**South Carolina General Assembly**

118th Session, 2009-2010

**H. 3211**

**STATUS INFORMATION**

General Bill

Sponsors: Rep. Gunn

Document Path: l:\council\bills\agm\19317mm09.docx

Introduced in the House on January 13, 2009

Currently residing in the House Committee on **Ways and Means**

Summary: Cigarette tax

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

1/13/2009 House Introduced and read first time [HJ](file:///h:\HJ%20Archive\2009\01-13-09.docx)‑95

1/13/2009 House Referred to Committee on **Ways and Means** [HJ](file:///h:\HJ%20Archive\2009\01-13-09.docx)‑96

**VERSIONS OF THIS BILL**

[1/13/2009](file:///p:\pprever\2009-10\3211_20090113.docx)

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 12‑21‑625 SO AS TO IMPOSE A SURTAX ON EACH CIGARETTE IN AN AMOUNT OF FOUR AND SIXTY‑FIVE HUNDREDTHS CENTS, PROVIDE FOR THE CREDITING OF THE REVENUE FROM THE SURTAX TO THE MEDICAID TRUST FUND AND THE HEALTH CARE ACCESS TRUST FUND, PROVIDE FOR REPORTING, PAYMENT, COLLECTION, AND ENFORCEMENT OF THE SURTAX, AND DEFINE “CIGARETTE”; TO AMEND SECTION 12‑21‑620, RELATING TO THE ORIGINAL CIGARETTE TAX, SO AS TO CONFORM DEFINITIONS; BY ADDING SECTION 11‑11‑230 SO AS TO CREATE AND ESTABLISH IN THE STATE TREASURY THE MEDICAID TRUST FUND AND THE HEALTH CARE ACCESS TRUST FUND, BOTH SO AS TO RECEIVE DEPOSITS OF THE REVENUES FROM THE CIGARETTE SURTAX AS SPECIFIED; TO PROVIDE FOR USE OF THE MEDICAID TRUST FUND FOR ADDITIONAL COVERAGE FOR THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM TO TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL AND, WITH ANY EXCESS FUNDS, FOR MEDICAID SERVICES TO LOW INCOME FAMILIES WITH INCOMES UP TO ONE HUNDRED PERCENT OF THE PREVAILING POVERTY LEVEL, AND TO PROVIDE FOR ANNUAL REPORTS ON THE MEDICAID TRUST FUND; BY ADDING CHAPTER 62 TO TITLE 38 SO AS TO CREATE AND ESTABLISH THE HEALTH CARE PREMIUM ASSISTANCE PROGRAM, PROVIDING FOR PREMIUM ASSISTANCE IN THE AVERAGE AMOUNT OF TWO THOUSAND DOLLARS TO AN ELIGIBLE INDIVIDUAL TOWARD THE PURCHASE OF A QUALIFYING HEALTH INSURANCE PLAN, DESCRIBING ELIGIBILITY REQUIREMENTS AND THE CERTIFICATION PROCESS, DEFINING THE QUALIFYING INDIVIDUALLY OR EMPLOYER‑SPONSORED INSURANCE PLANS, AND PROVIDING FOR ADMINISTRATION AND REPORTING BY THE DEPARTMENT OF INSURANCE; AND BY ADDING SECTION 38‑74‑75 SO AS TO CREATE THE HEALTH CARE ACCESS PROGRAM, ESTABLISHING A SELF‑SUSTAINING AND FINANCIALLY INDEPENDENT PORTION OF THE PREMIUM ASSISTANCE POOL, AND PROVIDING FOR ELIGIBILITY REQUIREMENTS, ADMINISTRATION, AND OPERATING GUIDELINES AND REPORTING BY THE DEPARTMENT OF INSURANCE.

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

SECTION 1. Article 5, Chapter 21, Title 12 of the 1976 Code is amended by adding:

“Section 12‑21‑625. (A) Effective July 1, 2010, there is imposed a surtax on cigarettes subject to the tax imposed pursuant to Section 12‑21‑620(1) in an amount equal to four and sixty‑five hundredths cents on each cigarette.

