CHAPTER 59

Claims Practices

ARTICLE 1

In General

**SECTION 38‑59‑10.** Proof of loss forms required to be furnished.

When an insurer under an insurance policy requires a written proof of loss after the notice of the loss has been given by the insured or beneficiary, the insurer or its representative shall furnish a blank to be used for that purpose. If the forms are not furnished within twenty days after the receipt of the notice, the claimant is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, character, and extent of the loss for which claim is made. The twenty‑day period after notice of loss to furnish forms applies to all types of insurance unless a lesser time period is specifically provided by law.

HISTORY: Former 1976 Code Section 38‑59‑10 [1976 Act No. 673; 1976 Act No. 745 Section 1] recodified as Section 38‑79‑10 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑9‑300 [1947 (45) 322; 1952 Code Section 37‑166; 1962 Code Section 37‑166] recodified as Section 38‑59‑10 by 1987 Act No. 155, Section 1.

CROSS REFERENCES

Notification to applicants or renewing policyholders, see Section 38‑75‑755.

Requirement that every risk retention group, its agents and its representatives comply with the claims settlement practices laws, see Section 38‑87‑40.

Library References

Insurance 3191(4).

Westlaw Topic No. 217.

C.J.S. Insurance Sections 1774, 1833, 2308.

RESEARCH REFERENCES

Encyclopedias

S.C. Jur. South Carolina Rules of Civil Procedure Section 12.2, Discussion.

NOTES OF DECISIONS

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1. In general

The purpose of former Code 1962 Section 37‑166 was to provide a method by which the insured could file proof of loss when the insurer’s form was unavailable (decided under former law). Williams v. South Carolina Farm Bureau Mut. Ins. Co. (S.C. 1969) 253 S.C. 53, 168 S.E.2d 794.

The purpose of former Code 1962 Section 37‑166 was not to prevent a waiver or an estoppel by the insurer, but to provide a method by which the insured could file proof of loss when the insurer’s form was unavailable (decided under former law). American Mut. Fire Ins. Co. v. Green (S.C. 1958) 233 S.C. 588, 106 S.E.2d 265.

**SECTION 38‑59‑20.** Improper claim practices.

Any of the following acts by an insurer doing accident and health insurance, property insurance, casualty insurance, surety insurance, marine insurance, or title insurance business, if committed without just cause and performed with such frequency as to indicate a general business practice, constitutes improper claim practices:

(1) Knowingly misrepresenting to insureds or third‑party claimants pertinent facts or policy provisions relating to coverages at issue or providing deceptive or misleading information with respect to coverages.

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, including third‑party claims arising under liability insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims, including third‑party liability claims, arising under its policies.

(4) Not attempting in good faith to effect prompt, fair, and equitable settlement of claims, including third‑party liability claims, submitted to it in which liability has become reasonably clear.

(5) Compelling policyholders or claimants, including third‑party claimants under liability policies, to institute suits to recover amounts reasonably due or payable with respect to claims arising under its policies by offering substantially less than the amounts ultimately recovered through suits brought by the claimants or through settlements with their attorneys employed as the result of the inability of the claimants to effect reasonable settlements with the insurers.

(6) Offering to settle claims, including third‑party liability claims, for an amount less than the amount otherwise reasonably due or payable based upon the possibility or probability that the policyholder or claimant would be required to incur attorneys’ fees to recover the amount reasonably due or payable.

(7) Invoking or threatening to invoke policy defenses or to rescind the policy as of its inception, not in good faith and with a reasonable expectation of prevailing with respect to the policy defense or attempted rescission, but for the primary purpose of discouraging or reducing a claim, including a third‑party liability claim.

(8) Any other practice which constitutes an unreasonable delay in paying or an unreasonable failure to pay or settle in full claims, including third‑party liability claims, arising under coverages provided by its policies.

HISTORY: Former 1976 Code Section 38‑37‑1110 [1962 Code Section 37‑591.56; 1974 (58) 2718] recodified as Section 38‑59‑20 by 1987 Act No. 155, Section 1.

CROSS REFERENCES

Requirement that every risk retention group, its agents and its representatives comply with the claims settlement practices laws, see Section 38‑87‑40.

Library References

Insurance 3141, 3334 to 3382.

Westlaw Topic No. 217.

C.J.S. Insurance Sections 1659 to 1670, 1872 to 1873, 1989, 2002, 2010, 2138 to 2148, 2309, 2323 to 2324, 2349 to 2350.

RESEARCH REFERENCES

Encyclopedias

S.C. Jur. Action Section 14, Determination of Private Rights.

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1. Private cause of action

Under South Carolina law, claims for negligence and gross negligence against insurer for refusing to pay underinsured motorist (UIM) benefits to insured could not be founded upon alleged negligent violation of section of Claims Practices Act that was clearly aimed at conduct that was performed with such frequency as to indicate a general business practice. Snyder v. State Farm Mut. Auto. Ins. Co., 2008, 586 F.Supp.2d 453. Insurance 3360

South Carolina’s Improper Claim Practices Act, as predicted by the federal district court, did not create private cause of action for first‑party insurance claimants. Ocean Winds Council of Co‑Owners, Inc. v. Auto‑Owners Ins. Co., 2002, 241 F.Supp.2d 572. Action 3; Insurance 3359

South Carolina Supreme Court would recognize cause of action for bad faith—unreasonable refusal to pay first party insurance benefits; insured would be able to waive contract and sue in common law tort for intentional, reckless or unreasonable refusal of insurance company to pay benefits clearly due under policy, recover compensatory damages not limited to face amount of policy, and recover punitive damages upon demonstration that insurer’s failure to pay benefits was willful or in reckless disregard of his rights. Robertsen v. State Farm Mut. Auto. Ins. Co. (D.C.S.C. 1979) 464 F.Supp. 876. Insurance 3360; Insurance 3374; Insurance 3376

To establish the materiality element for a claim against an insurance company for tort of fraudulently obtaining a release, the plaintiff must demonstrate the insurer had an obligation to pay by alleging and proving the liability of the insured tortfeasor. Gaskins v. Southern Farm Bureau Cas. Ins. Co. (S.C. 2003) 354 S.C. 416, 581 S.E.2d 169, rehearing denied. Insurance 3354

The Insurance Trade Practices Act and the Claims Practices Act do not create private causes of action. Masterclean, Inc. v. Star Ins. Co. (S.C. 2001) 347 S.C. 405, 556 S.E.2d 371.

