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Summary: HealthNet Program Act

**HISTORY OF LEGISLATIVE ACTIONS**

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12/17/2008 Senate Referred to Committee on **Banking and Insurance**

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**VERSIONS OF THIS BILL**

[12/17/2008](file:///p:\pprever\2009-10\201_20081217.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING CHAPTER 60 TO TITLE 38 SO AS TO ENACT THE “SOUTH CAROLINA HEALTHNET PROGRAM”; TO PROVIDE FOR THE CREATION OF A FIVE‑YEAR PILOT PROGRAM TO PROMOTE THE AVAILABILITY OF HEALTH INSURANCE COVERAGE TO EMPLOYEES REGARDLESS OF HEALTH STATUS OR CLAIMS EXPERIENCE, PREVENT ABUSIVE RATING PRACTICES AND REQUIRE DISCLOSURE OF RATING PRACTICES TO PURCHASERS, ESTABLISH RULES REGARDING RENEWAL OF COVERAGE, LIMITATIONS ON THE USE OF PREEXISTING CONDITIONS EXCLUSIONS, ASSURE FAIR ACCESS TO HEALTH PLANS AND IMPROVE OVERALL FAIRNESS AND EFFICIENCY OF THE GROUP HEALTH INSURANCE MARKET; TO PROVIDE FOR DEFINITIONS; TO PROVIDE FOR THE COMPOSITION AND AUTHORITY OF THE BOARD OF DIRECTORS; TO PROVIDE FAIR MARKETING STANDARDS; TO PROVIDE FOR THE ESTABLISHMENT OF CRITERIA FOR PLAN ADMINISTRATION IN THE PLAN OF OPERATION; TO PROVIDE FOR RATES; TO PROVIDE FOR PROVIDER PARTICIPATION; TO PROVIDE FOR THE APPLICABILITY AND SCOPE OF THE CHAPTER; TO PROVIDE THAT HEALTH INSURERS SHALL OFFER AND MARKET PLANS DEVELOPED BY THE SOUTH CAROLINA HEALTHNET PROGRAM WHO ARE ELIGIBLE; TO PROVIDE FOR HEALTH BENEFIT PLAN STANDARDS AND PROVIDE AN EXCEPTION; TO PROVIDE FOR ELIGIBILITY STANDARDS; TO PROVIDE FOR TERMINATION AND NONRENEWAL OF COVERAGE; TO PROVIDE FOR LOSS DATA TO BE REPORTED TO THE PROGRAM; AND TO AUTHORIZE THE DIRECTOR OF THE STATE DEPARTMENT OF INSURANCE TO PROMULGATE REGULATIONS TO IMPLEMENT THE PROVISIONS OF CHAPTER 60, TITLE 38 ADDED BY THIS ACT.

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 60

South Carolina HealthNet Program

Section 38‑60‑10. This chapter may be cited as the ‘South Carolina HealthNet Program’.

Section 38‑60‑20. The purpose and intent of this chapter is to establish under the regulatory jurisdiction of the Department of Insurance a program designed to:

(1) promote the availability of health insurance coverage to employees of small employers;

(2) expand fair access to health plans; and

(3) improve the overall fairness and efficiency of the small group health insurance market.

Section 38‑60‑30. As used in this chapter:

(1) ‘Actuarial oversight committee’ means the committee composed of the three insurance industry employee representatives that serve on the board as defined in Section 38‑60‑50(A)(2)(c).

(2) ‘Board’ means the board of directors of the South Carolina HealthNet Program.

(3) ‘Dependent’ is as defined in Section 38‑71‑1330(5) and sole proprietors.

(4) ‘Director or his designee’ is as defined in Section 38‑1‑20(15) and (16).

(5) ‘Eligible employee’ is as defined in Section 38‑71‑1330(17) and Section 38‑60‑110.

(6) ‘Health group cooperative’ means a health group cooperative formed pursuant to Section 38‑71‑1345.

(7) ‘Health insurance coverage’ is as defined in Section 38‑71‑840(14), but for purposes of this chapter excludes coverage provided by Medicaid Managed Care Organizations that only offer coverage to eligible individuals through programs established by the Department of Health and Human Services and coverage provided by self‑insured groups.

(8) ‘Insurer’ is as defined in Section 38‑71‑840(16), but for purposes of this chapter excludes Medicaid Managed Care Organizations that only offer coverage to eligible individuals through programs established by the Department of Health and Human Services and organizations that only provide third party administrator services for self‑insured groups.