(B) Notwithstanding another provision of law providing for the crediting of the revenues of license or other taxes, the annual revenue of the surtax imposed pursuant to this section must be credited each year one‑half to the Medicaid Trust Fund created pursuant to Section 11‑11‑230(A) and one‑half to the Health Care Access Trust Fund created pursuant to Section 11‑11‑230(B).

(C) For all purposes of reporting, payment, collection, and enforcement, the surtax imposed by this section is deemed to be imposed pursuant to Section 12‑21‑620.

(D) For purposes of this section, ‘cigarette’ means:

(1) any roll for smoking containing tobacco wrapped in paper or in any substance other than a tobacco leaf; or

(2) any roll for smoking containing tobacco, wrapped in any substance, weighing three pounds per thousand or less, however labeled or named, which because of its appearance, size, type of tobacco used in the filler, or its packaging, pricing, marketing, or labeling, is likely to be offered to, or purchased by, consumers as a cigarette described in item (1).”

SECTION 2. Section 12‑21‑620 of the 1976 Code is amended to read:

“Section 12‑21‑620. (A) There shall be levied, assessed, collected, and paid in respect to the articles containing tobacco enumerated in this section the following amounts:

(1) upon all cigarettes made of tobacco or any substitute for tobacco, three and one‑half mills on each cigarette;

(2) upon all tobacco products, as defined in Section 12‑21‑800, five percent of the manufacturer’s price.

Manufacturer’s price as used in this section is the established price at which a manufacturer sells to a wholesaler.

(B) As used in this section, ‘cigarette’ means:

(1) any roll for smoking containing tobacco wrapped in paper or in any substance other than a tobacco leaf; or

(2) any roll for smoking containing tobacco, wrapped in any substance, weighing three pounds per thousand or less, however labeled or named, which because of its appearance, size, type of tobacco used in the filler, or its packaging, pricing, marketing, or labeling, is likely to be offered to, or purchased by, consumers as a cigarette described in item (1) of this subsection.”

SECTION 3. Article 1, Chapter 11, Title 11 of the 1976 Code is amended by adding:

“Section 11‑11‑230. (A) There is created in the State Treasury the Medicaid Trust Fund. This fund is separate and distinct from the general fund of the State and all other funds. Earnings and interest on this fund must be credited to it and any balance in this fund at the end of a fiscal year carries forward in the fund in the succeeding fiscal year. Except as otherwise provided in this section, the State Treasurer shall transfer the funds to the Department of Health and Human Services quarterly to provide Medicaid services. The funds are supplementary and may not be used to replace general funds appropriated by the General Assembly or other funds used to support Medicaid.

(B) There is created in the State Treasury the Health Care Access Trust Fund. This fund is separate and distinct from the general fund of the State and all other funds. Earnings and interest on this fund must be credited to it and any balance in this fund at the end of a fiscal year carries forward in the fund in the succeeding fiscal year. The trust fund must transfer the appropriate amount of money annually to the Department of Insurance to fund the Health Care Premium Assistance Program.”

SECTION 4. (A) Beginning no later than March 1, 2011, and with appropriate federal approvals, the Department of Health and Human Services shall use the transfers from the Medicaid Trust Fund to increase coverage in the State Children’s Health Insurance Program to two hundred fifty percent of the prevailing federal poverty level. If a balance of funds remain in the Medicaid Trust Fund once the Department of Health and Human Services has increased coverage in the State Children’s Health Insurance Program to two hundred fifty percent of the prevailing federal poverty level, then the balance of funds must be used to provide Medicaid services to low income families with incomes above fifty percent but no more than one hundred percent of the prevailing federal poverty level. The Department of Health and Human Services may charge the Medicaid Trust Fund a quarterly administrative fee equal to an amount not to exceed one percent of the amount credited to the Medicaid Trust Fund in the previous quarter.