Principal could not sue surety in tort for bad faith refusal to pay obligee under performance bond, even though the Insurance Code regulates sureties and the surety’s liability was limited to the penal amount of the bond and had an incentive to delay payment; the bond was not insurance, and the surety was not an insurer. Masterclean, Inc. v. Star Ins. Co. (S.C. 2001) 347 S.C. 405, 556 S.E.2d 371. Insurance 1001; Insurance 1002; Principal And Surety 65

Former Section 38‑37‑1110 did not create a private cause of action for an insurer’s bad faith actions against third party claimants under automobile liability insurance policies (decided under former law). Swinton v. Chubb & Son, Inc. (S.C.App. 1984) 283 S.C. 11, 320 S.E.2d 495.

2. Administrative remedy

Under South Carolina law, appropriate channel for insured’s claims against underinsured motorist (UIM) insurer for alleged violations of Insurance Trade Practices Act or Claims Practices Act was administrative complaint through Department of Insurance. Snyder v. State Farm Mut. Auto. Ins. Co., 2008, 586 F.Supp.2d 453. Insurance 3141; Insurance 3541

Under South Carolina law, Insurance Claims Practices Act is clearly aimed at conduct that is performed with such frequency as to indicate a general business practice, and does not provide grounds for a private cause of action, but rather gives guidelines for administrative enforcement by the Department of Insurance. Snyder v. State Farm Mut. Auto. Ins. Co., 2008, 586 F.Supp.2d 453. Action 3; Insurance 3141; Insurance 3543

Complaint against homeowners’ insurance carrier and its agent for wrongful adjustment under Claims Practices Act failed to state cause of action, as Act did not create private cause of action, but only entitled third party plaintiffs to administrative remedy. Code 1976, Sections 38‑59‑10 to 38‑59‑50; Rules Civ.Proc., Rule 12(b)(6). Gaskins v. Southern Farm Bureau Cas. Ins. Co. (S.C.App. 2000) 343 S.C. 666, 541 S.E.2d 269, rehearing denied, certiorari granted, affirmed as modified 354 S.C. 416, 581 S.E.2d 169. Insurance 1654; Insurance 3379

Complaint against homeowners’ insurance carrier and its agent for wrongful adjustment under Claims Practices Act failed to state cause of action, as Act did not create private cause of action, but only entitled third party plaintiffs to administrative remedy. Code 1976, Sections Sections 38‑59‑10 to 38‑59‑50; Rules Civ.Proc., Rule 12(b)(6). Gaskins v. Southern Farm Bureau Cas. Ins. Co. (S.C.App. 2000) 343 S.C. 666, 541 S.E.2d 269, rehearing denied, certiorari granted, affirmed as modified 354 S.C. 416, 581 S.E.2d 169. Insurance 1654; Insurance 3379

Though slip and fall victim lacked standing to sue premises owner’s insurer for bad faith refusal to pay medical payments benefits, victim could maintain administrative action against insurer under the Claims Practices Act for improper claims practices. Kleckley v. Northwestern Nat. Cas. Co. (S.C. 2000) 338 S.C. 131, 526 S.E.2d 218. Insurance 3357

3. Representation by attorney

Under South Carolina law, insured corporation’s officer was entitled under general commercial liability policies to separate representation in sexual harassment actions against him and corporation, where policies covered only officers’ actions within scope of their duties, thereby giving corporation interest in demonstrating that any sexual harassment or retaliation was result of officer acting outside course and scope of his employment. Twin City Fire Ins. Co. v. Ben Arnold‑Sunbelt Beverage Co. of South Carolina, LP, 2004, 336 F.Supp.2d 610, affirmed 433 F.3d 365. Insurance 2929

Under South Carolina law, insured was not justified in rejecting attorney designated by insurers to conduct defense in employment discrimination action, even though insured claimed that attorney had conflict of interest because of insurers’ notice of reservation of rights with regard to several claims, where insurers proposed compromise whereby insured would be permitted to select independent attorney to work alongside attorney, with insurers paying for both attorneys under certain reasonable conditions. Twin City Fire Ins. Co. v. Ben Arnold‑Sunbelt Beverage Co. of South Carolina, LP, 2004, 336 F.Supp.2d 610, affirmed 433 F.3d 365. Insurance 2929

Under South Carolina law, as predicted by the district court, there was no per se disqualification rule giving insured right to retain independent counsel of its own choosing at insurer’s expense where only potential for conflict of interest existed because reservation of rights notice had been given. Twin City Fire Ins. Co. v. Ben Arnold‑Sunbelt Beverage Co. of South Carolina, LP, 2004, 336 F.Supp.2d 610, affirmed 433 F.3d 365. Insurance 2929

Under South Carolina law, insurer’s obligation to provide independent counsel is not based on insurance law; rather, it is based on lawyer’s duty of loyalty which prohibits him or her from representing conflicting interests. Twin City Fire Ins. Co. v. Ben Arnold‑Sunbelt Beverage Co. of South Carolina, LP, 2004, 336 F.Supp.2d 610, affirmed 433 F.3d 365. Insurance 2929

4. Bad faith refusal to pay

Under South Carolina law, when judging whether an insurance company is liable for a bad faith denial of benefits, the insurance company’s conduct must be judged by evidence it had before it at the time it denied the claim. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Insurance 3335

Under South Carolina law, elements of cause of action for bad faith refusal to pay first‑party benefits under contract of insurance are: (1) existence of mutually binding contract of insurance between plaintiff and defendant; (2) refusal by insurer to pay benefits due under contract; (3) resulting from insurer’s bad faith or unreasonable action in breach of implied covenant of good faith and fair dealing arising on contract; and (4) causing damage to insured. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Insurance 3360

Under South Carolina law, fact that disability insurer had paid all amounts due under policy at time suit was filed did not bar insured’s bad faith claim against insurer, where insured allegedly suffered mental and emotional distress created by insurer’s delay and bad faith refusal to pay, had to hire counsel to pursue claim, incurred costs and expenses in bringing action, and lost interest on money owed by insurer due to its refusal to timely honor claim. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Insurance 3360

Environmental cleanup costs incurred by insured for pesticide contamination resulting from routine operations of insured were excluded from liability coverage for property damage under pollution exclusion, and thus, insurer had reasonable basis to deny claim that did not constitute bad faith; cleanup costs did not fall under exception to pollution exclusion for “sudden and accidental” pollution in policy. Helena Chemical Co. v. Allianz Underwriters Ins. Co. (S.C. 2004) 357 S.C. 631, 594 S.E.2d 455. Insurance 2278(17); Insurance 3349

