COMMITTEE AMENDMENT ADOPTED

April 29, 2009

**S. 455**

Introduced by Senators Thomas and Rose

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Read the first time February 19, 2009.

**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 OF SMALL EMPLOYER GROUPS AND HEALTH GROUP COOPERATIVES REGARDLESS OF HEALTH STATUS OR CLAIMS EXPERIENCE, 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 SMALL 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 SMALL GROUP HEALTH INSURERS SHALL OFFER AND MARKET PLANS DEVELOPED BY THE SOUTH CAROLINA HEALTHNET PROGRAM; TO PROVIDE FOR HEALTH BENEFIT PLAN STANDARDS; TO PROVIDE FOR ELIGIBILITY STANDARDS AND PROVIDE EXCEPTIONS; TO PROVIDE FOR TERMINATION AND NONRENEWAL OF COVERAGE; TO PROVIDE FOR CLAIMS DATA TO BE REPORTED TO THE PROGRAM; TO REQUIRE THE BOARD TO SUBMIT A REPORT REGARDING THE IMPLEMENTATION OF 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.

Amend Title To Conform

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, health group cooperatives, and sole proprietors;

(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).

(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(6).

(6) ‘Health group cooperative’ means a private purchasing cooperative composed of small employers formed pursuant to Article 13, Chapter 71, Title 38.

(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’ means an entity that provides health insurance in this State. For purposes of this chapter, insurer includes an insurance company, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, including multiple employer self‑insured health plans licensed pursuant to the provisions of Chapter 41, Title 38, but 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(18).

(13) ‘Small employer insurer’ is as defined in Section 38‑71‑1330(19).

(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.

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) Pursuant to Section 38‑60‑70, the actuarial oversight committee shall develop the rates and fee 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 of operation, 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 of operation 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 program;

(4) establish procedures for the board review of South Carolina HealthNet plans;

(5) require producers to market South Carolina HealthNet plans 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 producer normally receives for an otherwise identical group from the same insurer;

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

(7) provide the means to obtain funding necessary to support the board and its activities subject to the requirements of this chapter.

(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 of South Carolina HealthNet plans;

(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;

(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; and

(10) appeal denials or disapprovals of plan of operation amendments to the Administrative Law Court pursuant to Section 1‑23‑380.

(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 into 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 fee schedules for the plan benefits and design developed by the board. The actuarial oversight committee and the independent actuary shall present the proposed rates and fee 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 fee schedules to the director or his designee for approval.

(B) For purposes of this section, the independent actuary must be credentialed by the MAAA 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 of a South Carolina HealthNet plan on the grounds that it 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 South Carolina HealthNet plans authorized under this chapter must provide in enrollment materials, plain‑language information on policy benefit coverage, benefit limits, cost‑sharing requirements, and exclusions. A notice, statement, or form required by this subsection must achieve a score of no lower than seventy on the Flesch Reading East Test and must be printed in bold and no smaller than twelve‑point type.

(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. Except as provided in Section 38‑60‑100(C), all policies are guaranteed issue and must be issued without regard to the applicant’s health status related factors.

(F) All South Carolina HealthNet plans authorized under this chapter and approved by the director or his designee are exempt from all state mandated coverages of health care services or health care benefits.

(G) Except as provided in subsection (F), all plans authorized by this chapter must be consistent with the statutory and regulatory requirements for small group health insurance products in this State.

(H) 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.

(I) A South Carolina HealthNet 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 a participating insurer for the reimbursement rates approved by the board. The board shall require each provider participating in the program and furnishing health care services to an individual insured by a South Carolina HealthNet plan to execute an agreement not to bill or otherwise hold South Carolina HealthNet plan participants financially responsible for services rendered except for the cost sharing requirements, including deductibles and copayments, provided for in the South Carolina HealthNet plan. An employing entity may execute one agreement on behalf of the employing entity and all of its providers. The provider’s agreement:

(1) must be given on forms prescribed or approved by the director or his designee;

(2) extends to all services furnished to the South Carolina HealthNet plan participant during the time he was covered under the program; and

(3) applies even where the provider or employing entity had not been paid by the insurer.

Section 38‑60‑100. (A) Each small employer insurer writing group health insurance coverage in this State shall participate in the program by offering and actively marketing South Carolina HealthNet plans.

(B) At the option of the employer or health group cooperative, 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 health group cooperative or as the sole benefit plan for that employer or health group cooperative.

(C) A sole proprietor and the dependents of a sole proprietor may participate in the program subject to the medical underwriting requirements and policies of the insurer to the extent they meet the eligibility requirements provided in this chapter.

Section 38‑60‑110. (A) The eligible employees of a small employer and of a sole proprietor 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 or of a sole proprietor 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 plan, 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, employer or health group cooperative requests coverage to end; or

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

Section 38‑60‑130. (A) An insurer participating in the program shall report claims data to the program on an annual basis 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) One year following the approval of the plan of operation and annually after that time, the board shall submit a report to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives regarding the implementation of the program and including a summary of claims data reported pursuant to subsection (A).

(C) The board shall include in the third annual report compiled and submitted pursuant to subsection (B) a report on 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. (A) Before termination of the program, participating insurers shall:

(1) offer to continue the South Carolina HealthNet plan 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 plan with a policy underwritten by the insurer that provides coverage similar to or greater than the South Carolina HealthNet plan at applicable rates offered by the insurer.

(B) An individual insured by a South Carolina HealthNet plan at the time of termination of the program shall have the right to transfer or continue coverage as provided for in subsection (A). A transfer or continuation of coverage is not subject to medical underwriting nor increased premiums based on actual or expected health‑status related factors. Creditable coverage must be provided for any waiting period or preexisting condition period specified in the policy to which the transfer is made.

(C) The provisions of this section apply to the transfer or continuation of coverage so long as the coverage is provided through any other plan offered by the same 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 plan of operation takes effect no earlier than January 1, 2010, but not later than January 1, 2011. The program terminates five years from the date of approval of the plan of operation unless extended by action of the General Assembly.

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