(B) The Department of Health and Human Services must provide an annual report on the Medicaid Trust Fund to the Chairman of the Senate Finance Committee, and the Chairman of the House Ways and Means Committee. The report must provide, at a minimum, a general description of the services provided and populations served, the number of people served, the average cost for each person, the additional administrative costs of the programs funded by Medicaid Trust Fund, and a three‑year forecast of the utilization of the fund.

SECTION 5. Title 38 of the 1976 Code is amended by adding:

“CHAPTER 62

Health Care Premium Assistance Program

Section 38‑62‑10. This chapter may be cited as the ‘Health Care Premium Assistance Program’.

Section 38‑62‑20. For the purposes of this section:

(A) ‘Department’ means the South Carolina Department of Insurance.

(B) ‘Federal poverty level’ means the federal poverty level guidelines published annually by the United States Department of Health and Human Services.

(C) ‘Health insurer’ means:

(1) an insurance company, a health maintenance organization, a community health plan approved by the Department of Health and Human Services, and another entity providing health insurance coverage, as defined in Section 38‑71‑670(6), which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation; and

(2) Medicaid managed care organizations qualified to offer services through the Department of Health and Human Service’s Healthy Connections Program.

(D) ‘Participant’ means an individual who has been issued a certificate of eligibility by the Department of Insurance and has purchased a qualifying health insurance plan within ninety days of the date of issue of the certificate.

(E) ‘Program’ means the Health Care Premium Assistance Program.

(F) ‘Qualifying health plan’ means a health insurance policy or health benefit plan that has a minimum actuarial value of three thousand dollars adjusted for age and gender and is offered as part of a health insurance policy or plan offered by a health insurer which provides health insurance coverage, as defined in Section 38‑71‑670(6), the South Carolina HealthNet Program, or a community health plan approved by the Department of Health and Human Services.

(G) ‘Small employer’ means, in connection with a health insurance plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or employer, as defined in Section 3(5) of the Employee Retirement Income Security Act of 1974, that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar year, employed no more than twenty‑five eligible employees or employed an average of no more than twenty‑five employees on business days during the preceding calendar year, and who employs at least two employees on the first day of the plan year.

Section 38‑62‑30. Beginning on July 1, 2011, individuals meeting the eligibility requirements of this chapter may receive an average of two thousand dollars of premium assistance actuarially adjusted for age and gender for the purchase of a qualifying health insurance plan. The premium assistance may not exceed the actual cost of the individual’s qualifying health plan.

Section 38‑62‑40. To be entitled to the premium assistance, an individual must receive a certificate of eligibility from the Department of Insurance. The department shall develop the form and manner for a person to apply to the department for a certificate and shall make the form readily available to health insurance agents and other persons authorized to sell health insurance in this State. For purposes of determining the taxpayer’s federal poverty level, the department, minimally, shall require a copy of the applicant’s state income tax return for the prior year and the applicant’s W‑2 form. The department also shall require the applicant to sign a verification under oath, subject to penalties of perjury, that the applicant meets the eligibility criteria for the program pursuant to Section 38‑62‑50. The department shall implement appropriate safeguards and use available existing resources to verify an applicant’s uninsured status. The department shall pursue the recoupment of premium assistance provided to an individual filing a false application.

Section 38‑62‑50. (A) The department shall issue an applicant a certificate, if the department determines that the person:

(1) earns at or less than two hundred percent of the federal poverty level;

(2) is a citizen of the United States and has been a resident of this State for the twelve‑month period immediately preceding the application;

(3) has not been covered under a health insurance policy for at least twelve consecutive months before the application;

(4) is not eligible for or enrolled in Medicare, Medicaid or any other state or federal government health insurance program;

(5) has not been awarded premium assistance pursuant to this chapter more than twice; and

(6) is between the ages of nineteen and sixty‑four.