Bad faith refusal to pay benefits under a contract of insurance includes: (1) the existence of a mutually binding contract of insurance between the plaintiff and defendant; (2) a refusal by the insurer to pay benefits due under the contract; (3) the refusal is the result of the insurer’s bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing arising on the contract; and the refusal to pay causes damage to the insured. Hansen ex rel. Hansen v. United Services Auto. Ass’n (S.C.App. 2002) 350 S.C. 62, 565 S.E.2d 114, rehearing denied, certiorari denied. Insurance 3335

Generally, if there is a reasonable ground for contesting an insurance claim, the denial of the claim does not constitute bad faith. Hansen ex rel. Hansen v. United Services Auto. Ass’n (S.C.App. 2002) 350 S.C. 62, 565 S.E.2d 114, rehearing denied, certiorari denied. Insurance 3336

Automobile liability insurer’s payment of the $30,000 minimum required by South Carolina law with respect to accident occurring in South Carolina did not constitute bad faith, in case in which benefits were sought under policy written in Ohio for deaths of insured driver’s children; although insured contended he paid premiums for liability coverage in amount of $200,000, policy’s “family exclusion” promised only the minimum amounts and types of coverages required by law if insured’s accident occurred in another state. Hansen ex rel. Hansen v. United Services Auto. Ass’n (S.C.App. 2002) 350 S.C. 62, 565 S.E.2d 114, rehearing denied, certiorari denied. Insurance 3347

Bad faith refusal to pay benefits under a contract of insurance includes: (1) the existence of a mutually binding contract of insurance between plaintiff and defendant; (2) refusal by insurer to pay benefits due under contract; (3) resulting from insurer’s bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing arising on contract; (4) causing damage to insured. Mixson, Inc. v. American Loyalty Ins. Co. (S.C.App. 2002) 349 S.C. 394, 562 S.E.2d 659, rehearing denied, certiorari denied. Insurance 3335

An insurer is not insulated from liability for bad faith merely because there is no clear precedent resolving a coverage issue raised under particular facts of case. Mixson, Inc. v. American Loyalty Ins. Co. (S.C.App. 2002) 349 S.C. 394, 562 S.E.2d 659, rehearing denied, certiorari denied. Insurance 3337

Insurer did not engage in bad faith refusal to pay benefits under South Carolina law after canceling 20‑year‑old life insurance policy without notice for non‑payment of premium after insured missed one payment, although insurer had accepted late payments from insured on 22 prior occasions. Wactor v. Jackson Nat. Life Ins. Co. (C.A.4 (S.C.) 2015) 604 Fed.Appx. 220, 2015 WL 1020653. Insurance 3360

5. Cooperation

Under South Carolina law, insured substantially failed to comply with provision of general commercial liability policies requiring it to cooperate with insurers in settlement of claims, and thus insurers had no duty to indemnify insured for sums paid in compromise settlements in sexual harassment actions, where insured rejected attorney selected by insurers after insurers gave notice of reservation of rights, rejected compromise proposed by insurers, and failed to obtain insurers’ approval of settlement. Twin City Fire Ins. Co. v. Ben Arnold‑Sunbelt Beverage Co. of South Carolina, LP, 2004, 336 F.Supp.2d 610, affirmed 433 F.3d 365. Insurance 3204; Insurance 3209

6. Reasonable ground for denial

Under South Carolina law, inland marine insurer did not deny insured equipment owner’s claim for fire loss in bad faith, where equipment that burned was not listed in policy due to misdescription in application not definitely traceable to insurer’s error; absence of listing provided reasonable ground for denial, and insurer adequately investigated claim, after being alerted to possibility that burned equipment might not be same as that listed, by hiring independent adjuster to investigate, who concluded that listing in policy did not match lost equipment. Myrick v. Prime Ins. Syndicate, Inc. (C.A.4 (S.C.) 2005) 395 F.3d 485. Insurance 3361

Under South Carolina law, insurer’s reasonable ground for contesting claim precludes finding of bad faith. Myrick v. Prime Ins. Syndicate, Inc. (C.A.4 (S.C.) 2005) 395 F.3d 485. Insurance 3337

7. Federal courts

Insurer did not waive its right to argue causation of bad faith damages in its motion for judgment notwithstanding the verdict (JNOV) concerning insured companies’ counterclaim against insurer in action seeking reimbursement of costs after settling five product defect lawsuits against insureds within deductible limits of applicable insurance policies, even though insureds asserted insurer’s motion for directed verdict failed to make the specific arguments in the motion for JNOV, where insurer plainly stated, albeit briefly, in its motion for directed verdict that the settlement amounts alone were insufficient to demonstrate what damages resulted from any alleged bad faith. Liberty Mut. Fire Ins. Co. v. JT Walker Industries, Inc. (C.A.4 (S.C.) 2014) 554 Fed.Appx. 176, 2014 WL 504086, on remand 2014 WL 6773517, appeal dismissed. Federal Civil Procedure 2602

8. Summary judgment

Genuine issues of material fact existed as to whether disability insurer closed insured’s file based on erroneous belief that she had agreed to advanced pay, and whether insurer unreasonably delayed making payments, precluding summary judgment in insured’s action against insurer for bad faith under South Carolina law. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Federal Civil Procedure 2501

Expert opinions regarding governing law constituted legal conclusions and had to be disregarded on insurer’s motion for summary judgment, in action against insurer alleging breach of contract, equitable estoppel, unjust enrichment, bad faith refusal to pay life insurance benefits, and breach of implied covenant of good faith and fair dealing predicated on insurer’s handling of claim. Wactor v. Jackson Nat. Life Ins. Co. (C.A.4 (S.C.) 2015) 604 Fed.Appx. 220, 2015 WL 1020653. Federal Civil Procedure 2481; Federal Civil Procedure 2501

9. Sufficiency of evidence

Under South Carolina law, insured companies failed to provide sufficient evidence of ascertainable loss, as required to support jury’s award of actual or consequential bad faith damages concerning insureds’ counterclaim against insurer in action seeking reimbursement of costs after settling five product defect lawsuits against insureds within deductible limits of applicable insurance policies, asserting that insureds did not desire the settlements; insureds relied upon estimated trial costs, reserves, and settlement amounts for each case, and considering all five underlying claims, the total estimate to defend the cases was $769,310 and the reserves, estimating insureds’ exposure, totaled $475,000, while the total settlement amount was $1,047,300, which was $197,010 less than the combined estimated defense costs and reserves, and insureds failed to present evidence calling those estimates into question and offered no evidence that the defense costs were overstated, nor did insureds provide substantial evidence that they would have prevailed had they proceeded to trial in the underlying cases. Liberty Mut. Fire Ins. Co. v. JT Walker Industries, Inc. (C.A.4 (S.C.) 2014) 554 Fed.Appx. 176, 2014 WL 504086, on remand 2014 WL 6773517, appeal dismissed. Insurance 3381(5)