(9) ‘Plan of operation’ means the plan of operation for the program established pursuant to this chapter and includes the initial South Carolina HealthNet plan approved by the director or his designee.

(10) ‘Program’ means the South Carolina HealthNet Program.

(11) ‘Resident’ means an individual who is a legal resident of the State of South Carolina as that term is defined by law.

(12) ‘Small employer’ is as defined in Section 38‑71‑1330(17).

(13) ‘Small employer insurer’ is as defined in Section 38‑71‑1330(18).

(14) ‘South Carolina HealthNet Plan’ means a plan of insurance coverage that has been approved by the director or his designee for participation in the program.

Section 38‑60‑40. The provisions of this chapter apply only to small employer insurers and health group cooperatives.

Section 38‑60‑50. (A) The board consists of fifteen voting members. The director or his designee shall serve as a member of the board in an ex officio capacity for the duration of the program. The consumer advocate, as defined in Section 37‑6‑602, shall serve as a member of the board for the duration of the program. The other members of the board must be selected as follows:

(1) the chairman must be appointed by the Governor for a three‑year term;

(2) the director shall appoint:

(a) two representatives from the hospital community from a list of nominees submitted by the South Carolina Hospital Association. One must be appointed for a two‑year term and the other for a three‑year term. Subsequent terms are for three years;

(b) one representative appointed from a list of nominees submitted by the South Carolina Association of Health Underwriters appointed to a one‑year term. Subsequent terms are for three years;

(c) three representatives from the insurance industry. A minimum of two of the three insurance industry representatives must be credentialed by the American Academy of Actuaries and have a minimum of five years’ experience setting health insurance rates. One must be a domestic insurer employee representative appointed from a list of nominees submitted by the South Carolina Alliance of Health Plans appointed to a three‑year term. One must be a foreign insurer employee representative appointed from a list of nominees submitted by the South Carolina Alliance of Health Plans appointed to a two‑year term. One must be an at‑large insurer employee representative appointed by the director to a two‑year term. Subsequent terms are for three years;

(d) two representatives appointed from a list of nominees provided by the South Carolina Medical Association. One must be appointed for a two‑year term and one for a three‑year term. Subsequent terms are for three years;

(e) one representative appointed from a list of nominees provided by the South Carolina Department of Health and Human Services appointed to a three‑year term. Subsequent terms are for three years; and

(f) one representative appointed from a list of nominees provided by the South Carolina Pharmacy Association to be appointed to a two‑year term. Subsequent terms are for three years; and

(3) three consumer representatives. One must be an employer appointed by the President Pro Tempore of the Senate from a list of three nominees provided by the South Carolina Chamber of Commerce, one must be an employer appointed by the Speaker of the House of Representatives from a list of three nominees provided by the South Carolina Small Business Chamber, and one must be appointed by the Consumer Advocate from a list of nominees provided by consumer groups. These consumer representatives must be members of the general public and must not be employed by or affiliated with an insurance company or plan, hospital, or other health care provider. The consumer representatives are appointed to a two‑year term. Subsequent terms are for three years.

(B) The director shall appoint an actuarial oversight committee pursuant to Section 38‑60‑30(1) to develop the rates and rate schedules for South Carolina HealthNet plans offered through the program.

(C) An individual board member may not serve more than two consecutive terms. The board shall conduct its business and meetings in accordance with the requirements of the Freedom of Information Act.

(D) If there is a tie vote of the board on any matter, the issue must be presented to the director or his designee for his approval or disapproval.

(E) The director or his designee shall give notice of the date, time, and place for the initial organizational meeting.

(F) The director, within thirty days of the effective date of this chapter, shall notify all nominating organizations designated in this section to provide nominations for board membership. Upon receipt of notification, the nominating organizations have thirty days to submit a list of nominees.

Section 38‑60‑60. (A) The board shall submit to the director or his designee a plan of operation for the program and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The director or his designee shall approve the plan of operation provided it is determined to be suitable to assure the fair, reasonable, and equitable administration of the program.

(B) If the board fails to submit a suitable plan of operation within one hundred twenty days after the initial organizational meeting, or at any time after that fails to submit suitable amendments to the plan, the department may develop the plan of operation or operating rules necessary to effectuate the provisions of this chapter. The department shall promulgate by regulation the approved plan of operation. The plan of operation or operating rules continue in force until modified by the department or superseded by a plan submitted by the board and approved by the director or his designee.

