**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑71‑292 AND SECTION 38‑71‑820 SO AS TO DEFINE TERMS AND REQUIRE INSURERS TO INCLUDE COST‑SHARING AMOUNTS PAID WHEN CALCULATING AN ENROLLEE’S CONTRIBUTION; BY ADDING SECTION 38‑71‑2270 SO AS TO REQUIRE PHARMACY BENEFITS MANAGERS TO INCLUDE COST‑SHARING AMOUNTS PAID WHEN CALCULATING AN ENROLLEE’S CONTRIBUTION; AND TO AMEND SECTION 38‑71‑2200, AS AMENDED, RELATING TO DEFINITIONS, SO AS TO DEFINE TERMS.

Whereas, citizens of South Carolina frequently rely on state‑regulated commercial insurers to secure access to the prescription medicines needed to protect their health; and

Whereas, commercial insurance designs increasingly require patients to bear significant out‑of‑pocket costs for their prescription medicines; and

Whereas, high out‑of‑pocket costs of prescription medicines impact the ability of patients to start new and necessary medicines and to stay adherent to their current medicines; and

Whereas, high or unpredictable cost‑sharing requirements are a main driver of elevated patient out‑of‑pocket costs and allow insurers to capture discounts and price concessions that are intended to benefit patients at the pharmacy counter; and

Whereas, insurers unfairly increase cost‑sharing burdens on patients by refusing to count third-party assistance toward patients’ cost‑sharing contributions; and

Whereas, the burdens of high or unpredictable cost‑sharing requirements are borne disproportionately by patients with chronic or debilitating conditions; and

Whereas, restrictions are needed on the ability of insurers and their intermediaries to use unfair cost‑sharing design to retain rebates and price concessions that should be directly passed on to patients as cost savings; and

Whereas, patients need equitable and accessible health coverage that does not impose unfair cost‑sharing burdens upon them. 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) As used in this section:

(1) ‘Insurer’ means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C. Section 300gg‑91, or any state or local governmental employer plan.

(2) ‘Cost‑sharing requirement’ means any copayment, coinsurance, deductible, or annual limitation on cost‑sharing including, but not limited to, a limitation subject to 42 U.S.C. Sections 18022(c) and 300gg‑6(b), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan.

(3) ‘Enrollee’ means any individual entitled to health care services from an insurer.

(4) ‘Health plan’ means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) ‘Health care service’ means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(6) ‘Person’ means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not‑for‑profit corporation, unincorporated organization, government, or governmental subdivision or agency.

(B) When calculating an enrollee’s contribution to any applicable cost‑sharing requirement, an insurer must include any cost‑sharing amounts paid by the enrollee, or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under Section 223 of the federal Internal Revenue Code, this requirement must apply for Health Savings Account‑qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223, except for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this subsection must apply regardless of whether the minimum deductible under Section 223 has been satisfied.

(C) This section applies to health plans, including the State Health Plan, that are entered into, amended, extended, or renewed on or after January 1, 2022.

(D) In implementing the requirements of this section, the State must regulate only an insurer to the extent permissible under applicable law.

(E) The Director of the Department of Insurance or his designee may promulgate such rules and regulations as it deems necessary to implement this section.”

SECTION 2. Article 5, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑820. (A) As used in this section:

(1) ‘Insurer’ means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C. Section 300gg‑91, or any state or local governmental employer plan.

(2) ‘Cost‑sharing requirement’ means any copayment, coinsurance, deductible, or annual limitation on cost‑sharing including, but not limited to, a limitation subject to 42 U.S.C. Sections 18022(c) and 300gg‑6(b), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan.

(3) ‘Enrollee’ means any individual entitled to health care services from an insurer.

(4) ‘Health plan’ means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) ‘Health care service’ means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(6) ‘Person’ means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not‑for‑profit corporation, unincorporated organization, government, or governmental subdivision or agency.

(B) When calculating an enrollee’s contribution to any applicable cost‑sharing requirement, an insurer must include any cost‑sharing amounts paid by the enrollee, or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under Section 223 of the federal Internal Revenue Code, this requirement must apply for Health Savings Account‑qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223, except for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this subsection must apply regardless of whether the minimum deductible under Section 223 has been satisfied.

(C) This section applies to health plans, including the State Health Plan, that are entered into, amended, extended, or renewed on or after January 1, 2022.