(B) The department shall issue eligible individuals certificates in the order in the applications are received. The maximum number of eligible individuals receiving premium assistance is reached when the anticipated amount of claims for premium assistance payments reaches ninety percent of the amount of money allocated for premium assistance payments. The director of the department shall establish a waiting list for applicants that are otherwise qualified for registration but cannot be registered because the maximum number of individuals is reached. The director shall notify all persons who applied for a certificate and who were not issued a certificate of the reason that they did not receive a certificate and whether they were placed on the waiting list.

Section 38‑62‑60. The certificate is valid for the twelve months following the purchase of a qualifying health plan, if the plan is purchased within ninety days of the date the certificate was issued.

Section 38‑62‑70. (A) The department shall develop the form and manner for a person to apply for a renewal certificate and shall make the form readily available to health insurance agents and other persons authorized to sell health insurance in this State. A participant is responsible for obtaining and completing the form and forwarding it and any documentation required by the department. The department shall process renewal applications along with new applications in accordance with Section 38‑62‑50. Priority must be given to renewal applications.

(B) In the case of individually sponsored insurance, sixty days before the expiration of the policy term, the insurer shall send the insured a certificate renewal application promulgated by the department. The insured is responsible for completing the form and forwarding it and any documentation required by the department.

(C) In the case of employer‑sponsored insurance, sixty days before the expiration of the policy term, the employer shall send the insured a certificate renewal application promulgated by the department. The insured is responsible for completing the form and forwarding it and any documentation required by the department.

(D) The department may issue a renewal certificate only if the applicant remains eligible.

Section 38‑62‑80. (A) In the case of individually sponsored insurance, the department shall provide the premium assistance directly to the individual’s choice of participating qualifying insurers. To obtain the premium assistance, an insurer shall present a valid certificate to the department. The release of the premium assistance to the insurer is contingent upon the insurer submitting proof of the individual satisfying his share of the premium liability. The amount paid in premium assistance may not exceed the total cost of coverage for the individual. The department shall make quarterly premium assistance payments to insurers.

(B)(1) In the case of employer‑sponsored insurance, the department shall provide the premium assistance directly to the individual’s participating employer. To obtain the premium assistance, an employer shall present a valid certificate to the department. A participating small employer shall share the premium assistance with the employee in proportion to the percentage of the cost of coverage paid by the employer and the employee. The amount paid in premium assistance to a small employer may not exceed the total cost of coverage for the employee. The release of the premium assistance to the employer is contingent upon the employer submitting proof of the individual and the small employer satisfying his respective share of the premium liability. The department shall make quarterly premium assistance payments to small employers.

(2) If the covered individual ceases to be employed, the employer shall return the certificate to the individual and notify the department that the employer no longer covers the individual under a qualifying health plan. Any remaining value of the certificate may be used to obtain a qualifying health plan.

Section 38‑62‑90. This chapter is not intended, nor shall it operate, to guarantee health insurance coverage to any individual.

Section 38‑62‑100. The department may charge the Health Care Access Trust Fund a quarterly administrative fee of up to one percent of the amount credited to the Health Care Access Trust Fund in the preceding quarter.

Section 38‑62‑110. The department shall provide an annual report on the Health Care Access Trust Fund to the Chairman of the Senate Finance Committee, the Chairman of the House Ways and Means Committee, the Chairman of the Senate Banking and Insurance Committee, the Chairman of the House Labor, Commerce, and Industry Committee, and the Board of Economic Advisors. The report must provide, at a minimum, a general description of the services provided and populations served, the number of people served, the average cost for each person, the additional administration costs of the programs funded by the Health Care Access Trust Fund, and a three‑year forecast of the utilization of the fund.

Section 38‑62‑120. The Department of Insurance shall develop and implement a public awareness program for the Health Care Premium Assistance Program.”

SECTION 6. Chapter 74, Title 38 of the 1976 Code is amended by adding:

“Section 38‑74‑75. (A) There is created the ‘Health Care Access’ program of the pool. The program must be funded by the Health Care Access Trust Fund created in Section 11‑11‑230(B), and must be self‑sustaining and financially independent from the remainder of the pool.

