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**VERSIONS OF THIS BILL**

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A bill

TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY ENACTING THE “PATIENTS’ RIGHT TO TRANSPARENCY AND TIMELY ACCESS TO HEALTHCARE SERVICES ACT” BY ADDING CHAPTER 116 TO TITLE 44 SO AS TO DEFINE NECESSARY TERMS; TO EXCLUDE CERTAIN HEALTHCARE PROVIDERS FROM PREAUTHORIZATION REQUIREMENTS WHO MEET AN EIGHTY PERCENT THRESHOLD OF PREAUTHORIZATION REQUESTS FOR MEDICATIONS AND TREATMENTS DURING A PARTICULAR TIME PERIOD; TO REQUIRE A FAIR AND TRANSPARENT PRIOR AUTHORIZATION PROCESS FOR MEDICATIONS AND TREATMENTS; TO ESTABLISH TIMELINES FOR PREAUTHORIZATION DECISIONS; TO PROHIBIT ONGOING PRIOR AUTHORIZATION REQUIREMENTS FOR PATIENTS LIVING WITH CHRONIC CONDITIONS AFTER PRIOR AUTHORIZATION HAS BEEN PROVIDED UNDER CERTAIN CIRCUMSTANCES; TO PROHIBIT INSURANCE COMPANIES FROM SWITCHING PHARMACEUTICALS DURING A POLICY YEAR; TO ALLOW FOR STEP THERAPY EXCEPTIONS; TO PROVIDE THAT ONCE PRIOR AUTHORIZATION IS GRANTED, HEALTH CARRIERS MUST PAY FOR THE SERVICE WITH EXCEPTIONS; TO REQUIRE CONTINUITY OF CARE WHEN A PATIENT CHANGES INSURANCE POLICIES; TO REQUIRE CERTAIN FILINGS FOR INSURANCE COMPANIES FOR TRANSPARENCY CONCERNING APPROVAL AND DENIAL RATES; AND TO PROVIDE FOR ENFORCEMENT OF THE CHAPTER.

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

SECTION 1. This act may be cited as the “Patients’ Right to Transparency and Timely Access to Healthcare Services Act.”

SECTION 2. Title 44 of the S.C. Code is amended by adding:

CHAPTER 116

Patients’ Right to Transparency and Timely Access to Healthcare Services

Section 44‑116‑10. For the purposes of this chapter:

(1) “Administrators of insurance benefit plans” means an administrator licensed pursuant to Chapter 51, Title 38.

(2) “Adverse determination” means a determination by a health carrier or its designee that an admission, availability of care, continued stay, or other healthcare service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness; or is experimental or investigational and involves a condition that is life‑threatening or seriously disabling, and the requested service or payment for the service is, therefore, denied, reduced, or terminated.

(3) “Authorization” means a determination by a health carrier or its designee that an admission, availability of care, continued stay, or other healthcare service has been reviewed and, based on the information provided, is a covered benefit and satisfies the health carrier’s requirements for medical necessity and appropriateness and that payment will be made for that healthcare service.

(4) “Authorized representative” means a person to whom a covered person has given express written consent to represent the covered person, a person authorized by law to provide substituted consent for a covered person, or a family member of the covered person, or, when the covered person is unable to provide consent, the covered person’s treating healthcare professional.

(5) “Chronic health condition” means a physical or mental condition that is expected by a patient’s treating physician to last one year or more and that requires ongoing medical attention to effectively manage or prevent an adverse health event from or that limits one or more activities of daily living.

(6) “Clinical review criteria” means the written clinical policies, written clinical screening procedures, drug formularies, or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the health carrier or its designee to determine the necessity and appropriateness of healthcare services.

(7) “Covered benefits” means those healthcare services to which a covered person is entitled under the terms of a health benefit plan.

(8) “Covered person” means an insured, subscriber, enrollee, or other individual entitled to covered benefits under a health benefit plan.