10. Damages

Under South Carolina law, insured may recover punitive damages in bad faith action against insurer if insured proves insurer’s conduct was willful or in reckless disregard of his rights under contract. Myrick v. Prime Ins. Syndicate, Inc. (C.A.4 (S.C.) 2005) 395 F.3d 485. Insurance 3419

Genuine issue of material fact existed as to whether disability insurer had corporate business plan to deny benefits to insured persons even where payment of benefits was clearly warranted, precluding summary judgment on insured’s claim for punitive damages under South Carolina law in action alleging that insurer engaged in bad faith. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Federal Civil Procedure 2501

Under South Carolina law, insured could not recover future value of disability insurance policy as consequential damages in her bad faith action against insurer; insurer had already admitted to liability under policy, and punitive damages were recoverable to punish insurer and to deter future wrongdoing. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Insurance 3374; Insurance 3376

In South Carolina, if an insured can demonstrate bad faith or unreasonable action by the insurer in processing a claim under their mutually binding insurance contract, she can recover consequential damages in a tort action. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Insurance 3335; Insurance 3374

In an action for recovery of insurance benefits under a theft provision of a homeowner’s policy, plaintiff could recover punitive damages for the wilful or reckless failure to settle or investigate his claim where the evidence indicated that there was virtually no effort on the part of the insurer to investigate plaintiff’s claim; further, plaintiff would be entitled to attorney fees, under former Section 38‑9‑320, since defendant’s failure to adequately investigate plaintiff’s claim supported a determination that the subsequent refusal to pay was without reasonable cause (decided under former law). Trimper v. Nationwide Ins. Co. (D.C.S.C. 1982) 540 F.Supp. 1188.

11. Attorney fees

Under South Carolina law, insured substantially failed to comply with provision of general commercial liability policies requiring it to cooperate with insurers in settlement of claims, and thus was not entitled to reimbursement for attorney fees and costs expended in defending employment discrimination charges, where insured rejected attorney selected by insurers after insurers gave notice of reservation of rights, rejected compromise proposed by insurers, and failed to obtain insurers’ approval of attorney it retained. Twin City Fire Ins. Co. v. Ben Arnold‑Sunbelt Beverage Co. of South Carolina, LP, 2004, 336 F.Supp.2d 610, affirmed 433 F.3d 365. Insurance 3204; Insurance 3211

Counsel fees should have been allowed insured for defense in declaratory judgment action brought by insurer to avoid coverage under policy where policy includes obligation to defend any suit against insured (decided under former law). Hegler v. Gulf Ins. Co. (S.C. 1978) 270 S.C. 548, 243 S.E.2d 443.

Under South Carolina law, insureds were not entitled to attorney fees as consequential damages on their bad faith counterclaim against insurer in action seeking reimbursement of costs after settling five product defect lawsuits against insureds within deductible limits of applicable insurance policies, asserting that insureds did not desire the settlements. Liberty Mut. Fire Ins. Co. v. JT Walker Industries, Inc. (C.A.4 (S.C.) 2014) 554 Fed.Appx. 176, 2014 WL 504086, on remand 2014 WL 6773517, appeal dismissed. Insurance 3375

12. Review

Insured’s allegation that his automobile liability insurance provider engaged in unfair insurance practices because it attempted to settle his insurance claim for the Ohio minimum limit of $25,000 was not preserved for appeal, where argument was not raised to the trial court in action for declaratory relief. Hansen ex rel. Hansen v. United Services Auto. Ass’n (S.C.App. 2002) 350 S.C. 62, 565 S.E.2d 114, rehearing denied, certiorari denied. Declaratory Judgment 393

**SECTION 38‑59‑25.** Coverage decisions not constituting practice of medicine.

A determination of medical necessity of a decision affecting the diagnosis and/or treatment of a patient is not the practice of medicine, provided:

(A) it is a coverage decision denying health care services by an insurer that is based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract; or

(B) it is a coverage decision approving a covered benefit for health care services that provides for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; or

(C) it is a coverage decision denying coverage for a covered benefit for a health care service that provides diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease excluding, except where otherwise provided for by law, experimental, investigational, or cosmetic purposes, if the denial is issued by a licensed physician who has not wilfully and knowingly, or with reckless disregard or gross negligence, or with the intent solely to delay payment of the claim in bad faith, ignored nationally recognized protocols or standards of medical care in rendering such a decision. A good faith request for records or additional information is not a delay for purposes of this section. A person providing medical necessity review services for a health insurer or health maintenance organization who is subject to an inquiry regarding whether the person has been practicing medicine pursuant to this section has the right to remove the case to the Administrative Law Court upon petition of the person. If the Administrative Law Court determines that a complaint is filed, pursuant to this section, to harass or intimidate a person or is otherwise not based on a good faith belief that the provisions of this section are being violated, the defendant is entitled to an award of attorney’s fees and the costs of defending the case.

HISTORY: 2008 Act No. 411, Section 7, eff June 25, 2008.

**SECTION 38‑59‑30.** Notice and hearing by director or designee; penalties.

If, after due notice and hearing, the director or his designee determines that the insurer has engaged in any of the improper claim practices defined in Section 38‑59‑20, he shall order the insurer to cease and desist from the practice and may impose a penalty as provided in Section 38‑2‑10. If the penalty is imposed, the penalty may not be considered a cost of the insurer for purposes of determining whether or not the rates of the insurer warrant adjustment.

HISTORY: Former 1976 Code Section 38‑37‑1120 [1962 Code Section 37‑591.57; 1974 (58) 2718] recodified as Section 38‑59‑30 by 1987 Act No. 155, Section 1; 1988 Act No. 374, Section 30; 1993 Act No. 181, Section 723.

CROSS REFERENCES

Requirement that every risk retention group, its agents and its representatives comply with the claims settlement practices laws, see Section 38‑87‑40.

