**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑71‑295 SO AS TO PROHIBIT PREEXISTING CONDITION EXCLUSIONS IN INDIVIDUAL, GROUP, AND SMALL EMPLOYER HEALTH BENEFIT PLANS; TO AMEND SECTION 38‑71‑143, RELATING TO HEALTH PLAN COVERAGE FOR CHILDREN PLACED FOR ADOPTION, SO AS TO MAKE CONFORMING CHANGES; TO AMEND SECTION 38‑71‑340, RELATING TO REQUIRED PROVISIONS IN INSURANCE POLICIES, SO AS TO MAKE CONFORMING CHANGES; TO AMEND SECTION 38‑71‑530, RELATING TO SPECIFIC STANDARDS REQUIRED FOR THE SALE OF INSURANCE POLICIES, SO AS TO MAKE CONFORMING CHANGES; TO AMEND SECTION 38‑71‑650, RELATING TO THE RIGHT TO TRANSFER A POLICY OF EQUAL OR LESSER BENEFITS WITH THE SAME INSURER, SO AS TO MAKE CONFORMING CHANGES; TO AMEND SECTION 38‑71‑730, RELATING TO REQUIREMENTS FOR GROUP ACCIDENT AND GROUP HEALTH POLICIES, SO AS TO MAKE CONFORMING CHANGES; TO AMEND SECTION 38‑71‑760, RELATING TO STANDARDS FOR GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE, SO AS TO MAKE CONFORMING CHANGES; TO AMEND SECTION 38‑71‑1360, RELATING TO THE REQUIREMENT FOR INSURERS TO OFFER ALL PLANS ACTIVELY MARKETED TO SMALL EMPLOYERS, SO AS TO MAKE CONFORMING CHANGES; TO REPEAL SECTION 38‑71‑560 RELATING TO THE USE OF SIMPLIFIED APPLICATION FORMS; AND TO REPEAL SECTION 38‑71‑850 RELATING TO PREEXISTING CONDITIONS.

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

SECTION 1. Article 1, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑295. (A) No individual, group or small employer health benefit plans, including the State Health Plan and health maintenance organizations in this State may impose preexisting condition exclusions with respect to coverage under the plan.

(B) ‘Preexisting condition exclusion’ means a limitation or an exclusion or denial of benefits due to a condition that was present before the effective date of coverage under a group health plan or individual health insurance plan, whether or not any medical diagnosis, care, or treatment was recommended or received before that day.

(C) Every insurer that offers health insurance coverage in this State must accept every employer and individual of this State that applies for coverage who is eligible to apply.

(D) With respect to premium rates charged by an insurer offering an individual or small employer health benefit plan, the insurer must base its premium rates on, and vary the premium rates with respect to the particular plan or coverage, only by the following case characteristics:

(1) whether the plan or coverage covers an individual or family;

(2) geographic rating area, established pursuant to federal law;

(3) age, except that the rate must not vary by more than three to one for adults; and

(4) tobacco use, except that the rate must not vary by more than one and one‑fifteenth to one.

(E) With respect to family coverage under an individual or small employer health benefit plan, the insurer must apply the rating variations permitted under this section based on the portion of the premium that is attributable to each family member covered under the plan in accordance with rules of the commissioner.

(F) The insurer must not adjust the premium charged with respect to any particular individual or small employer health benefit plan more frequently than annually, except that the insurer may change the premium rates to reflect:

(1) with respect to a small employer health benefit plan, changes to the enrollment of the small employer;

(2) changes to the family composition of the policyholder or employee;

(3) with respect to an individual health benefit plan, changes in geographic rating area of the policyholder or changes in tobacco use, as provided in subsection (D).

(4) changes to the health benefit plan requested by the policyholder or small employer; or

(5) other changes required by federal law or regulations or otherwise expressly permitted by state law or regulation.

(G) The commissioner may adopt rules and regulations to implement and administer this section to assure that rating practices used by insurers are consistent with the purposes of this section.”

SECTION 2. Section 38‑71‑143 of the 1976 Code is amended to read:

“Section 38-71-143. (A) If an individual or group health plan provides coverage for dependent children of participants or beneficiaries, the plan ~~shall~~ must provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.

(B) ~~A group health plan may not restrict coverage under the plan of a dependent child adopted by a participant or beneficiary or placed with a participant or beneficiary for adoption solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.~~

~~(C)~~ For the purposes of this section:

(1) ‘child’ means, in connection with an adoption or placement for adoption of the child, an individual who has not attained age eighteen as of the date of the adoption or placement for adoption;

(2) ‘placement for adoption’ means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child’s placement with a person terminates upon the termination of the legal obligations.”

