

State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

166C0012

HOUSE ENGROSSED NO. **HB1011** - 2/5/99

Introduced by: Representatives Hunt, Cerny, Duenwald, and Hagen and Senators Kloucek and Lawler at the request of the Interim Health and Human Services Committee

1 FOR AN ACT ENTITLED, An Act to provide covered persons in managed care plans with
2 reasonable access to providers.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

4 Section 1. Terms used in this Act mean:

5 (1) "Managed care contractor," a person who establishes, operates, or maintains a
6 network of participating providers; or contracts with an insurance company, a hospital
7 or medical service plan, an employer, an employee organization, or any other entity
8 providing coverage for health care services to operate a managed care plan;

9 (2) "Managed care entity," a licensed insurance company, hospital or medical service
10 plan, health maintenance organization, an employer or employee organization, or a
11 managed care contractor that operates a managed care plan;

12 (3) "Managed care plan," a plan operated by a managed care entity that provides for the
13 financing or delivery of health care services, or both, to persons enrolled in the plan
14 through any of the following:

15 (a) Arrangements with selected providers to furnish health care services;

16 (b) Explicit standards for the selection of participating providers; or

1 (c) Financial incentives for persons enrolled in the plan to use the participating
2 providers and procedures provided for by the plan;

3 (4) "Provider," any person who furnishes health services and is licensed or otherwise
4 authorized to render such services in the state.

5 Section 2. A managed care plan shall maintain a network that is sufficient in numbers and
6 types of providers to assure that all services to covered persons are accessible within a
7 reasonable distance or travel time. Sufficiency shall be determined in accordance with the
8 requirements of this section. The director shall establish sufficiency standards, in rules
9 promulgated pursuant to chapter 1-26, by reference to any reasonable criteria, including:
10 provider-covered person ratios by specialty; primary care provider-covered person ratios;
11 geographic accessibility; waiting times for appointments with participating providers; hours of
12 operation; and the volume of technological and specialty services available to serve the needs of
13 covered persons requiring technologically advanced or specialty care. In determining whether
14 a plan has complied with this provision, the director shall give due consideration to the relative
15 availability of health care providers in the service area under consideration. If the managed care
16 plan has an insufficient number or type of participating providers to provide a covered benefit
17 within a reasonable distance or travel time, the managed care plan shall ensure that the covered
18 person obtains the covered benefit at no greater cost than if the benefit were obtained from
19 participating providers.

20 Section 3. If the director of the Division of Insurance and the secretary of the Department
21 of Health find that the requirements of any private accrediting body meet the requirements of
22 network adequacy as set forth in this Act, the managed care plan may, at the discretion of the
23 director and secretary, be deemed to have met the applicable requirements.

24 Section 4. Nothing in this Act applies to dental only, vision only, accident only, school
25 accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed

1 occurrence, or fixed per procedure benefit without regard to expenses incurred.

2 Section 5. For purposes of this Act, a managed care plan does not include individual health

3 policies if:

4 (1) The policy does not use an individual or group to determine where or when services
5 will be rendered, the course of treatment, or who will provide the services;

6 (2) The policy does not require pre-authorization for services provided under the policy;
7 and

8 (3) The difference in policy benefits does not exceed ten percent, whether an insured uses
9 a participating provider or nonparticipating provider.

10 Section 6. The division shall separately monitor complaints regarding managed care for those
11 policies that are exempt pursuant to section 5 of this Act.

1 **BILL HISTORY**

2 1/12/99 First read in House and referred to Health and Human Services. H.J. 33

3 1/27/99 Scheduled for Committee hearing on this date.

4 1/27/99 Scheduled for Committee hearing on this date.

5 1/29/99 Scheduled for Committee hearing on this date.

6 1/29/99 Health and Human Services Do Pass Amended, Passed, AYES 11, NAYS 1. H.J. 307

7 2/4/99 Motion to Amend, Passed. H.J. 375

8 2/4/99 House of Representatives Do Pass Amended, Passed, AYES 48, NAYS 13. H.J. 381