(9) “Designee” means an entity, including an administrator of insurance benefit plans, pharmacy benefit managers, or a utilization review entity that performs utilization review, including prior authorization and step therapy, on behalf of a health carrier or other organization providing a health benefit plan.

(10) “Effectiveness” means a determination based on clinical considerations, not based on cost determination.

(11) “Emergency medical care” means healthcare services provided in an emergency facility to evaluate and treat a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect without medical attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to a bodily function; serious dysfunction of or damage to any bodily organ or part; or death or the threat of death. “Emergency medical care” includes the medically necessary surgical treatment of a condition discovered in the course of a surgical procedure originally intended for another purpose, so long as the subsequent surgical procedure is a covered benefit under the healthcare plan, and whether or not the originally‑intended surgical procedure or the subsequent surgical procedure for the condition discovered during surgery is subject to a prior authorization requirement.

(12) “Facility” means an institution providing healthcare services or a healthcare setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(13) “Health benefit plan” means all individual and group health insurance policies and health maintenance organizations issued, delivered, or renewed in this State, to include the State Health Plan, but otherwise not to include the administrative services performed on behalf of a self‑funded plan subject to the Employee Retirement Income Security Act (ERISA) of 1974 or other plans exempted by Section 38‑71‑1920(9).

(14) “Health carrier” means an entity, or the entity’s designee, that provides health insurance coverage in this State and an insurance company, a health maintenance organization, or any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to the state insurance regulation.

(15) “Healthcare professional” means a physician, dentist, or other person licensed and properly authorized by South Carolina law to furnish healthcare services.

(16) “Healthcare provider” means a healthcare professional or a facility licensed in South Carolina.

(17) “Healthcare services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, including the provision of pharmaceutical products or services or durable medical equipment.

(18) “Managed care organization” means a licensed insurance company, a hospital or medical services plan contract, a health maintenance organization, or any other entity that is subject to regulation by the South Carolina Department of Insurance and that operates a managed care plan.

(19) “Medically necessary healthcare services” or “medical necessity” means healthcare services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, maintenance of care, or treating an illness, injury, disease, or its symptoms in a manner that is in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site and duration, and not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider.

(20) “Nonurgent medical care” means any healthcare service that is not urgent or emergency medical care.

(21) “Prior authorization” means the process by which to determine the medical necessity or medical appropriateness of otherwise covered healthcare services prior to rendering the healthcare services. Prior authorization also includes any health carrier’s requirement that a covered person or healthcare provider notify the health carrier or its designee prior to providing a healthcare service.

(22) “Step therapy protocol” means a protocol, policy, or program that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are covered by an insurer or health plan.

(23) “Step therapy exception” means a step therapy protocol should be overridden in favor of immediate approval of the healthcare provider’s selected prescription drug.

(24) “Terminal illness” means an illness, a progressive disease, or an advanced disease state from which there is no expectation of recovery and from which death as a result is reasonably expected within six months.

(25) “Urgent medical care” means a healthcare service for a non‑life‑threatening condition that, in the opinion of a physician with knowledge of a patient’s medical condition, requires prompt medical care in order to prevent a serious threat to life, limb, or eyesight; worsening impairment of a bodily function that threatens the body’s ability to regain maximum function; worsening dysfunction or damage of any bodily organ or part that threatens the body’s ability to recover from the dysfunction or damage; or severe pain that cannot be managed without prompt medical care.

(26) “Utilization review” means a system for reviewing the necessary, appropriate, and efficient allocation of healthcare resources and services given or proposed to be given to a patient or a group of patients, including prior authorization and step therapy.

(27) “Utilization review entity” means a private review agent licensed pursuant to Chapter 70, Title 38 that performs utilization reviews on behalf of a health carrier, managed care organization, or the State for any health benefit plan including, but not limited to, exclusive provider organization plans, preferred provider organization plans, health maintenance organization plans, or point of service plans.