SECTION 3. Section 38‑71‑340(2) of the 1976 Code is amended to read:

“(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES:

After two years from the issue date only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability that starts after the two‑year period.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age fifty or (b) in the case of a policy issued after age forty‑four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parenthesis may be omitted at the insurer’s option) ‘INCONTESTABLE’:

~~(a)~~ Misstatements in the application:

After this policy has been in force for two years during the insured’s lifetime (excluding any period during which the insured is disabled), the company cannot contest the statements contained in the application.

~~(b)~~ ~~Preexisting conditions:~~

~~No claim for loss incurred or disability that starts after two years from the issue date will be reduced or denied because a sickness or physical condition not excluded by name or specific description before the date of loss had existed before the effective date of coverage.~~”

SECTION 4. Section 38‑71‑530 of the 1976 Code is amended to read:

“Section 38-71-530. (a) The department shall promulgate regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of accident and health insurance or subscriber contracts of nonprofit hospital, medical, and dental service associations which must be in addition to and in accordance with applicable laws of this State and which may cover, but are not limited to, the following:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage provisions;

(4) coverage of dependents;

(5) ~~preexisting conditions~~ Reserved;

(6) termination of insurance;

(7) probationary periods;

(8) limitations;

(9) exceptions;

(10) reductions;

(11) elimination periods;

(12) requirements for replacement;

(13) recurrent conditions.

~~(14)~~ The definition of terms including, but not limited to, the following:

(i) hospital;

(ii) accident;

(iii) sickness;

(iv) injury;

(v) physician;

(vi) accidental means;

(vii) total disability;

(viii) partial disability;

(ix) nervous disorder;

(x) guaranteed renewable;

(xi) noncancelable.

(b) The department may promulgate regulations that specify prohibited policy provisions not otherwise specifically authorized by law which in the opinion of the director or his designee are unjust, unfair, or unfairly discriminatory to the policy holder, any person insured under the policy, or beneficiary.”

SECTION 5. Section 38‑71‑650 of the 1976 Code is amended to read:

“Section 38‑71‑650. Any person purchasing an individual accident, health, or accident and health insurance policy after July 1, 1991, ~~shall have~~ has the right to transfer to any individual policy of equal or lesser benefits offered for sale by the insurer at the time the transfer is sought. Any special provision excluding coverage for a specified condition may remain after transfer, and any waiting period ~~or preexisting condition period~~ specified in the policy to which the transfer is made may be required to be served after the transfer.”

SECTION 6. Section 38‑71‑730(4), (5), and (6) of the 1976 Code is amended to read:

“(4) ~~Except for group health insurance coverage as defined in Section 38‑71‑840, the policies may contain a provision limiting coverage for preexisting conditions. The preexisting conditions must be covered no later than twelve months without medical care, treatment, or supplies ending after the effective date of the coverage or twelve months after the effective date of the coverage, whichever occurs first. Policies of disability income insurance may exclude coverage for disabilities beginning during the first twelve months after the effective date of coverage which result from a preexisting condition. Preexisting conditions are defined as those conditions for which medical advice or treatment was received or recommended no more than twelve months before the effective date of a person’s coverage. However, whenever a covered person moves from one insured group to another, the insurer of the group to which the covered person moves shall give credit for the satisfaction of the preexisting condition period or portion thereof already served under the prior plan if the coverage is selected when the person first becomes eligible and the coverage is continuous to a date not more than thirty days prior to the effective date of the new coverage. Service under a probationary waiting period required by the employer is not considered to interrupt continuous service. The requirements with respect to limitations on preexisting condition exclusions for group health insurance coverage are described in Section 38‑71‑850.~~

~~(5)~~ Except as provided in item (1)(b)(vii) of this section, the premium for the policy must be paid by the policyholder from the policyholder’s funds or from funds contributed by the insured persons, or from both.

~~(6)~~(5) A group policy or subscriber contract of accident and health insurance which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare must equal, and may exceed, the minimum standards for Medicare supplement policies as contained in regulations promulgated by the department.”

SECTION 7. Section 38‑71‑760(m) of the 1976 Code is amended to read:

“(m) This subsection applies to all groups.

(1) Each person who is eligible for coverage in accordance with the succeeding carrier’s plan of benefits with respect to classes eligible and actively at work and nonconfinement rules must be covered by the succeeding carrier’s plan of benefits. For health insurance coverage as defined in Section 38‑71‑840, nonconfinement rules are not permitted and absence from work due to any health status‑related factor must be treated as being actively at work.

(2) Each person not covered under the succeeding carrier’s plan of benefits in accordance with item (1) ~~of this subsection (m)~~ nevertheless must be covered by the succeeding carrier in accordance with the following rules if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class of individuals eligible for coverage under the succeeding carrier’s plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual’s status immediately prior to the date the succeeding carrier’s coverage becomes effective.

