COMMITTEE REPORT

April 2, 2009

**H. 3371**

Introduced by Reps. Harvin, Kennedy, Alexander, Funderburk, Gunn, Hart, McEachern, McLeod, Ott, J.E. Smith, Spires, Weeks and Bowers

S. Printed 4/2/09--H.

Read the first time January 28, 2009.

**THE COMMITTEE ON**

**LABOR, COMMERCE AND INDUSTRY**

To whom was referred a Bill (H. 3371) 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, etc., respectfully

**REPORT:**

That they have duly and carefully considered the same and recommend that the same do pass with amendment:

Amend the bill, as and if amended, by striking all after the enacting words and inserting:

/ 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) ‘Continuation of care’ means the provision of in‑network level benefits for services rendered by certain out‑of‑network providers for a definite period of time in order to ensure continuity of care for covered persons for a serious medical condition. Continuation of care must be provided for ninety days or until the termination of the benefit period, whichever is greater.

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

(3) ‘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).

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

(5) ‘Serious medical condition’ means a health condition or illness, that requires medical attention, and where failure to provide the current course of treatment through the current provider would place the person’s health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy. Such attestation by the treating physician must be made upon the request of the patient and in a written form approved by the Department of Insurance or prescribed through regulation, order, or bulletin.

(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. Continuation of care must not be provided if suspension or revocation of the provider’s license occurs.

(C) If a provider contract is terminated or nonrenewed, the issuer and the provider shall comply with the following requirements:

(1) The issuer is liable for covered benefits rendered in the continuation of care by a provider to a covered person for a serious medical condition. Except as required by this section, the benefits payable for services rendered during the continuation of care are subject to the policy’s or contract’s regular benefit limits.

(2) The issuer shall not require a covered person to pay a deductible or copayment which is greater than the in network rate for services rendered during the continuation of care.

(3) An issuer offering health insurance coverage shall not require a covered person, 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 covered person or the dependent of a covered person.

(4) The provider shall accept as payment in full for services rendered within in the continuation of care the negotiated rate under the provider contract.

(5) Except for an applicable deductible or a copayment, a provider shall not bill or otherwise hold a covered person financially responsible for services rendered in the continuation of care and furnished by the provider, unless the provider has not received payment in accordance with item (4) of this subsection and in accordance with Article 2, Chapter 59 of this title.

(6) Upon receipt of the patient’s request accompanied by the physician’s attestation on the prescribed form, the issuer shall notify the provider and the covered person of the provider’s date of termination from the network and of the continuation of care provisions as provided for in this section.

(7) The issuer is responsible for determining if a covered person qualifies for continuation of care and may request additional information in reaching such determination.

Section 38‑71‑245. Each provider contract must contain a continuation of care provision consistent with the language of Section 38‑71‑243.

Section 38‑71‑247. Each health insurance issuer shall include a plain language description of the continuation of care provisions set forth in Section 38‑71‑243 in the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.”

SECTION 2. The Department of Insurance may promulgate regulations necessary for implementation of this act.

SECTION 3. 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 4. 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 after December 31, 2009. /

Renumber sections to conform.

Amend title to conform.

WILLIAM E. SANDIFER for Committee.

**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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