**SECTION 38‑59‑40.** Liability for attorneys’ fees where insurer has refused to pay claim.

(1) In the event of a claim, loss, or damage which is covered by a policy of insurance or a contract of a nonprofit hospital service plan or a medical service corporation and the refusal of the insurer, plan, or corporation to pay the claim within ninety days after a demand has been made by the holder of the policy or contract and a finding on suit of the contract made by the trial judge that the refusal was without reasonable cause or in bad faith, the insurer, plan, or corporation is liable to pay the holder, in addition to any sum or any amount otherwise recoverable, all reasonable attorneys’ fees for the prosecution of the case against the insurer, plan, or corporation. The amount of reasonable attorneys’ fees must be determined by the trial judge and the amount added to the judgment. The amount of the attorneys’ fees may not exceed one‑third of the amount of the judgment.

(2) If attorneys’ fees are allowed and, on appeal by the defendant, the judgment is affirmed, the Supreme Court or the court of appeals shall allow to the respondent an additional sum as the court adjudges reasonable as attorneys’ fees of the respondent on the appeal.

(3) Nothing in this section may be construed to alter or affect the Tyger River Pine Co. v. Maryland Casualty Co., 161 SE 491, 163 SC 229, doctrine.

(4) This section applies to cases filed or removed to federal court and cases appealed in the federal court system.

HISTORY: Former 1976 Code Section 38‑9‑320 [1962 Code Section 37‑167.1; 1972 (57) 2203] recodified as Section 38‑59‑40 by 1987 Act No. 155, Section 1; 1989 Act No. 148, Section 50; 1999 Act No. 55, Section 38.

CROSS REFERENCES

Requirement that every risk retention group, its agents and its representatives comply with the claims settlement practices laws, see Section 38‑87‑40.

Library References

Insurance 3375.

Westlaw Topic No. 217.

C.J.S. Insurance Sections 1670, 2146, 2148.

RESEARCH REFERENCES

Encyclopedias

S.C. Jur. Attorney Fees Section 50, Delay of Claim Payment.

S.C. Jur. Attorney Fees Section 76, Size of Judgment as Not a Limiting Factor.

Forms

South Carolina Litigation Forms and Analysis Section 39:8 , Attorney’s Fees.

LAW REVIEW AND JOURNAL COMMENTARIES

1981 Survey: Insurance Law; Tortious breach of duty of good faith and fair dealing. 34 S.C. L. Rev. 28 (August 1982).

Annual Survey of South Carolina Law: Business Law: Insurance. 33 S.C. L. Rev. 8 (August 1981).

Annual Survey of South Carolina Law: Insurance: Insurer’s liability for attorney’s fees. 28 S.C. L. Rev. 357.

Recovery of Attorneys’ Fees as Costs or Damages in South Carolina. 38 S.C. L. Rev. 823.

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1. In general

Where a contract action was vacated on grounds that the insured was not entitled to double recovery of his actual damages based on contract and tort actions, the award of attorneys’ fees, made on the basis of former Section 38‑9‑320(1), should also have been vacated (decided under former law). Nichols v. State Farm Mut. Auto. Ins. Co. (S.C. 1983) 279 S.C. 336, 306 S.E.2d 616.

Former Section 38‑9‑320 did not require payment of attorney’s fees in every contested case won by insured; attorney’s fees will not be allowed where case involves legal principles of novel impression. Nelson v. United Fire Ins. Co. of New York (S.C. 1980) 275 S.C. 92, 267 S.E.2d 604.

Award of attorneys’ fees held proper pursuant to this section where jury verdict indicated a finding of breach of contract accompanied by fraudulent act on the part of insurer (decided under former law). Thompson v. Home Sec. Life Ins. (S.C. 1978) 271 S.C. 54, 244 S.E.2d 533.

Plaintiff entitled to attorneys’ fees where, after full review of record, Supreme Court could not say judge erred in finding insurers did in fact unreasonably refuse to pay insured’s claims (decided under former law). Hutson v. Continental Assur. Co. (S.C. 1977) 269 S.C. 322, 237 S.E.2d 375.

The determination of an insurer’s liability under statute providing for attorney’s fees, on the grounds of wrongful refusal to pay a claim for benefits, is a matter for decision by the judge who tries the case (decided under former law). Coker v. Pilot Life Ins. Co. (S.C. 1975) 265 S.C. 260, 217 S.E.2d 784. Insurance 2942; Insurance 3382

2. Constitutional issues

State law is pre‑empted where federal employee’s federal insurance policy and regulations pertaining thereto are concerned, and consequently it was unnecessary for District Court to decide whether federal insurer’s refusal to pay was without reasonable cause or in bad faith under former South Carolina Code Section 38‑9‑320 (decided under former law). Myers v. U.S. (C.A.4 (S.C.) 1985) 767 F.2d 1072.

3. Insurance policy

Under South Carolina law, payment and performance bonds issued for subcontractor’s work on construction projects were not “insurance policies,” and thus statute requiring insurers to pay attorney fees resulting from bad faith refusal to pay claims under insurance policies did not apply in contractor’s action to recover under bonds. Boldt Co. v. Thomason Elec. and American Contractors Indem. Co., 2007, 820 F.Supp.2d 703. Insurance 1001; Principal and Surety 73

4. Without reasonable cause or in bad faith

In an action for recovery of insurance benefits under a theft provision of a homeowner’s policy, plaintiff could recover punitive damages for the wilful or reckless failure to settle or investigate his claim where the evidence indicated that there was virtually no effort on the part of the insurer to investigate plaintiff’s claim; further, plaintiff would be entitled to attorney fees, under former Section 38‑9‑320, since defendant’s failure to adequately investigate plaintiff’s claim supported a determination that the subsequent refusal to pay was without reasonable cause (decided under former law). Trimper v. Nationwide Ins. Co. (D.C.S.C. 1982) 540 F.Supp. 1188.

An insurer did not as a matter of law act unreasonably, fraudulently, or in bad faith in exercising its right to litigate its alleged liability under its policy, in view of the unsettled state of the law on the legal issue whether the words “loss of income due to disability” in the personal injury protection endorsement on the plaintiff’s automobile liability insurance policy meant that the plaintiff should be paid for loss of time from work while visiting his doctor; accordingly, the plaintiff’s recovery would not extend to attorney’s fees under former Section 38‑9‑320 or punitive damages and was necessarily limited to any loss of income to the plaintiff due to disability resulting from his accident, where the insurer’s actions were not unreasonable, fraudulent or in bad faith (decided under former law). Wiggins v. Travelers Ins. Co. (D.C.S.C. 1979) 498 F.Supp. 211, affirmed 636 F.2d 1215.

