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COMMITTEE REPORT

April 11, 2013

**H. 3818**

Introduced by Reps. K.R. Crawford, Sandifer, Erickson, Simrill, G.M. Smith, Gambrell and Bannister

S. Printed 4/11/13--H.

Read the first time March 13, 2013.

**THE COMMITTEE ON**

**LABOR, COMMERCE AND INDUSTRY**

To whom was referred a Bill (H. 3818) to amend Section 38‑71‑1730, Code of Laws of South Carolina, 1976, relating to closed panel health plans, so as to remove the requirement that certain, 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, Section 38‑71‑1790(A)(5), as contained in SECTION 1, page 7, lines 17‑27, by deleting the item in its entirety and inserting:

/ (~~5~~4) A point‑of‑service option or closed panel health plan ~~offered pursuant to this article~~ may not discriminate against a physician, a podiatrist, an optometrist, an oral surgeon, a physical therapist, an occupational therapist, or a chiropractor by excluding the provider from participating in the plan on the basis of the profession. A health care plan may not exclude these providers from providing health care services which they are licensed to provide and which are covered by the plan and as determined by medical necessity under utilization review guidelines. Nothing in this section interferes in any way with the medical decision of the primary health care provider to use or not use any health care professional on a case‑by‑case basis. /

Renumber sections to conform.

Amend title to conform.

WILLIAM E. SANDIFER III for Committee.

**A** **BILL**

TO AMEND SECTION 38‑71‑1730, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO CLOSED PANEL HEALTH PLANS, SO AS TO REMOVE THE REQUIREMENT THAT CERTAIN EMPLOYERS THAT OFFER ONLY CLOSED PANEL HEALTH PLANS TO ITS EMPLOYEES ALSO OFFER A POINT‑OF‑SERVICE OPTION TO ITS EMPLOYEES, TO MAKE CONFORMING CHANGES, AND TO INCREASE THE ALLOWABLE DIFFERENCES BETWEEN COINSURANCE PERCENTAGES FOR IN‑NETWORK AND OUT‑OF‑NETWORK COVERED SERVICES AND SUPPLIES UNDER A POINT‑OF‑SERVICE OPTION.

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

SECTION 1. Section 38‑71‑1730(A) of the 1976 Code is amended to read:

“(A) For purposes of health plans offered pursuant to this section:

(1) ~~An employer who employs more than fifty eligible employees and who offers to employees major medical, hospitalization, and surgical health insurance coverage only under a closed panel health plan, also shall offer to employees at the time of their eligibility as major medical, hospitalization, and surgical health insurance coverage a point‑of‑service option. An employee of an employer offering only a closed panel health plan has the right to choose whether to remain in the closed panel health plan or to choose a point‑of‑service option.~~

~~(2)~~ An employer may require an employee who chooses a point‑of‑service option to be responsible for payment of premiums, deductibles, copayments, or other payments in excess of the benefits provided by the closed panel health plan.

(~~3~~2) Differences between coinsurance percentages for in‑network and out‑of‑network covered health care services or supplies in a point‑of‑service option may not exceed a maximum differential of ~~twenty~~ thirty percent. The coinsurance percentage for in‑network and out‑of‑network covered health care services or supplies provided by dentists may not exceed a maximum difference of five percent.

(~~4~~3) An employee, a spouse, or a dependent receiving treatment for an illness covered under a closed panel health plan may continue to receive services from a provider who elects to discontinue participation as a closed panel plan provider, subject to the terms of the contract between the provider and the health plan. This right of continuation is limited to a period of ninety days or the anniversary date of the plan, whichever occurs first.

(~~5~~4) A point‑of‑service option or closed panel health plan ~~offered pursuant to this article~~ may not discriminate against a physician, a podiatrist, an optometrist, an oral surgeon, or a chiropractor by excluding the provider from participating in the plan on the basis of the profession. A health care plan may not exclude these providers from providing health care services which they are licensed to provide and which are covered by the plan and as determined by medical necessity under utilization review guidelines. Nothing in this section interferes in any way with the medical decision of the primary health care provider to use or not use any health care professional on a case‑by‑case basis.

(~~6~~5) A pharmacist may provide professional services under the pharmacist’s scope of practice so long as the services are provided pursuant to a prescription written by a medical doctor or dentist with whom the patient has an established physician‑patient relationship. Nothing in this subsection requires a managed care plan to provide reimbursement to a pharmacist. An advanced practice nurse functioning as authorized by the State Board of Nursing Regulation 91‑6 may provide professional services under the advanced practice nurse’s scope of practice so long as the services provided are pursuant to protocols by a medical doctor with whom the patient has an established physician‑patient relationship. A point‑of‑service option offered pursuant to this section may not discriminate against an advanced practice nurse. Nothing in this subsection requires a managed care plan to provide reimbursement to an advanced practice nurse.

(~~7~~6) Nothing contained in this article affects in any way a plan exempted by the federal Employee Retirement Income Security Act of 1974 or any South Carolina law in existence before January 1, 1999, and state employee health insurance programs or any political subdivision self‑funded health insurance program; and this article does not affect the right of an employer to specify plan design or affect the right of a plan to credential or re‑credential a provider. Nothing contained in this article affects accident‑only, blanket accident and sickness, specified disease, credit, Medicare supplement, long‑term care, or disability income insurance, coverage issued as a supplement to liability or other insurance coverage designed solely to provide payments on a per diem, fixed‑indemnity, or nonexpense incurred basis, coverage for Medicare or Medicaid services pursuant to a contract with state or federal government, worker’s compensation or similar insurance, or automobile medical payment insurance.”

SECTION 2. This act takes effect forty‑five days after approval by the Governor.

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