(C) The plan of operation must:

(1) establish procedures for the handling and accounting of assets and monies of the program;

(2) establish procedures for filling vacancies on the board of directors;

(3) develop and implement a public awareness program to promote the existence of the plan;

(4) establish procedures for the board review of the health insurance plans;

(5) require producers to market the plan and the commissions, if any, to be paid at a reduced rate that must be no more than sixty percent of the commission rate that the agent normally receives for an otherwise identical group from the same insurer;

(6) establish a procedure to determine compliance with the program;

(7) authorize the board to appeal denials or disapprovals of plan amendments to the Administrative Law Court pursuant to Section 1‑23‑380; and

(8) provide the means to obtain funding necessary to support the board and its activities subject to the requirements in subsection (D) and Section 38‑60‑70(A).

(D) The program through its board has the following general powers including, but not limited to, the specific authority to:

(1) enter into contracts necessary to carry out the provisions of this chapter, including the authority, with the approval of the director or his designee, to enter into contracts with similar programs or nonprofit entities of other states or the federal government, such as Medicaid, for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal actions necessary or proper for recovery of funds for the program; however, in no situation may any legal action be taken against any individual member of the board as a result of their service on the board and a member of the board may not be liable for an independent action of an insurer under the program;

(3) take legal action as necessary to protect the interests and assets of the program;

(4) appoint, from among the board membership, the committees necessary to facilitate the operation of the program;

(5) apply for and accept grants, monetary and other donations, or other funding to cover the costs of administering the program;

(6) develop forms, level of coverage, benefits and plan design;

(7) review and approve the rates developed by the actuarial oversight committee;

(8) cause to be audited on an independent basis each year the finances of the program and submit the report of audit to the department by July first. The department shall forward the report of audit to the chairman of the Senate Finance Committee and the chairman of the House Ways and Means Committee within fifteen days of receipt; and

(9) hire the staff necessary for the effective administration of the program and contract with independent professionals meeting requirements in subsection (E) upon such reasonable basis of compensation as may be agreed upon, or as the board may determine, commensurate with the services rendered or to be rendered to the end that no excessive or unreasonable fees or compensation is allowed.

(E) All professional assistance required by the board must be provided by independent, appropriately licensed or professionally designated resources who are under contract with the board. All accounting determinations must be rendered by an independent certified public accountant, all actuarial assessments must be rendered by an independent member of the American Academy of Actuaries (MAAA) and all legal determinations must be rendered by an independent member of the South Carolina Bar.

(F) Nothing prohibits the board from entering public‑private partnerships with Medicaid or other government‑sponsored programs as a means of providing insurance coverage to the most people possible.

(G) Subject to the availability of funds, members of the board may receive for each meeting attended the per diem, subsistence, and mileage provided by law for members of state boards, commissions, and committees. The secretary of the board shall approve all vouchers.

Section 38‑60‑70. (A) The actuarial oversight committee, in consultation with an independent actuary, shall develop the rates and rate schedules for the plan benefits and design developed by the board. The minimum rate schedule developed by the actuarial oversight committee must be equal to the minimum schedule of Medicare plus ten percent for physicians and Medicare plus twenty percent for hospitals. The actuarial oversight committee and the independent actuary shall present the proposed rates and rate schedules to the board for its review and approval and adjustments, if necessary. Upon approval by the board, the actuarial oversight committee and the independent actuary shall present the rates and rate schedules to the director or his designee for approval.

(B) The rating methodology for South Carolina HealthNet plans under the program must be consistent with the rating requirements for the federal Medicare Program. The board, upon recommendation of the actuarial oversight committee, may add a percentage to the Medicare rate to cover the costs of providing health insurance under this program.

(C) For purposes of this section, the independent actuary must be credentialed by the American Academy of Actuaries and have a minimum of five years’ experience setting health insurance rates and meet the requirements provided for in Section 38‑60‑60(E).

Section 38‑60‑80. (A) An insurer shall file with the director or his designee, in the form and manner prescribed by the director or his designee, South Carolina HealthNet plans authorized under this chapter.