Under South Carolina law, insured apartment owner was not entitled to award of attorney fees on ground that insurer was allegedly unreasonable in asserting that two concrete slabs beneath apartments that had burned were repairable, which insured asserted caused several month delay in reconstruction, where attorney fees were not expended as a result of the allegedly unreasonable behavior, insurer paid to have the buildings rebuilt, and insured did not have to sue insurer to recover for the rebuilding. Shadow Creek Apartments, L.L.C. v. Hartford Fire Ins.Co. (C.A.4 (S.C.) 2002) 44 Fed.Appx. 640, 2002 WL 1932358, Unreported. Insurance 3375

Under South Carolina law, attorney fees are available when insurer denies claim in bad faith or without reasonable cause. Shadow Creek Apartments, L.L.C. v. Hartford Fire Ins.Co. (C.A.4 (S.C.) 2002) 44 Fed.Appx. 640, 2002 WL 1932358, Unreported. Insurance 3375

Bad faith refusal to pay benefits under a contract of insurance includes: (1) the existence of a mutually binding contract of insurance between plaintiff and defendant; (2) refusal by insurer to pay benefits due under contract; (3) resulting from insurer’s bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing arising on contract; (4) causing damage to insured. Mixson, Inc. v. American Loyalty Ins. Co. (S.C.App. 2002) 349 S.C. 394, 562 S.E.2d 659, rehearing denied, certiorari denied. Insurance 3335

Attorney fees were properly denied to the beneficiary of life insurance policies in her successful action to recover benefits, where the insurer’s refusal to pay was not unreasonable or in bad faith, the insurer should not be penalized for its decision to litigate a meritorious issue (decided under former law). Greene v. Durham Life Ins. Co. (S.C. 1985) 287 S.C. 197, 336 S.E.2d 478.

Insurer’s refusal to pay claim is without reasonable cause or in bad faith for purposes of former Section 38‑9‑320, where evidence relied on by insurer to establish arson is equally consistent with proposition that insured property was accidentally destroyed, and where there exists direct and unimpeached testimony that destruction was accidental (decided under former law). Flynn v. Nationwide Mut. Ins. Co. (S.C.App. 1984) 281 S.C. 391, 315 S.E.2d 817.

In an action to recover disability benefits under an insurance policy, the trial court was plainly justified in awarding attorneys’ fees to plaintiff under former Section 38‑9‑320, where the insurer’s defense was patently unreasonable and was raised in a manner calculated to mislead the court and increase plaintiff’s burden of litigation, and where the insurer’s verified response to plaintiff’s request for admissions amounted to a false declaration under oath, in that it contained denials regarding receipt of the claim forms on which plaintiff had indicated he would be receiving social security when it clearly had notice of plaintiff’s social security benefits before he filed his first lawsuit (decided under former law). Sciarrone v. Life Ins. Co. of Virginia (S.C.App. 1984) 280 S.C. 446, 313 S.E.2d 322.

Where legal and factual issues were in dispute such that the action of an insurer could not be said to have been without reasonable cause or in bad faith, as contemplated by former Section 36‑9‑320, the trial court properly denied the insureds’ motion for attorneys’ fees (decided under former law). Waites v. South Carolina Windstorm and Hail Underwriting Ass’n (S.C. 1983) 279 S.C. 362, 307 S.E.2d 223.

Attorney fees were improperly awarded pursuant to former Section 38‑9‑320 in a successful action to collect the proceeds of a life insurance policy, where the insurance company’s conduct in letting the case go to trial did not demonstrate bad faith or lack of just cause since the company sought to determine whether or not the deceased had knowledge at the time the insurance contract was executed that he was “under the care of a doctor” for cancer or knew he had cancer (decided under former law). Strickland v. Prudential Ins. Co. of America (S.C. 1982) 278 S.C. 82, 292 S.E.2d 301.

In a successful action by the owner of an automobile destroyed by fire to recover on the policy insuring the vehicle, the award of a fee to the owner’s attorney on the ground that the insurance company’s refusal to settle had been without reasonable cause and in bad faith would be vacated where the verdict of $3,950 was only slightly more than the company’s pretrial offer of $3,800, where the parties had reached a settlement before the owner retained the attorney who had sharply escalated his demands to as much as $5,400, and where there had been no unreasonable delay in the company’s failure to retain the services of an independent appraiser until 18 months after the loss since the company had been under no duty to retain an appraiser in the first place (decided under former law.) Brown v. State Farm Mut. Ins. Co. (S.C. 1980) 275 S.C. 276, 269 S.E.2d 769.

The payment of attorney’s fees is not required in every contested case won by the insured; under this section, such fees should be awarded only when a company’s refusal to pay is “without reasonable cause or in bad faith.” Madden v. Pilot Life Ins. Co. (S.C. 1979) 272 S.C. 264, 251 S.E.2d 196. (Decided under former law.) Insurance 3336

Statute providing for attorneys’ fees where an insurer refuses “without reasonable cause or in bad faith” to pay a claim, would justify such an award, where policy of insurance was issued by insurance carrier with full knowledge that the insured was a member of the Armed Forces, a full premium for medical payments coverage was collected, the amount of the claim was not in dispute, and there had been a finding that refusal to pay the claim was without reasonable cause (decided under former law). Blackburn v. Government Employees Ins. Co. (S.C. 1975) 264 S.C. 535, 216 S.E.2d 192.

5. Appeals

The determination of an insurer’s liability for attorneys’ fees pursuant to former Section 38‑9‑320 was a matter for decision by the trial judge, and where it did not appear from the record that the issue was raised or decided in the trial court, it would not be considered on appeal (decided under former law). Gurley v. United Services Auto. Ass’n (S.C.App. 1983) 279 S.C. 449, 309 S.E.2d 11.

Supreme Court may weigh the evidence on the issue of award of attorney’s fees and may find facts in accordance with its own view, regardless of the lower court’s findings (decided under former law). Baker v. Pilot Life Ins. Co. (S.C. 1977) 268 S.C. 609, 235 S.E.2d 300.

