

# State of South Dakota

SEVENTY-EIGHTH SESSION  
LEGISLATIVE ASSEMBLY, 2003

400I0231

## HOUSE BILL NO. 1043

Introduced by: The Committee on Commerce at the request of the Department of Commerce  
and Regulation

1 FOR AN ACT ENTITLED, An Act to revise the nonrenewal and preexisting requirements for  
2 individual health benefit plans.

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

4 Section 1. That § 58-17-82 be amended to read as follows:

5 58-17-82. An individual health benefit plan subject to §§ 58-17-66 to 58-17-87, inclusive,  
6 is renewable with respect to any person or dependent at the option of the person and may not  
7 be terminated by the insurer at any time, except as provided in § 58-17-15 or in any of the  
8 following cases:

- 9 (1) The individual has failed to pay premiums or contributions in accordance with the  
10 terms of the health insurance coverage or the insurer has not received timely premium  
11 payments;
- 12 (2) Fraud or intentional misrepresentation of material fact by the person;
- 13 (3) In the case of a health insurance issuer that offers health insurance coverage in the  
14 market through a network plan, there are no longer any enrollees in connection with  
15 the plan who live, reside, or work in the service area of the issuer or in the area for



1 which the issuer is authorized to do business and the issuer would deny enrollment  
2 with respect to the plan as provided for in § 58-18B-37;

3 (4) Election by the carrier not to renew all of its individual health benefit plans delivered  
4 or issued for delivery to persons in the state. In such a case, the carrier shall provide  
5 advance notice of its decision under this subdivision to the director in each state in  
6 which it is licensed and provide notice of the decision not to renew coverage to all  
7 affected individuals and to the director in each state in which an affected insured  
8 individual is known to reside at least one hundred eighty days before the nonrenewal  
9 of any individual health benefit plans by the carrier. Notice to the director under this  
10 subdivision shall be provided at least three working days before the notice to the  
11 affected individuals. In such instances, the director shall assist the affected persons in  
12 finding replacement coverage;

13 (5) In the case of health insurance coverage that is made available only through one or  
14 more bona fide associations, the membership of an employer in the association (on the  
15 basis of which the coverage is provided) ceases but only if the coverage is terminated  
16 uniformly without regard to any health status-related factor relating to any covered  
17 individual; or

18 (6) The insured individual becomes eligible for medicare coverage under Title XVIII of  
19 the Social Security Act, unless federal law requires that medicare coverage under Title  
20 XVIII be excluded as a reason for renewability of coverage;

21 (7) If the issuer decides to discontinue offering a particular type of individual health  
22 insurance offered in the individual market, coverage of such type may be discontinued  
23 if:

24 (a) The issuer provides notice to each insured provided coverage of this type in

1 such market (and any participant and beneficiary covered under such coverage)  
2 of the discontinuation at least ninety days prior to the date of the  
3 discontinuation of the coverage;

4 (b) The issuer offers to each insured provided coverage of this type in such market,  
5 the option to purchase all other health insurance coverage currently being  
6 offered by the issuer to an individual health plan in such market; or

7 (c) In exercising the option to discontinue coverage of this type and in offering the  
8 option of coverage under subsection (b), the issuer acts uniformly without  
9 regard to the claims experience of those insured or any health status-related  
10 factor relating to any participant or beneficiary covered or any new participant  
11 or beneficiary who may become eligible for such coverage.

12 Section 2. That § 58-17-84 be amended to read as follows:

13 58-17-84. Any health benefit plan covering individuals shall comply with the following  
14 provisions:

15 (1) No health benefit plan may deny, exclude, or limit benefits for a covered individual for  
16 claims incurred more than twelve months following the effective date of the person's  
17 coverage due to a preexisting condition. No health benefit plan may define a  
18 preexisting condition more restrictively than:

19 (a) A condition that would have caused an ordinarily prudent person to seek  
20 medical advice, diagnosis, care, or treatment during the twelve months  
21 immediately preceding the effective date of coverage;

22 (b) A condition for which medical advice, diagnosis, care, or treatment was  
23 recommended or received during the twelve months immediately preceding the  
24 effective date of coverage; or

