

State of South Dakota

NINETIETH SESSION
LEGISLATIVE ASSEMBLY, 2015

940W0344

SENATE COMMERCE AND ENERGY ENGROSSED NO. **SB 118** - 02/05/2015

Introduced by: Senators Rampelberg, Brown, Heinert, Holien, and Novstrup (David) and Representatives Heinemann (Leslie), Bolin, Hawley, Munsterman, Sly, and Willadsen

1 FOR AN ACT ENTITLED, An Act to provide additional transparency for prescription drug
2 plans.

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

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

5 58-17F-4. Any health carrier shall provide to any prospective enrollee written information
6 describing the terms and conditions of the plan. If the plan is described orally, easily understood,
7 truthful, objective terms shall be used. The written information need not be provided to any
8 prospective enrollee who makes inquiries of a general nature directly to a carrier. In the
9 solicitation of group coverage to an employer, a carrier is not required to provide the written
10 information required by this section to individual employees or their dependents and if no
11 solicitation is made directly to the employees or dependents and if no request to provide the
12 written information to the employees or dependents is made by the employer. All written plan
13 descriptions shall be readable, easily understood, truthful, and in an objective format. The
14 format shall be standardized among each plan that a health carrier offers so that comparison of



1 the attributes of the plans is facilitated. The following specific information shall be
2 communicated:

3 (1) Coverage provisions, benefits, and any exclusions by category of service, provider,
4 and if applicable, by specific service, including prescription drugs and drugs
5 administered in a physician office or clinic;

6 (2) Any and all authorization or other review requirements, including preauthorization
7 review, and any procedures that may lead the patient to be denied coverage for or not
8 be provided a particular service;

9 (3) The existence of any financial arrangements or contractual provisions with review
10 companies or providers of health care services that would directly or indirectly limit
11 the services offered, restrict referral, or treatment options;

12 (4) Explanation of how plan limitations impact enrollees, including information on
13 enrollee financial responsibility for payment of coinsurance or other non-covered or
14 out-of-plan services;

15 (5) A description of the accessibility and availability of services and an easily accessible
16 online list of providers and facilities, including a list of providers participating in the
17 managed care network and of the providers in the network who are accepting new
18 patients, the addresses of primary care physicians and participating hospitals, and the
19 specialty of each provider in the network. The list of providers and facilities must be
20 updated at least once every six months; and

21 (6) A description of any drug formulary provisions in the plan and the process for
22 obtaining a copy of the current formulary upon request and the method by which an
23 enrollee or prospective enrollee may determine whether a specific drug is available
24 on the current formulary. There shall be a process for requesting an exception to the

1 formulary and instructions as to how to request an exception to the formulary and a
2 description of an easily accessible method to obtain a prior authorization or step edit
3 requirement for each specific drug included on the formulary; and

4 (7) The description of the drug formularies in subdivision (6) shall be promptly updated
5 with any adverse change.

6 The provisions of this section do not apply to plans that are not actively marketed by a
7 carrier.

8 Section 2. This Act is effective January 1, 2016.