Under subdivision (2) of former 1962 Code Section 37‑167.1 [former 1976 Code Section 38‑9‑320], Supreme Court is without authority to make award of attorneys’ fees where fees were not awarded by trial judge, award was not affirmed on appeal, and appeal was not prosecuted by insurer; the only time Supreme Court may make separate and additional award for prosecution of an appeal, which is regulated by its discretion and not subject to the limitation of subsection 1, is when the insured has satisfied the three conditions set forth in subsection 2; otherwise, the maximum allowable fee is controlled by subsection 1 and is to be set by the trial judge, subject to review for any abuse of discretion (decided under former law). Cook v. Government Emp. Ins. Co. (S.C. 1976) 266 S.C. 309, 223 S.E.2d 33. Insurance 3375

“All reasonable attorneys’ fees” include handling of the case before the lower court and for appeal to Supreme Court where lower court did not award fees in light of erroneous construction of statute (decided under former law). Cook v. Government Emp. Ins. Co. (S.C. 1976) 266 S.C. 309, 223 S.E.2d 33.

6. Refusal to defend insured

Although the legislature did not intend that attorney fees should be paid in every contested case won by an insured, such fees were properly awarded where an insurer’s refusal to defend its insured was without reasonable cause (decided under former law). Boggs v. Aetna Cas. and Sur. Co. (S.C. 1979) 272 S.C. 460, 252 S.E.2d 565. Insurance 3375

When insurer refuses to defend insured under liability insurance contract and insured is compelled to conduct own defense, insured may recover from insurer reasonable expenses of litigation, including costs and attorneys fees (decided under former law). Sloan Const. Co., Inc. v. Central Nat. Ins. Co. of Omaha (S.C. 1977) 269 S.C. 183, 236 S.E.2d 818. Insurance 2934(2)

Insured has no action against defaulting insurance company where two companies insure identical risk, both policies provide for furnishing insured with defense, and one company denies liability and refuses to defend, even if insured nominally bears cost of defense, where burden is actually born by nondefaulting insurer, through guise of loan receipt, in absence of any damage flowing to insured as result of defaulting insurers refusal to defend (decided under former law). Sloan Const. Co., Inc. v. Central Nat. Ins. Co. of Omaha (S.C. 1977) 269 S.C. 183, 236 S.E.2d 818.

7. Settlements

Under South Carolina law, insured substantially failed to comply with provision of general commercial liability policies requiring it to cooperate with insurers in settlement of claims, and thus was not entitled to reimbursement for attorney fees and costs expended in defending employment discrimination charges, where insured rejected attorney selected by insurers after insurers gave notice of reservation of rights, rejected compromise proposed by insurers, and failed to obtain insurers’ approval of attorney it retained. Twin City Fire Ins. Co. v. Ben Arnold‑Sunbelt Beverage Co. of South Carolina, LP, 2004, 336 F.Supp.2d 610, affirmed 433 F.3d 365. Insurance 3204; Insurance 3211

Attorney fees may be proper when case is settled prior to trial judgment. Brown v. Johnson (S.C. 1981) 276 S.C. 68, 275 S.E.2d 876.

Insureds were not entitled to attorney fees pursuant to South Carolina statute, which provided for an attorney fees award when an insurer refused to defend or pay a claim without reasonable cause, on their bad faith claim against insurer in action seeking reimbursement of costs after settling five product defect lawsuits against insureds within deductible limits of applicable insurance policies, asserting that insureds did not desire the settlements; insurer’s settlements did not equate to a failure to defend or refusal to pay that left a policyholder to fend for itself in the underlying dispute. Liberty Mut. Fire Ins. Co. v. JT Walker Industries, Inc. (C.A.4 (S.C.) 2014) 554 Fed.Appx. 176, 2014 WL 504086, on remand 2014 WL 6773517, appeal dismissed. Insurance 3375

8. Tort actions

South Carolina Supreme Court would recognize cause of action for bad faith ‑ unreasonable refusal to pay first party insurance benefits; insured would be able to waive contract and sue in common law tort for intentional, reckless or unreasonable refusal of insurance company to pay benefits clearly due under policy, recover compensatory damages not limited to face amount of policy, and recover punitive damages upon demonstration that insurer’s failure to pay benefits was willful or in reckless disregard of his rights (decided under former law). Robertsen v. State Farm Mut. Auto. Ins. Co. (D.C.S.C. 1979) 464 F.Supp. 876. Insurance 3360; Insurance 3374; Insurance 3376

Question of whether insured was entitled to attorney fees pursuant to former Section 38‑9‑320 on basis of insurance company’s refusal to defend insured in tort action must be determined in declaratory judgment action concerning coverage brought by insured against company and cannot be reserved for determination in tort action (decided under former law). Hubbs v. Government Employees Ins. Co. (S.C. 1986) 287 S.C. 579, 340 S.E.2d 532.

9. Federal courts

The State legislature is powerless to compel the award of attorneys’ fees in an action brought in the United States District Court, and does not attempt to do so by this section [Code 1962 Section 37‑167.1], but limits its applicability to a common pleas or county court (decided under former law). Louthian v. State Farm Mut. Ins. Co. (D.C.S.C. 1973) 357 F.Supp. 894, affirmed 493 F.2d 240.

10. Summary judgment

Fact question as to whether property insurer exercised bad faith in its processing of insurer’s claim under policy, precluded summary judgment on breach of implied covenant of good faith and fair dealing claim against insurer, and on issue of whether insurer was required to pay insured’s attorney fees under South Carolina statute. Ocean Winds Council of Co‑Owners, Inc. v. Auto‑Owners Ins. Co., 2002, 241 F.Supp.2d 572. Federal Civil Procedure 2501

Genuine issue of material fact existed as to whether insurer acted reasonably in denying claim of insured to recover $1,940.00 in cash that was stolen from automatic teller machine (ATM) located within insured’s convenience store, precluding summary judgment on insured’s claim for bad faith refusal to pay; more than one inference could be drawn from evidence, and once trial court concluded the ATM fit within common definition of a safe and was covered under terms of policy in insured’s breach of contract claim, it became law of the case, and not an issue of novel impression. Mixson, Inc. v. American Loyalty Ins. Co. (S.C.App. 2002) 349 S.C. 394, 562 S.E.2d 659, rehearing denied, certiorari denied. Judgment 185.3(12)

Whether automobile insurer initially refused to pay liability claim without reasonable cause or in bad faith involved questions of fact precluding summary judgment on insureds’ request for attorney fees and costs in suit arising out of claim to liability coverage for named insured’s spouse driving rental vehicle without permission of lessor (decided under former law). Dorman v. Allstate Ins. Co. (S.C.App. 1998) 332 S.C. 176, 504 S.E.2d 127. Judgment 181(23)

11. Questions of fact

Under South Carolina law, the determination of an insurer’s liability for attorney fees for its alleged refusal to pay a policyholder’s claim without reasonable cause or in bad faith is an issue of fact. Code 1976, Sections 38‑59‑40. University Medical Associates of Medical University of S.C. v. UnumProvident Corp., 2004, 335 F.Supp.2d 702. Insurance 3382

12. Review

Either a settlement of a pending action or a judgment is required before the trial judge may make an attorney fee award under former Section 38‑9‑320(1); accordingly, a fee award made under the statute would be vacated where a judgment for the insured was reversed on appeal (decided under former law). Rutledge v. St. Paul Fire and Marine Ins. Co. (S.C.App. 1985) 286 S.C. 360, 334 S.E.2d 131.