(28) “Value‑based reimbursement” means reimbursement that ties a payment for the provision of healthcare services to the quality of healthcare provided and rewards a healthcare provider for efficiency and effectiveness. A “value‑based reimbursement” may impose a risk‑sharing requirement on a healthcare provider for healthcare services that do not meet the healthcare insurer’s requirements for quality, effectiveness, and efficiency.

Section 44‑116‑20. (A) No health benefit plan may require prior authorization of:

(1) healthcare services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings provided to women as described in Code of Federal Regulations, Title 45, Section 147.130;

(2) outpatient treatment for a mental health condition as defined in Section 38‑71‑290, except for prescription drugs. Decisions regarding prescription drugs must be made in accordance with the response timelines set forth in Section 44‑116‑50 and in conformance with Sections 44‑116‑70 and 44‑116‑80;

(3) outpatient treatment for substance use disorder including, but not limited to, providing medication assisted treatment for the treating opioid‑use disorder; and

(4) pain medication for the treatment of a patient who is terminally ill.

(B) A healthcare provider who received approval for eighty percent or more of his prior authorization requests for a particular healthcare service is exempt from having to obtain prior authorization for that healthcare service for twelve months.

(1) Health carriers must annually conduct a six‑month retrospective review of prior authorization requests from the previous twelve‑month period for each participating healthcare provider by healthcare service and must notify each healthcare provider in writing, without being requested, that they qualify for an exemption for the subsequent twelve months, without recission.

(2) If a healthcare provider qualifies for an exemption for a twelve‑month period but does not for the next twelve‑month period based on the required annual review by the health carrier, the healthcare provider may appeal the decision to an external review organization without having to participate in an internal appeal process. The health carrier must bear the costs of the appeal. The finding by the external review organization is binding. If the external review organization determines as part of the appeal that the health carrier denied prior authorization requests in bad faith or to prevent a healthcare provider from qualifying for the exemption, then healthcare provider qualifies for another twelve‑month exemption period.

(3) A health carrier may extend an exemption to a healthcare provider for a particular healthcare service for additional twelve‑month periods without conducting another review at the discretion of the health carrier.

(C) No health carrier or designee may conduct or require prior authorization if a health carrier and a healthcare provider are engaged in a value‑based reimbursement arrangement for a particular healthcare service or for specific patients who are included in that value‑based reimbursement arrangement.

Section 44‑116‑30. (A) When prior authorization is required by a health carrier or its designee and is permitted pursuant to this chapter, covered persons have a right to a utilization review process that is fair, transparent, clinically appropriate, and based on evidence‑based protocols and assistance in submitting necessary information.

(1) A health carrier shall make publicly accessible on its website, categorized by health benefit plan, any current prior authorization requirements and restrictions including, but not limited to, a list of each healthcare service to which prior authorization applies, a uniform process for obtaining authorization, and written clinical review criteria. Requirements shall be described in detail, including ICD and CPT codes for reference, but also in easily understandable language. If a health carrier intends to implement a new prior authorization requirement or restriction or amend an existing an requirement or restriction, the health carrier shall provide covered persons and contracted healthcare providers written notice of the new or amended requirement or amendment no fewer than sixty days before the new or amended requirement or restriction is implemented, and it shall ensure that the new or amended requirement is not implemented unless the health carrier’s website has been updated to reflect the new or amended requirement or restriction.

(2) Adverse determinations must be made by a physician licensed to practice medicine in this State and who has experience treating patients with the medical condition or disease for which the healthcare service is being requested. A covered person’s treating physician may request that prior authorization be reviewed by another South Carolina licensed physician in the same specialty as the physician making the request, by a South Carolina licensed physician in another appropriate specialty, or by a pharmacologist.

(B) If a health carrier questions the appropriateness or medical necessity of a healthcare service, the health carrier or its designee must notify the covered person’s healthcare provider prior to issuing an adverse determination, and the requesting healthcare provider must have a reasonable opportunity to discuss the appropriateness or medical necessity of the healthcare service on the telephone with the reviewing licensed physician who is responsible for determining authorization for the healthcare service under review.