(D) In implementing the requirements of this section, the State must regulate only an insurer to the extent permissible under applicable law.

(E) The Director of the Department of Insurance or his designee may promulgate such rules and regulations as it deems necessary to implement this section.”

SECTION 3. Article 21, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑2270. (A) When calculating an enrollee’s contribution to any applicable cost‑sharing requirement, a pharmacy benefits manager must include any cost‑sharing amounts paid by the enrollee, or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under Section 223 of the federal Internal Revenue Code, this requirement must apply for Health Savings Account‑qualified High Deductible Health Plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under Section 223, except for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this subsection must apply regardless of whether the minimum deductible under Section 223 has been satisfied.

(B) This section applies to health plans, including the State Health Plan, that are entered into, amended, extended, or renewed on or after January 1, 2022.

(C) In implementing the requirements of this section, the State must regulate only an insurer to the extent permissible under applicable law.”

SECTION 4. Section 38‑71‑2200 of the 1976 Code, as last amended by Act 48 of 2019, is further amended to read:

“Section 38‑71‑2200. As used in this article:

(1) ‘Claim’ means a request from a pharmacy or pharmacist to be reimbursed for the cost of administering, filling, or refilling a prescription for a drug or for providing a medical supply or device.

(2) ‘Claims processing services’ means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include:

(a) receiving payments for pharmacist services;

(b) making payments to pharmacists or pharmacies for pharmacist services; or

(c) both receiving and making payments.

(3) ‘Cost‑sharing requirement’ means any copayment, coinsurance, deductible, or annual limitation on cost‑sharing including, but not limited to, a limitation subject to 42 U.S.C. Sections 18022(c) and 300gg‑6(b), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan.

(4) ‘Enrollee’ means any individual entitled to health care services from an insurer.

(5) ‘Health benefit plan’ means any individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer in this State as defined in Section 38‑71‑670(6) and 38‑71‑840(14), including the state health plan as defined in Section 1‑11‑710. Notwithstanding this section, the state health plan is not subject to the provisions of this title unless specifically referenced.

~~(4)~~(6) ‘Health care insurer’ means an entity that provides health insurance coverage in this State as defined in Section 38‑71‑670(7) and Section 38‑71‑840(16).

(7) ‘Health care service’ means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

~~(5)~~(8) ‘Maximum Allowable Cost List’ means a listing of generic drugs used by a pharmacy benefits manager to set the maximum allowable cost at which reimbursement to a pharmacy or pharmacist may be made.

~~(6)~~(9) ‘Other prescription drug or device services’ means services other than claims processing services, provided directly or indirectly by a pharmacy benefits manager, whether in connection with or separate from claims processing services, including without limitation:

(a) negotiating rebates, discounts, or other financial incentives and arrangements with drug companies;

(b) disbursing or distributing rebates;

(c) managing or participating in incentive programs or arrangements for pharmacist services;

(d) negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(e) developing formularies;

(f) designing prescription benefit programs; or

(g) advertising or promoting services.

(10) ‘Person’ means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not‑for‑profit corporation, unincorporated organization, government, or governmental subdivision or agency.

~~(7)~~(11) ‘Pharmacist’ has the same meaning as provided in Section 40‑43‑30(65).

~~(8)~~(12) ‘Pharmacist services’ means products, goods, and services, or any combination of products, goods, and services, provided as a part of the practice of pharmacy.

~~(9)~~(13) ‘Pharmacy’ has the same meaning as provided in Section 40‑43‑30(67).

~~(10)~~(14) ‘Pharmacy benefits manager’ means ~~an~~ any person, business or other entity that contracts with pharmacists or pharmacies on behalf of an insurer, third party administrator, or the South Carolina Public Employee Benefit Authority to, either directly or indirectly through an intermediary:

(a) process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

(b) pay pharmacies or pharmacists for prescription drugs or medical supplies; ~~or~~

(c) negotiate rebates with manufacturers for drugs paid for or procured as described in this article;

(d) manage the performance of drug utilization review and the process of drug prior authorization requests;

(e) manage the adjudication of appeals or grievances related to the prescription drug benefit; or

(f) control the cost of covered prescription drugs.

~~(11)~~(15) ‘Pharmacy benefits manager affiliate’ means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefits manager.”

SECTION 5. This act takes effect upon approval by the Governor.

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