**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑71‑243 SO AS TO REGULATE A PROVIDER OF HEALTH CARE AND THE ISSUER OF INDIVIDUAL HEALTH INSURANCE WHEN AN ISSUER NEGOTIATES RATES WITH A PROVIDER FOR COVERED HEALTH CARE SERVICES AND THEN TERMINATES OR OTHERWISE NONRENEWS THE PROVIDER’S CONTRACT.

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 38‑71‑243. (A) As used in this section:

(1) ‘Health insurance coverage’ means as defined in Sections 38‑71‑670(6) and 38‑71‑840(14).

(2) ‘Health insurance issuer’ or ‘issuer’ means an entity that provides health insurance coverage in this State as defined in Sections 38‑71‑670(7) and 38‑71‑840(16).

(3) ‘State health plan’ means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.

(B) This section applies to an individual health plan, a group health plan, or a health benefit plan, including the state health plan, that is delivered, issued for delivery, or renewed in this State and which provides health insurance coverage.

(C) A health insurance issuer that negotiates rates with a provider for covered health care services and that terminates or otherwise nonrenews the provider contract shall conform to the following requirements, except as provided for in subsection (D):

(1) The issuer is liable for covered benefits rendered by the provider to a covered person until the termination of the benefit period. The benefits payable during the benefit period may be subject to the policy’s or contract’s regular benefit limits such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.

(2) An insurer shall not require a covered person to pay a deductible or copayment which is greater than the in‑network rate during the benefit period.

(D) A provider that terminates or otherwise nonrenews a contract for negotiated rates with a health insurance issuer or whose contract has been terminated or otherwise nonrenewed as a result of no longer meeting the credentialing requirements of the issuer shall conform to the following requirements:

(1) The provider shall accept as payment in full for covered health care services the negotiated rate under the provider contract.

(2) Except for an applicable deductible or a copayment, a provider shall not bill or otherwise hold a covered person financially responsible for covered health care services furnished by the provider.

(E) An issuer offering health insurance coverage shall not require an individual, as a condition of continued coverage under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of covered benefits rendered as provided for in this section to the individual or to an individual enrolled under the plan as a dependent of the individual.”

SECTION 2. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

SECTION 3. This act takes effect upon approval by the Governor and applies to an individual health plan, a group health plan, or a health benefit plan, including the state health plan, issued, renewed, delivered, or entered into on or after that date.

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