(B) A person eligible for pool coverage may opt to participate in the Health Care Access program of the pool, if the person also:

(1) is at least nineteen years of age;

(2) provides evidence of United States citizenship and of South Carolina residency for the sixty months immediately preceding the application for coverage;

(3) provides his previous year’s state income tax return and corresponding W‑2 forms evidencing total household gross income that did not exceed seventy‑five thousand dollars in the previous taxable year; and

(4) agrees to participate in the Health Care Access program and to comply with all care coordination plans, case management procedures, and managed care criteria of the program developed by the Department of Insurance.

(C) The Department of Insurance shall oversee the Health Care Access program. The department shall:

(1) select a qualified entity, in accordance with the procedures contained in Section 38‑74‑40, to administer the program including:

(a) establishing accounting policies for the Health Care Access Trust Fund;

(b) establishing premium billing and collection policies including policies regarding nonpayment of premiums;

(c) hiring independent actuarial support from a qualified Member of the Academy of Actuaries to develop and publish actuarially determined annual premium rates that are self‑sustaining and actuarially sound. Rates may be adjusted by age and gender and other appropriate characteristics determined by the contracted actuary;

(d) developing an application for participation and establish policies and procedures for initially determining eligibility, the periodic redetermination of eligibility, monitoring of compliance with program rules and managed care provisions and termination of participation, and the premium assistance for noncompliance;

(e) establishing a schedule of medical benefits, exclusions, and limitations for the program;

(f) developing stringent care coordination plans, case management procedures, and other managed care criteria which serve as a requirement for eligible persons to participate in this program; and

(g) developing and implementing a public awareness program of the plan; and

(2) promulgate regulations necessary to implement the provisions of this section.

(D) Participation in the Health Care Access program is limited to the funds available in the Health Care Access Trust Fund in order to prevent any loss in program operations. The Department of Insurance or its contracted entity shall accept and process applications and award the premium assistance provided for in this section in the order in which the applications are received. The department is may establish a waiting list if there are insufficient funds available to allow all applicants to participate. The department also may implement a maximum limit on individual coverage to prevent an operating loss. The program must not be funded in any part by the funding mechanisms of the existing pool. The Department of Insurance may charge the Health Care Access Trust Fund a quarterly administrative fee of up to one percent of the amount credited to the Health Care Access Trust Fund in the preceding year.

(E) Beginning on July 1, 2012, and then only to the extent sufficient funds exist in the Health Care Access Trust Fund, participants in the Health Care Access Program are entitled to a premium assistance equal to the difference between the self‑supporting actuarial premium for this pool and the amount that the individual would have been required to pay for an equivalent product pursuant to Section 38‑62‑30.

(F) The Department of Insurance may initiate periodic transfers in the amount of the approved premium assistance from the Health Care Access Trust Fund to the administering entity of the Health Care Access program to be credited against the premiums owed by the program and any additional funds to maintain the solvency of the program.

(G) Neither the establishment of rates, forms, or procedures nor other joint or collective action required by this section may be the basis of legal action, criminal or civil liability, or penalty against the program. A cause of action does not arise against the program’s agents, employees, or representatives, for any good faith act or omission in the performance of their powers and duties pursuant to this section.

(H) The department shall provide an annual report on the Health Care Access program of the pool to the Senate Finance Committee, the Chairman of the House Ways and Means Committee, the Chairman of the Senate Banking and Insurance Committee, the Chairman of the House Labor, Commerce, and Industry Committee, and the Board of Economic Advisors. The report must provide, at a minimum, a general description of the services provided and populations served, the number of people served, the average cost per person, the additional administration costs of the programs funded by Health Care Access Trust Fund, and a three‑year forecast of the utilization of the fund.”

SECTION 7. Except where otherwise provided, this act takes effect upon approval by the Governor.

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