) ‘Qualified individual’ means an individual, including a minor, who:

(a) is seeking to enroll in a qualified health plan offered to individuals through the exchange;

(b) resides in the State of South Carolina;

(c) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(d) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(10) ‘Small employer’ means an employer that employed an average of not more than fifty employees during the preceding calendar year. However, beginning on January 1, 2016, ‘small employer’ means an employer that employed an average of not more than one hundred employees during the preceding calendar year. For purposes of this item:

(a) All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 must be treated as a single employer.

(b) An employer and any predecessor employer must be treated as a single employer.

(c) All employees must be counted, including part-time employees and employees who are not eligible for coverage through the employer.

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether this employer is a small employer must be based on the average number of employees this employer is reasonably expected to employ on business days in the current calendar year.

(e) An employer that makes enrollment in qualified health plans available to its employees through the small employer exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the small employer exchange available to its employees.

Section 38-96-40. (A) There is established the South Carolina Health Benefit Exchange within the Office of the Governor to effectuate the purposes provided for in this chapter.

(B) The exchange must be governed by the Health Benefit Exchange Board of Directors, the members of which must be appointed by the Governor with the advice and consent of the Senate. The board must be composed of the following members:

(1) Director of the Department of Insurance, or his designee, who shall serve ex officio;

(2) Director of the Department of Health and Human Services, or his designee, who shall serve ex officio;

(3) Chairman of the House Labor, Commerce and Industry Committee, or his designee, who shall serve ex officio;

(4) Chairman of the Senate Banking and Insurance Committee, or his designee, who shall serve ex officio;

(5) three representatives of the health insurance industry, upon the recommendation of the Director of the Department of Insurance; one of whom must represent a company providing health insurance that is domiciled in this State and one of whom must represent a company providing health insurance that holds less than five percent of the market share of health insurance in this State;

(6) two insurance producers, both of whom must have no fewer than ten years experience in the health insurance industry, one of whom must be recommended by the Professional Insurance Agents of South Carolina and one of whom must be recommended by the Independent Insurance Agents and Brokers of South Carolina;

(7) three consumer advocates;

(8) one business owner;

(9) one business owner recommended by the National Federation of Independent Business;

(10) one member recommended by the South Carolina Small Business Chamber of Commerce;

(11) one member recommended by the South Carolina Chamber of Commerce;

(12) one member recommended by the South Carolina Nurses Association;

(13) one member recommended by the South Carolina Primary Care Association;

(14) one physician recommended by the South Carolina Medical Association;

(15) one member recommended by the South Carolina Hospital Association;

(16) one actuary recommended by the American Academy of Actuaries.

(C) A person appointed to the board of directors must not be employed by, a consultant to, on the board of, or a lobbyist or other representative for an entity in the business of, or potentially in the business of, selling products or services of significant value to the exchange. These entities include, but are not limited to, insurance carriers that provide coverage of health benefits, producers, vendors, and health care providers selling services directly to the exchange.

(D) As designated by the Governor, of the initial appointees, seven shall serve terms of four years, five shall serve terms of three years, and five shall serve terms of two years. Thereafter members shall serve terms of four years and until their successors are appointed and qualify. If a vacancy occurs on the board, the member must be appointed in the manner of the original appointment for the unexpired portion of the term. Members may serve two consecutive four year terms; however, the initial appointees only may serve one four year term following the expiration of their initial term.

(E) The Governor shall appoint a member of the board to serve as chairman of the board and the board shall elect from its membership a vice chairman. The board shall adopt rules for its governance and shall meet at least once each quarter and at such other times as determined to be necessary.

(F) Members of the board are entitled to receive mileage, per diem, and subsistence as provided by law for members of state boards, commissions, and committees.

(G) Board members are immune from liability in any suit at law or in equity for any conduct performed in good faith and which is within the scope of authority provided board members pursuant to this chapter.

Section 38-96-50. The Governor shall appoint the Director of the Health Benefit Exchange who shall serve as the chief executive officer of the exchange. The director shall:

(1) administer all of the exchange’s activities and contracts;

(2) hire and supervise the staff of the exchange;

(3) advise the board on all matters related to the exchange.

Section 38-96-60. The exchange has the authority to:

(1) promulgate regulations necessary for the implementation and operation of the exchange and the powers and duties provided pursuant to this chapter.

(2) enforce all state and federal laws and regulations concerning the exchange;

(3) apply for and expend any state, federal, or private grant funds available to assist with the implementation and operation of the exchange;

(4) contract with any and all vendors necessary to assist with the implementation and operation of the exchange.

Section 38-96-70. The exchange shall:

(1) implement procedures for the certification, recertification, and decertification of health benefit plans as qualified plans;

(2) provide for the operation of a toll-free telephone hotline to receive and respond to requests for assistance;

(3) provide for enrollment periods;

(4) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on these plans and may enroll in these plans;

(5) assign a rating to each qualified health plan offered through the exchange and determine each qualified health plan’s level of coverage;

(6) use a standardized format for presenting health benefit options in the exchange;

(7) inform individuals of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, the Children’s Health Insurance Program (CHIP) under Title XXI of the Social Security Act, and any applicable state or local public program; and if through screening of the application by the exchange, the exchange determines that any individual is eligible for any state or local public program, shall refer that individual to the program so that he or she may have access to enrollment in the program;

(8) establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any state or federal cost-sharing reduction;

(9) facilitate the purchase and sale of qualified health plans;

(10) establish a small employer exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the small employer exchange at the specified level of coverage;

(11) review the rate of premium growth within the exchange and outside the exchange;

(12) receive and process any federal or state tax credits or other premium support payments for health insurance as may be provided for in law;

(13) create advisory committees to the board consisting of stakeholders relevant to carrying out the activities required under this chapter;

(14) meet the requirements of this chapter and fully comply with all requirements established by state and federal law and regulations.

Section 38-96-80. The exchange may select entities to serve as consumer information specialists to:

(1) conduct public education activities to raise awareness of the availability of qualified health plans;

(2) distribute fair and impartial information concerning enrollment in qualified health plans, the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986, and any cost-sharing reductions;

(3) facilitate enrollment in qualified health plans; however, a person must not receive any form of compensation as consideration for the facilitation of enrollment of a person in a qualified health plan through the exchange unless that person is an insurance producer that is licensed by the Department of Insurance pursuant to law;

(4) provide referrals to licensed insurance producers to facilitate enrollment in qualified health plans;

(5) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate state agency, for any enrollee with a grievance, complaint, or question regarding their health benefit plan, coverage, or a determination under that plan or coverage; and

(6) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

Section 38-96-90. (A) The exchange may contract with an eligible entity to perform any of its functions described in this chapter. An eligible entity includes, but is not limited to, an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities to be assumed by the entity, but a health insurance carrier or an affiliate of a health insurance carrier is not an eligible entity.

(B) The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this chapter if these agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

Section 38-96-100. (A) The exchange shall make qualified health plans available to qualified individuals and qualified employers with effective dates commencing on January 1, 2014.

(B)(1) The exchange must not make available any health benefit plan that is not a qualified health plan.

(2) The exchange may allow a health insurance carrier to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits as may be provided for in regulation.

(C) Neither the exchange nor the carrier offering health benefit plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual’s employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Section 38-96-110. (A) The exchange may charge assessments or user fees to health insurance carriers or otherwise may generate funding necessary to support its operation pursuant to this chapter.

(B) The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the exchange, on an Internet website to educate consumers on these costs. This information must include information on monies lost to waste, fraud, and abuse.”

SECTION 2. This act takes effect upon approval by the Governor.

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