(C)(1) Adverse determinations must be based on medical necessity, written clinical review criteria, and medical and scientific evidence as defined in Section 38‑71‑1920(16). “Medical necessity” includes “medical appropriateness,” “primary coverage criteria,” and any other terminology used by a plan that refers to a determination that is based in whole or in part on clinical justification for a service.

(2) Adverse determinations must be made in writing within the timeframe provided for in Section 44‑116‑40 and conveyed to the treating physician and the patient or the patient’s authorized representative with a detailed but easily understandable explanation to support the determination. It also must include the name, phone number, and email address of the individual to contact to discuss the determination, an explanation of how to comply with the health carrier’s internal appeal process, the required statement pursuant to the Health Carrier External Review Act in Article 19, Chapter 71, Title 38, and, if applicable, the patient’s right to an expedited review under S.C. Code Section 38‑71‑144.

(D) A healthcare provider may submit a benefit inquiry to a health benefit plan for a healthcare service not yet provided to determine if the healthcare service meets medical necessity and other requirements for payment. A decision must include a determination as to whether the patient is covered by a plan and eligible to receive the requested service and, if it is determined that the service does not meet medical necessity or other requirements, a detailed explanation as to why.

(E) If a healthcare provider accepts a patient’s insurance plan, it must assist the patient in providing necessary information to a health carrier to obtain prior authorization of a recommended or prescribed healthcare service.

Section 44‑116‑40. (A) If a health benefit plan requires prior authorization of a healthcare service and prior authorization is permitted pursuant to this chapter, then the health carrier shall:

(1) make an authorization or adverse determination and notify the patient and the patient’s healthcare provider of the decision regarding nonurgent medical care within forty‑eight hours of obtaining all necessary information to make the authorization or adverse determination; and

(2) render an expedited authorization or adverse determination concerning urgent medical care and notify the patient and the patient’s healthcare provider of that expedited prior authorization or adverse determination within twenty‑four hours after obtaining all necessary information to make the authorization or adverse determination.

(B) A health benefit plan shall not require prior authorization for prehospital transportation for or for provision of emergency medical care and health carriers, including managed care organizations, shall comply with the Access to Emergency Medical Care Act in the S.C. Code Article 15, Chapter 71, Title 38.

Section 44‑116‑50. Once granted, a patient’s authorization for:

(1) a healthcare service, except prescription drugs, to treat a chronic health condition does not expire and shall remain valid for the length of the treatment and the health carrier or its designee shall not require prior authorization for that healthcare service again unless the treating physician changes the treatment or the standard of treatment for that chronic health condition changes; and

(2) prescription drugs for treatment of a chronic health condition does not expire and shall remain valid for the policy year and in conformance with Section 44‑116‑60.

Section 44‑116‑60. (A) Outside of open enrollment periods, no health carrier or its designee shall:

(1) remove any covered prescription drug from its list of covered drugs during the policy year unless the United States Food and Drug Administration has issued a statement about the drug which calls into question the clinical safety of the drug or the manufacturer of the drug has notified the United States Food and Drug Administration of any manufacturing discontinuance or potential discontinuance as required by Section 506C of the Federal Food Drug and Cosmetic Act, 21 U.S.C. 356c; or

(2) reclassify a drug to a more restrictive drug tier or increase the amount that an insured must pay for a copayment, coinsurance, or a deductible for prescription drug benefits, or move a drug to a higher cost‑sharing tier during the policy year unless a generic equivalent product becomes available.

(B) The prohibitions contained in subsection (A) shall apply beginning on the date on which open enrollment begins for a policy year and through the end of the policy year to which the open enrollment period applies.

(C) The provisions contained in this section do not prohibit:

(1) the addition of prescription drugs to such policy’s list of covered drugs during the policy year; or

(2) a health carrier from requiring a pharmacist to effect substitutions of prescription drugs consistent with laws of this State.

