**South Carolina General Assembly**

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**S. 845**

**STATUS INFORMATION**

General Bill

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Introduced in the Senate on June 2, 2015

Currently residing in the Senate Committee on **Finance**

Summary: Financial Responsibility and Opportunity Health Care Program Act

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

6/2/2015 Senate Introduced and read first time ([Senate Journal‑page 10](file:///h:\SJ%20Archive\2015\06-02-15.docx))

6/2/2015 Senate Referred to Committee on **Finance** ([Senate Journal‑page 10](file:///h:\SJ%20Archive\2015\06-02-15.docx))

View the latest [legislative information](http://www.scstatehouse.gov/billsearch.php?billnumbers=845&session=121&summary=B) at the website

**VERSIONS OF THIS BILL**

[6/2/2015](file:///p:\pprever\2015-16\845_20150602.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 11‑11‑260 SO AS TO ENACT THE “FINANCIAL RESPONSIBILITY AND OPPORTUNITY HEALTH CARE PROGRAM ACT” TO ENABLE LOW‑INCOME INDIVIDUALS TO PURCHASE HEALTH INSURANCE; TO PROVIDE THAT BEGINNING IN FISCAL YEAR 2016‑2017, IN THE ANNUAL GENERAL APPROPRIATIONS ACT, THE GENERAL ASSEMBLY SHALL AUTHORIZE SUFFICIENT FEDERAL FUNDS TO CREATE A FISCALLY SUSTAINABLE AND COST‑EFFECTIVE HEALTH CARE PROGRAM AS AN ALTERNATIVE TO THE MEDICAID PROGRAM; TO REQUIRE THE GENERAL ASSEMBLY TO APPROPRIATE FUNDING TO OPERATE THE PROGRAM AND IDENTIFY EXISTING SOURCES OF FUNDS FOR APPROPRIATION; TO PROVIDE THAT THE PROGRAM IS CONTINGENT UPON SPECIFIED LEVELS OF FEDERAL MEDICAID FUNDING, TO PROVIDE THAT THE STATE ASSUMES NO OBLIGATION OTHER THAN AS SPECIFIED; AND TO SPECIFY THE MANNER IN WHICH THE PROGRAM SHALL OPERATE.

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

SECTION 1. Article 1, Chapter 11, Title 11 of the 1976 Code is amended by adding:

“Section 11‑11‑260. (A) There is created the ‘Financial Responsibility and Opportunity Health Care Program’.

(B)(1) Each year in the annual general appropriations act, beginning in Fiscal Year 2016‑2017, the General Assembly shall:

(a) authorize sufficient federal funds to submit cost‑effective waivers set forth in this section; and

(b) appropriate as funds for the program:

(i) any revenues collected pursuant to Article 11, Chapter 23, Title 12 to the extent that those revenues are not used to fund disproportionate health care; and

(ii) funds appropriated in Fiscal Year 2014‑2015 for the Healthy Outcomes Initiative, Primary Care Safety Net, and Healthy Connections Checkup Program.

(2) Funds appropriated may be carried forward to the next fiscal year to be used for the same purpose.

(C) For a fiscally sustainable, cost‑effective, personally responsible, and opportunity‑driven program utilizing competitive and value‑based purchasing, the Department of Health and Human Services shall design options that reform the Medicaid Program to:

(1) maximize the available service options through the health care marketplace;

(2) promote accountability, personal responsibility, and transparency;

(3) encourage and reward healthy outcomes and responsible choices; and

(4) promote efficiencies that will deliver value to the taxpayers.

(D) The State shall take an integrated and market‑based approach to covering low‑income South Carolinians through offering new coverage opportunities, stimulating market competition, and offering alternatives through Medicaid funding to allow for the purchase of private insurance through the health care market for individuals not covered under the state’s Medicaid program.

(E) The purpose of the Financial Responsibility and Opportunity Health Care Program is to:

(1) improve access to quality health care;

(2) attract insurance carriers and enhance competition in this state’s insurance marketplace;

(3) promote individually owned health insurance;

(4) strengthen personal responsibility through cost‑sharing;

(5) improve continuity of coverage;

(6) reduce the size of the state‑administered Medicaid program;

(7) encourage appropriate care, including early intervention, prevention, and wellness;

(8) increase quality and delivery system efficiencies;

(9) facilitate this state’s continued payment innovation, delivery system reform, and market‑driven improvements;

(10) discourage overutilization; and

(11) reduce waste, fraud, and abuse.

(F)(1) As part of the Financial Responsibility and Opportunity Health Care Program’s design and creation, the department shall submit a waiver to the Center on Medicare and Medicaid Services to utilize a private insurance option for adults that ensure that private health care options increase and government‑operated programs such as Medicaid decrease.

