**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑71‑292 SO AS TO PROHIBIT INSURERS AND HEALTH CARE PROVIDERS FROM ENGAGING IN SURPRISE BILLING; AND BY ADDING SECTION 39‑5‑45 SO AS TO MAKE IT AN UNFAIR TRADE PRACTICE FOR AN INSURER OR HEALTH CARE PROVIDER TO ENGAGE IN THE PRACTICE OF SURPRISE BILLING.

Whereas, it is the goal of the State of South Carolina to protect patients from “surprise bills” from medical providers; and

Whereas, surprise billing occurs when a patient unknowingly receives medical care from an out‑of‑network health care provider, either because of emergency treatment or because an out‑of‑network health care provider participated in or provided routine, scheduled care without the patient affirmatively choosing to receive out‑of‑network care; and

Whereas, it is against public policy for South Carolina citizens to receive exorbitant and unexpected medical bills, which frequently arrive even before the patient has recovered from the unplanned, emergency health crisis. Now, therefore,

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 38‑71‑292. (A) This section may be cited as the ‘Stop Surprise Bills Act’.

(B) ‘Surprise bill’ means a bill for health care services, including laboratory services and tests, received by an insured for services rendered by an out‑of‑network health care provider at an in‑network facility, during a service or procedure performed by an in‑network provider or during a service or procedure previously approved or authorized by the insurer and the insured did not knowingly elect to obtain services from an out‑of‑network provider. It also includes emergency services rendered at an out‑of‑network health care provider. ‘Surprise bill’ does not include a bill for health care services received by an insured when an in‑network health care provider is available to render such services and the insured knowingly elects to obtain services from an out‑of‑network health care provider.

(C) No health insurer may impose a coinsurance, copayment, deductible, or other out‑of‑pocket expense for emergency services, including laboratory tests and services, rendered by an out‑of‑network health care provider that is greater than the coinsurance, copayment, deductible or other out‑of‑pocket expense that would be imposed if such emergency services were rendered by an in‑network health care provider.

(D)(1) If an insured receives emergency services, including laboratory tests and services, from an out‑of‑network health care provider, such health care provider may bill the insurer directly and the insurer must reimburse the health care provider the greatest of the following amounts:

(a) the amount the insured’s health care plan would pay for the same services if rendered by an in‑network health care provider;

(b) the usual, customary, and reasonable rate for the same services; or

(c) the amount Medicare would reimburse for the same services.

(2) Nothing in this subsection prohibits an insurer and out‑of‑network health care provider from agreeing to a greater reimbursement amount.

(E) An insurer may not require prior authorization for the rendering of emergency services, including laboratory tests and services to an insured.

(F) With respect to a surprise bill:

(1) an insured only may be required to pay the applicable coinsurance, copayment, deductible, or other out‑of‑pocket expense that would be imposed for such health care services if such services were rendered by an in‑network health care provider; and

(2) an insurer must reimburse the out‑of‑network health care provider or insured, as applicable, for health care services rendered at the in‑network rate under the insured’s health care plan as payment in full, unless the insurer and health care provider agree otherwise.

(G) It is an unfair trade practice in violation of Chapter 5, Title 39 for any health care provider, including a laboratory, to request from an insured payment other than the applicable coinsurance, copayment, deductible, or other out‑of‑pocket expenses that would be imposed for such health care services if the services were rendered by an in‑network provider for:

(1) emergency services covered under a health care plan and rendered by an out‑of‑network health care provider; or

(2) a surprise bill, as defined in subsection (B).

(H) Within one year following the effective date of this section, the Department of Insurance must report to the Governor and the General Assembly on the efficacy of dispute resolution practices between providers, including physicians, laboratories, and hospitals and insurers and make recommendations for any changes that should be made based on best practices from surprise billing laws in other states. The Department of Insurance also shall post this information on its agency website.”

SECTION 2. Article 1, Chapter 5, Title 39 of the 1976 Code is amended by adding:

“Section 39‑5‑45. It is an unfair trade practice pursuant to Section 39‑5‑20 for a health care insurer or provider to engage in ‘surprise billing’ as defined in Section 38‑71‑292(B).”

SECTION 3. This act takes effect upon approval by the Governor.

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