Section 44‑116‑70. (A) Clinical review criteria used to establish a step therapy protocol shall be based on clinical practice guidelines that:

(1) recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol;

(2) are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

(a)(i) requiring members to disclose any potential conflict of interests with healthcare entities including, but not limited to, insurers, health plans, and pharmaceutical manufacturers and to recuse themselves from voting if they have a conflict of interest;

(ii) using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(iii) offering opportunities for public review and comments; or

(b) considering peer reviewed publications in the absence of clinical guidelines that meet the requirements of this item.

(3) are based on high quality studies, research, and medical practice;

(4) are created by an explicit and transparent process that:

(a) minimizes biases and conflicts of interest;

(b) explains the relationship between treatment options and outcomes;

(c) rates the quality of the evidence supporting recommendations; and

(d) considers relevant patient subgroups and preferences; and

(5) are continually updated through a review of new evidence, research, and newly developed treatments.

(B) When establishing a step therapy protocol, a health carrier shall also take into account the needs of atypical patient populations and diagnoses when establishing clinical review criteria.

(C) A health carrier, including a pharmacy benefit manager, shall:

(1) upon written request, provide all specific written clinical review criteria relating to a particular condition or disease including clinical review criteria relating to a step therapy protocol override determination; and

(2) make available the clinical review criteria and other clinical information on its internet site and to a healthcare professional on behalf of a covered person upon written request.

(D) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a health carrier through the use of a step therapy protocol, the patient and prescribing healthcare professional shall have access to a clear, readily accessible and convenient process to request a step therapy exception. The process shall be made easily accessible on the health carrier’s website. A health carrier must disclose all rules and criteria related to the step therapy protocol on its website and in writing to all prescribing healthcare professionals, including the specific information and documentation that must be submitted by a prescribing healthcare professional or patient to be considered a complete exception request.

(E)(1) A step therapy exception shall be expeditiously granted if the:

(a) required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;

(b) required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;

(c) patient has tried the required prescription drug while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(d) required prescription drug is not in the best interest of the patient, based on medical necessity; or

(e) patient is stable on a prescription drug selected by their healthcare provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

(F) Upon a step therapy exception being granted, the health carrier or its designee shall authorize use of the prescription drug prescribed by the patient’s treating healthcare professional.

(G) The health carrier shall grant or deny a step therapy exception request or an appeal within seventy‑two hours of receipt. In cases where exigent circumstances exist, a health carrier shall respond within twenty‑four hours of receipt. If a request for a step therapy override exception is incomplete or additional clinically relevant information is required, the health carrier shall notify the prescribing healthcare professional within seventy‑two hours of submission, or twenty‑four hours in exigent circumstances, what additional or clinically relevant information is required in order to approve or deny the step therapy exception request or appeal pursuant to the criteria required in subsection (A). Once the requested information is submitted, the applicable time period to grant or deny a step therapy exception request or appeal shall apply. Should a determination or request for incomplete or clinically relevant information by a health carrier or its designee not be received by the prescribing healthcare professional within the time allotted, the exception or appeal shall be deemed granted. In the event of a denial, the health carrier or its designee or health plan must inform the patient of an appeal process.

(H) Any step therapy exception shall be eligible for appeal by an insured person.

(I) Nothing in this section prevents:

(1) a health carrier from requiring a patient to try an AB‑rated generic equivalent or interchangeable biological product (as defined by 42 U.S.C. Section 262(i)(3)), unless such a requirement meets any of the criteria of subsection (E) pursuant to a step therapy exception request, prior to providing coverage for the equivalent branded prescription drug;

(2) a health carrier from requiring a pharmacist to effect substitutions of prescription drugs consistent with the laws of this State; or

(3) a healthcare professional from prescribing a prescription drug that is determined to be medically appropriate.

(J) Nothing in this subsection requires health carriers, health plans, or the State to establish a new entity to develop clinical review criteria used for step therapy protocols.