(B) The director or his designee, at any time after providing notice and an opportunity for a hearing to the insurer, may disapprove the continued use by an insurer or health group cooperative of a South Carolina HealthNet plan on the grounds that the plan does not meet the requirements of this chapter.

(C) A policy, contract, certificate, or other evidence of coverage issued under this chapter conspicuously must display ‘South Carolina HealthNet’ on the face and declarations pages of the policy.

(D) All plans authorized under this chapter must provide in enrollment materials, plain‑language information on policy benefit coverage, benefit limits, cost‑sharing requirements, and exclusions.

(E) An insurer shall use the same underwriting and administration requirements for groups covered by the program as it uses for other equivalent groups in the small employer insurance market. All policies are guaranteed issue and must be issued without regard to the applicant’s health status related factors.

(F) All plans authorized under this chapter and approved by the director or his designee are exempt from all South Carolina insurance mandates. Except for the state mandate exemption, all plans authorized by this chapter must be consistent with the statutory and regulatory requirements for small group health insurance products in this State.

(G) An insurer that requires an employer to maintain a certain employee participation percentage for its group health insurance plan shall include the program coverage in the required participation percentage requirement.

(H) A plan authorized under this chapter may not be offered for sale in this State until it has been reviewed and approved by the director or his designee.

Section 38‑60‑90. A provider may contract with the insurer for the reimbursement rates approved by the board. A provider participating in a contract with the program and furnishing health care services to an individual insured by a South Carolina HealthNet plan may not balance bill that individual or otherwise hold that individual financially responsible for services rendered.

Section 38‑60‑100. Each small employer insurer writing group health insurance coverage in this State and any health group cooperative formed in accordance with Section 38‑71‑1345 shall participate in the program by offering and actively marketing South Carolina HealthNet plans. At the option of the employer, the South Carolina HealthNet plan must be offered to eligible employees of the small employer group either as an optional benefit plan to any other plan offered by the same insurer to that employer or as the sole benefit plan for that employer.

Section 38‑60‑110. (A) The eligible employees of a small employer in this State who provides health insurance coverage to its employees are eligible for coverage under the program, provided the eligible employee is a citizen of the United States and has been a legal resident of this State for a minimum of six months and uninsured for the preceding twelve months except as provided in subsection (C).

(B) The dependent of an eligible employee of a small employer in this State who provides health insurance coverage to its employees is eligible for coverage under the program, provided the dependent is a citizen of the United States and has been a legal resident of this State for a minimum of six months and uninsured for the preceding twelve months except as provided in subsection (C).

(C) An employee who cancels health insurance coverage under an employer group policy is not eligible for coverage in the program for a period of twelve months from the date of cancellation under the employer group plan. However, if an employee’s group participation is cancelled due to termination of employment, the employee is eligible to participate in the South Carolina HealthNet program, if any, offered by a subsequent employer.

Section 38‑60‑120. Plan coverage under the program ceases:

(1) upon a termination or nonrenewal of health insurance coverage by the insurer, provided the termination or nonrenewal complies with Section 38‑71‑870;

(2) on the date an employee or employer requests coverage to end; or

(3) at the time a person ceases to meet the eligibility requirements of this section.

Section 38‑60‑130. (A) An insurer participating in the program shall report claims data to the program in the manner prescribed by the board. The department may specify, by bulletin, the requirements for reporting claims data and other required information to the department.

(B) The board shall submit a report to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives no later than January 1, 2014, regarding the effectiveness of the program, including any recommendations relating to the successful implementation and administration of the program.

Section 38‑60‑140. The department may promulgate regulations necessary for implementation of this chapter.

Section 38‑60‑150. Before termination of the program, insurers participating in the plan shall:

(1) offer to continue the South Carolina HealthNet coverage for a maximum of one additional year to allow the participant the opportunity to find alternative coverage; or

(2) offer to replace the South Carolina HealthNet policy with a policy underwritten by the insurer that provides coverage similar to or better than the South Carolina HealthNet policy at applicable rates offered by the insurer.”

SECTION 2. The General Assembly shall provide initial funding for the program in the amount of ninety‑five thousand dollars appropriated from the insurance premium taxes deposited in the general fund of the State pursuant to Section 38‑7‑20.

SECTION 3. This act takes effect upon approval by the Governor. The program takes effect no earlier than January 1, 2010, but not later than July 1, 2010. This program terminates five years from the date of its first date of operation unless extended by action of the General Assembly.

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