- 1 (c) A pregnancy existing on the effective date of coverage;
- 2 (2) A health benefit plan shall waive any time period applicable to a preexisting condition  
3 exclusion or limitation period with respect to particular services for the aggregate  
4 period of time a person was previously covered by creditable coverage, excluding  
5 limited benefit plans and dread disease plans that provided benefits with respect to  
6 such services, if the creditable coverage was continuous to a date not more than  
7 sixty-three days before the application for the new coverage. A period of time a  
8 person was previously covered may not be aggregated if there was a break in  
9 coverage of sixty-three days or more. The plan shall count a period of creditable  
10 coverage without regard to the specific benefits covered under the plan, unless the  
11 plan elects to credit it based on coverage of benefits within several classes or  
12 categories of benefits specified in rules adopted pursuant to chapter 1-26, by the  
13 director;
- 14 (3) A health maintenance organization which does not utilize a preexisting waiting period  
15 may use an affiliation period in lieu of a preexisting waiting period. No affiliation  
16 period may exceed two months in length. No premium may be charged for any  
17 portion of the affiliation period. If the health maintenance organization utilizes neither  
18 a preexisting waiting period nor an affiliation period, the health maintenance  
19 organization may use other criteria designed to avoid adverse selection provided that  
20 those criteria are approved by the director;
- 21 (4) Genetic information may not be treated as a condition for which a preexisting  
22 condition exclusion may be imposed in the absence of a diagnosis of the condition  
23 related to such information; and
- 24 (5) ~~A carrier may not exclude coverage for a preexisting condition which~~ condition may

1            not be defined or considered as preexisting if the condition arose after a person began  
2            creditable coverage and if there was not a break in coverage which exceeded  
3            sixty-three days.

4            For purposes of this section, the effective date of coverage is the first day the person became  
5 covered for either accidents or sicknesses.

6            Section 3. That § 58-18-45 be amended to read as follows:

7            58-18-45. Health benefit plans shall comply with the following provisions:

- 8            (1) No health benefit plan may deny, exclude, or limit benefits for a covered individual for  
9            claims incurred more than twelve months following the effective date of the  
10           individual's coverage due to a preexisting condition. No health benefit plan may define  
11           a preexisting condition more restrictively than a condition for which medical advice,  
12           diagnosis, care, or treatment was recommended or received during the six months  
13           immediately preceding the effective date of coverage;
- 14           (2) A health benefit plan shall waive any time period applicable to a preexisting condition  
15           exclusion or limitation period for the aggregate period of time an individual was  
16           previously covered by creditable coverage that provided benefits with respect to such  
17           services, if the creditable coverage was continuous to a date not more than sixty-three  
18           days prior to the effective date of the new coverage. The waiver for prior creditable  
19           coverage also applies to late enrollees. A period of time a person was previously  
20           covered may not be aggregated if there was a break in coverage of sixty-three days  
21           or more. The plan shall count a period of creditable coverage, without regard to the  
22           specific benefits covered under the plan, unless the plan elects to credit it based on  
23           coverage of benefits within several classes or categories of benefits specified in rules  
24           adopted by the director. ~~A carrier may not exclude coverage for a preexisting~~

1 ~~condition which~~ condition may not be defined or considered as preexisting if the  
2 condition arose after a person began creditable coverage and if there was not a break  
3 in coverage which exceeded sixty-three days;

4 (3) A health benefit plan may exclude coverage for late enrollees for the greater of  
5 eighteen months or for an eighteen-month preexisting condition exclusion. However,  
6 if both a period of exclusion from coverage and a preexisting condition exclusion are  
7 applicable to a late enrollee, the combined period may not exceed eighteen months  
8 from the date the individual enrolls for coverage under the health benefit plan;

9 (4) Genetic information may not be treated as a condition for which a preexisting  
10 condition exclusion may be imposed in the absence of a diagnosis of the condition  
11 related to such information;

12 (5) A health maintenance organization which does not utilize a preexisting waiting period  
13 may use an affiliation period in lieu of a preexisting waiting period. No affiliation  
14 period may exceed two months in length. No premium may be charged for any  
15 portion of the affiliation period. If the health maintenance organization utilizes neither  
16 a preexisting waiting period nor an affiliation period, the health maintenance  
17 organization may use other criteria designed to avoid adverse selection provided that  
18 those criteria are approved by the director. In the case of a late enrollee who is subject  
19 to an affiliation period, the affiliation period may not exceed three months.

20 For purposes of this section, the effective date of coverage is the first day the person became  
21 covered for either accidents or sicknesses.