(2) The department shall submit Medicaid state plan amendments and apply for any federal waivers necessary to implement the program in a manner consistent with this section.

(G)(1) Implementation of the program is conditioned upon the receipt of necessary federal approvals. If the department does not receive the necessary federal approvals, the program must not be implemented.

(2) Decisions regarding the design, operation, and implementation of this option, including cost, remain within the purview of this State and not federal authorities.

(H)(1) The Financial Responsibility and Opportunity Health Care Program must include premium assistance for eligible individuals to enable their enrollment in a qualified health plan through the health insurance marketplace.

(2) The department is authorized to pay premiums and supplemental cost‑sharing subsidies directly to the qualified health plans for enrolled eligible individuals. The intent of these payments is to increase participation and competition in the health insurance market, intensify price pressures, and reduce costs for both publicly and privately funded health care.

(3) The program must include allowable cost sharing for eligible individuals that is comparable to that for individuals as approved through the waiver.

(I)(1) The Financial Responsibility and Opportunity Health Care Program terminates within one hundred twenty days after a reduction in any of the following federal medical assistance percentages:

(a) one hundred percent in 2015 or 2016;

(b) ninety‑five percent in 2017;

(c) ninety‑four percent in 2018;

(d) ninety‑three percent in 2019; and

(e) ninety percent in 2020 or any year after 2020.

(2) An eligible individual enrolled in the program shall alternatively acknowledge that the program is not a perpetual federal or state right, and that the program is subject to cancellation upon appropriate notice.

(J)(1) State obligations for uncompensated care must be projected, tracked, and reported to identify potential incremental future decreases. The department shall recommend appropriate adjustments to the General Assembly. Adjustments must be made by the General Assembly as appropriate.

(2) On a quarterly basis, the Department of Health and Human Services and the Department of Insurance shall report to the General Assembly information regarding:

(a) program enrollment;

(b) patient experience;

(c) economic impact including enrollment distribution;

(d) carrier competition; and

(e) avoided uncompensated care.

(K) The State of South Carolina is not responsible or otherwise obligated to make any payments or assume any obligations to a carrier for other than the premiums and cost sharing as specified in this section.

(L) Health care coverage must be achieved through a qualified health plan at the silver level as provided in 42 U.S.C. Sections 18022 and 18071, as existing on January 1, 2015, that restricts cost sharing to amounts that do not exceed Medicaid cost‑sharing limitations.

(M)(1) All participating carriers in the health insurance marketplace shall offer health care coverage conforming to the requirements of this section.

(2) Health insurance carriers offering health care coverage for program eligible individuals shall participate in department program payment improvement initiatives including:

(a) assignment of primary care clinician;

(b) support for patient‑centered medical home; and

(c) access to clinical performance data for providers.

(N) By February 1, 2016, the Department of Insurance shall implement through certification requirements, regulations, or both, the applicable provisions of this section.

(O) The General Assembly shall assure that a mechanism within the health insurance marketplace is established and operated to facilitate enrollment of eligible individuals. The enrollment mechanism must include an automatic verification system to guard against waste, fraud, and abuse in the program.

(P) For purposes of this section:

(1) ‘Carrier’ means a private entity certified by the Department of Insurance and offering plans through the health insurance marketplace.

(2) ‘Cost sharing’ means the portion of the cost of a covered medical service that must be paid by or on behalf of eligible individuals, consisting of copayments or coinsurance but not deductibles.

(3) ‘Department’ means the Department of Health and Human Services.

(4) ‘Eligible individuals’ means individuals who:

(a) are adults between nineteen years of age and sixty‑five years of age with an income that is equal to or less than one hundred thirty‑eight percent of the federal poverty level including, without limitation, individuals who would not be eligible for Medicaid under laws and rules in effect on January 1, 2015; and

(b) have been authenticated to be United States citizens or documented, qualified aliens according to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104‑193, as existing on January 1, 2015.

(5) ‘Health care coverage’ means health care benefits as defined by certification or rules, or both, promulgated by the Department of Insurance for the qualified health plans or available in the health care marketplace.

(6) ‘Health insurance marketplace’ means the vehicle created to help individuals, families, and small businesses in this State shop for and select health insurance coverage in a way that permits comparison of available qualified health plans based upon price, benefits, services, and quality, regardless of the governance structure of the marketplace.

(7) ‘Premium’ means a charge that must be paid as a condition of enrolling in health care coverage.

(8) ‘Program’ means the Financial Responsibility and Opportunity Health Care Program established by the waiver approved by the federal government.

(9) ‘Qualified health plan’ means a Department of Insurance certified individual health insurance plan offered by a carrier through the health insurance marketplace.”

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

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