(A) The minimum level of benefits to be provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier’s plan reduced by any benefits payable by the prior plan.

(B) Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:

(i) The date the individual becomes eligible under the succeeding carrier’s plan as described in item (1) ~~of this subsection (m)~~.

(ii) For each type of coverage, the date the individual’s coverage would terminate in accordance with the succeeding carrier’s plan provisions applicable to individual termination of coverage, such as at termination of employment or ceasing to be an eligible dependent, as the case may be.

(iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which subsections (f) through (j) ~~of this section~~ require an extension of benefits or accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by those subsections or, if the prior carrier’s policy or contract is not subject to those subsections, would have been required of that carrier had its policy or contract been subject to those subsections at the time the prior plan was discontinued and replaced by the succeeding carrier’s plan.

(3) For health insurance coverage as defined in Section 38‑71‑840, in the case of an individual who was totally disabled at the time the prior plan was discontinued and replaced by a group health plan with similar benefits, and in the case in which subsection (1) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier’s plan. This benefit may be reduced by any benefits paid by the prior plan.

(4) ~~In the case of a preexisting conditions limitation included in the succeeding carrier’s plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier’s plan in accordance with this subsection (m) during the period of time this limitation applies under the new plan must be the lesser of:~~

~~(A)~~ ~~the benefits of the new plan determined without application of the preexisting conditions limitation; and~~

~~(B)~~ ~~the benefits of the prior plan.~~

~~(5)~~ The succeeding carrier, in applying any deductibles, coinsurance amounts applicable to the out‑of‑pocket maximums or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions or coinsurance amounts applicable to the out‑of‑pocket maximums, the credit must apply for the same or overlapping benefit periods and must be given for expenses actually incurred and applied against the deductible provisions or to the out‑of‑pocket maximums of the prior carrier’s plan during the ninety days preceding the effective date of the succeeding carrier’s plan but only to the extent these expenses are recognized under the terms of the succeeding carrier’s plan and are subject to similar deductible or coinsurance provisions.

~~(6)~~(5) In any situation where a determination of the prior carrier’s benefit is required by the succeeding carrier, at the succeeding carrier’s request the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this section, benefits of the prior plan are determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding carrier.”

SECTION 8. Section 38‑71‑1360(A) of the 1976 Code is amended to read:

“(A)(1) Every small employer insurer shall, as a condition of transacting business in this State with small employers, actively offer to small employers all health insurance plans actively marketed to small employers in this State, including at least two health insurance plans. One health insurance plan offered by each small employer insurer must be a basic health insurance plan and one plan must be a standard health insurance plan.

(2) Coverage under such health insurance plan must be offered to every eligible employee of a small employer and his or her dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the health insurance plan and may not place any restriction which is inconsistent with Section 38‑71‑860 on an eligible employee being a participant or beneficiary. A small employer insurer may not offer coverage only to certain individuals in a small employer group, or to only part of the group~~, except as provided in Section 38‑71‑850 for late enrollees~~.

(3) ~~Except with respect to applicable preexisting condition limitation periods or late enrollees as provided in Section 38‑71‑850,~~ A small employer insurer shall not modify a health insurance plan with respect to a small employer or any eligible employee or dependent through rider, endorsement, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered under the plan.

(4)(a) Except as provided in subsections (C) and (D), a small employer insurer shall issue these health insurance plans to any eligible small employer that applies for any such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health insurance plan relating to employer contribution rules and group participation rules and not inconsistent with this article.

(b) In the case of a small employer insurer that establishes more than one class of business pursuant to Section 38‑71‑920, the small employer insurer shall maintain and issue to eligible small employers these health insurance plans in addition to at least one basic health insurance plan and at least one standard health insurance plan in each class of business so established. A small employer insurer may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(i) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health insurance plan;

(ii) the criteria are not related to the health status or claim experience of the small employer;

(iii) the criteria are applied consistently to all small employers applying for coverage in the class of business; and

(iv) the small employer insurer provides for the acceptance of all eligible small employers into one or more classes of business.

The requirement to offer these health insurance plans to small employers shall not apply to a class of business into which the small employer insurer is no longer enrolling new small businesses.

(5) The provisions of this subsection (A) of this section shall be effective one hundred eighty days after the director’s approval of the basic health insurance plan and the standard health insurance plan developed pursuant to Section 38‑71‑1420; provided that if the Small Employer Insurer Reinsurance Program created pursuant to Section 38‑71‑1410 is not yet operative on that date, the provisions of this paragraph shall be effective on the date that the program begins operation.”

SECTION 9. Section 38‑71‑560 of the 1976 Code is repealed.

SECTION 10. Section 38‑71‑850 of the 1976 Code is repealed.

SECTION 11. This act takes effect upon approval by the Governor.

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