Section 44‑116‑80. (A) When prior authorization is provided for a healthcare service to a covered person, a health carrier shall not retroactively deny a claim for that healthcare service and shall pay a claim for that healthcare service, without limitation, restriction, or conditions, regardless of the terminology used by the health carrier or designee when reviewing the claim, unless:

(1) the authorized healthcare service was never performed;

(2) the submission of the claim for the healthcare service with respect to the covered person was not timely under the terms of the applicable provider contract or policy;

(3) the subscriber had not exhausted contract or policy benefit limitations based on information available to the health carrier at the time of the authorization but subsequently exhausted contract or policy benefit limitations after the authorization was issued, in which case the health carrier or its designee shall include language in the notice of authorization to the covered person and healthcare provider that the visits or services authorized might exceed the limits of the contract or policy and would accordingly not be covered under the contract or policy; or

(4) there is specific information available for review by the appropriate state or federal agency that the covered person or healthcare professional has engaged in material misrepresentation, fraud, or abuse regarding the claim for the authorized service.

(B) A health carrier may not deny or limit coverage of a healthcare service that the covered person has already received solely on the basis of lack of prior authorization if the service would otherwise have been covered had the prior authorization properly been obtained.

Section 44‑116‑90. Upon receipt of information documenting prior authorization from a covered person or from a covered person’s healthcare provider, a health carrier shall honor a prior authorization granted to a covered person from a previous health carrier for at least the initial sixty days of a covered person’s coverage under a new health plan. During that time period, a health carrier may perform its own review to grant a prior authorization. If there is a change in coverage of, or approval criteria for, a previously authorized healthcare service, the change in coverage or approval criteria does not affect a covered person who received prior authorization before the effective date of the change for the remainder of the covered person’s plan year. A health carrier shall continue to honor a prior authorization it has granted to a covered person when the covered person changes products under the same health insurance company.

Section 44‑116‑100. (A) Annually, on or before the first day of June, each health carrier subject to the provisions of this chapter shall report to the Department of Insurance for the previous year the:

(1) number of prior authorization requests for which an authorization was issued;

(2) number of prior authorization requests for which an adverse determination was issued, sorted by healthcare service; whether the adverse determination was appealed; and whether the adverse determination was upheld or reversed on appeal;

(3) number of healthcare providers granted exemptions by the health carrier from prior authorization requests, sorted by healthcare service;

(4) number or prior authorization exemptions by healthcare service by year that were rescinded by the health carrier;

(5) number of step therapy exception requests by exception that were approved; and

(6) number of step therapy exception requests that were denied, sorted by exception; whether the denial was appealed; and whether the denial was upheld or reversed on appeal.

(B) The Department of Insurance and each health carrier shall make the report available on their website within thirty days of the reports being made.

Section 44‑116‑110. The provisions of this chapter shall be enforced by the Department of Insurance. The penalties in Chapter 2, Title 38 apply to violations of this chapter by insurance companies and administrators of insurance benefit plans, including Pharmacy Benefit Managers, health maintenance organizations, private review agents, or any other accident and health insurer licensed pursuant to Title 38. A covered person, the covered person’s authorized representative, or the covered person’s provider may file a complaint with the Department of Insurance for violations of the covered person’s rights under this chapter.

SECTION 3. The Department of Insurance shall promulgate regulations effective on or before January 1, 2028, providing, at a minimum:

(1) a retrospective review process that health carriers must utilize to determine annual eligibility for the exemption provided for in Section 44‑116‑20(B) for each participating healthcare provider and healthcare service;

(2) a process for notifying healthcare providers, in writing, who qualify for an exemption provided for in Section 44‑116‑20(B) for each twelve‑month period, without the healthcare provider having to request it, by healthcare service and health benefit plan; and

(3) for healthcare providers who fail to requalify for an exemption, a binding external expedited appeals process by an independent review organization, without having to first engage in a health carrier’s internal appeal process, the costs of which must be borne by the health carrier.

SECTION 4. The Department of Insurance shall promulgate regulations necessary for the enforcement of this act.

SECTION 5. 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 6. This act takes effect upon approval by the Governor and applies to health insurance or health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2027.

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