Where trial judge erroneously determined that attorneys’ fees could not be awarded because insurance company had made sufficient tender, case will be remanded to trial judge for determination whether insurance company refused payment without reasonable cause or in bad faith (decided under former law). Cook v. Government Emp. Ins. Co. (S.C. 1976) 266 S.C. 309, 223 S.E.2d 33.

**SECTION 38‑59‑50.** Payment or settlement of benefits in merchandise or services prohibited.

It is unlawful for an insurer to make payment or settlement of benefits arising under life, endowment, accident, health, or hospitalization policies written by the insurer in merchandise, services rendered or agreed to be rendered, or to issue a policy which provides for settlement in merchandise or services rendered or to be rendered.

An insurer violating this section pays a penalty of ten times the amount of the policy, certificate, or other evidence of insurance to be collected in a suit by the policyholder or his legal representatives or beneficiary. An officer, agent, or servant of an insurer who violates this section is guilty of a misdemeanor and, upon conviction, must be fined in the discretion of the court or imprisoned not more than three years, or both.

HISTORY: Former 1976 Code Section 38‑9‑330 [1947 (45) 322; 1952 Code Section 37‑168; 1958 (50) 1554; 1962 Code Section 37‑168] recodified as Section 38‑59‑50 by 1987 Act No. 155, Section 1; 1988 Act No. 374, Section 31; 1993 Act No. 184, Section 220.

CROSS REFERENCES

Penalties for violations of the insurance laws of this state, see Section 38‑2‑10 et seq.

Requirement that every risk retention group, its agents and its representatives comply with the claims settlement practices laws, see Section 38‑87‑40.

Library References

Insurance 3398.

Westlaw Topic No. 217.

C.J.S. Insurance Sections 1985, 2211.

RESEARCH REFERENCES

Encyclopedias

S.C. Jur. South Carolina Rules of Civil Procedure Section 12.2, Discussion.

ARTICLE 2

South Carolina Health Care Financial Recovery and Protection Act

**SECTION 38‑59‑200.** Citation of article.

This article may be cited as the “South Carolina Health Care Financial Recovery and Protection Act”.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑210.** Definitions.

As used in this article:

(1) “Insurer” means an insurance company, a health maintenance organization, and any other entity providing health insurance coverage, as defined in Section 38‑71‑670(6), which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

(2) “Health care services” means services included in furnishing an individual medical care or hospitalization, or services incident to the furnishing of medical care or hospitalization, and other services to prevent, alleviate, cure, or heal human illness, injury, or physical disability.

(3) “Health maintenance organization” means an organization as defined in Section 38‑33‑20(8).

(4) “Health insurance plan” means a health insurance policy or health benefit plan offered by a health insurer or a health maintenance organization that provides health insurance coverage, as defined in Section 38‑71‑670(6).

(5) “Physician” means a doctor of medicine or doctor of osteopathic medicine licensed by the South Carolina Board of Medical Examiners.

(6) “Provider” means a physician, hospital, or other person properly licensed, certified, or permitted, where required, to furnish health care services.

(7) “Participating provider” means a provider who provides covered health care services to an insured or a member pursuant to a contract with an insurer or health insurance plan.

(8) “Clean claim” means an eligible electronic or paper claim for reimbursement that:

(a) is received by the insurer within one hundred twenty business days of the date the health care services at issue were performed;

(b)(i) when submitted via paper has all the elements of the standardized CMS 1500 or UB 04 claim form, or the successor of each as either may be amended from time to time; or

(ii) when submitted via an electronic transaction, uses only permitted standard code sets and has all the elements of the standard electronic formats as required by the Health Insurance Portability and Accountability Act of 1996 and other federal and state regulatory authority;

(c) is for health care services covered by the health insurance plan and rendered to an insured person by a provider eligible for reimbursement under the health insurance plan;

(d) has any corresponding referral that may be required for the applicable claim;

(e) is a claim for which the insurer is the primary payor, or for which the insurer’s responsibility as a secondary payor has been clearly established;

(f) has no material defect, error, or impropriety that would affect the adjudication of the claim;

(g) includes all required substantiating documentation or coding;

(h) is not subject to any particular circumstance that the insurer reasonably believes, subject to review by the Department of Insurance, would prevent accurate or timely payment from being made on the claim under the terms of the health insurance plan, the participating provider agreement, or the insurer’s published filing requirements; and

(i) is under a health insurance plan for which the insurer has been timely paid all applicable premiums.

(9) “Force majeure” means any act of God, governmental act, act of terrorism, war, fire, flood, earthquake, hurricane, or other natural disaster, explosion or civil commotion.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

Library References

Insurance 1002, 1252.

Westlaw Topic No. 217.

C.J.S. Insurance Section 37.

**SECTION 38‑59‑220.** Requesting fee schedule from insurer; confidentiality.

(A) Within six months of the effective date of this article, each insurer, upon written request from a physician who is also a participating provider will provide, by CD‑ROM, or electronically at the insurer’s option, the fee schedule that is contracted with that physician for up to 100 CPT(r) Codes customarily and routinely used by the specialty type of such physician. Each physician may request from an insurer an updated fee schedule no more than two times annually.

(B) A physician requesting a fee schedule pursuant to subsection (A) may elect to receive a hard copy of the fee schedule in lieu of the foregoing; however, the insurer may charge the physician a reasonable fee to cover the increased administrative costs of providing the hard copy.

(C) The physician shall keep all fee schedule information provided pursuant to this section confidential. The physician shall disclose fee schedule information only to those employees of the physician who have a reasonable need to access this information in order to perform their duties for the physician and who have been placed under an obligation to keep this information confidential. Any failure of a physician’s office to abide by this subsection shall result in the physician’s forfeiture of the right to receive fee schedules pursuant to this section and at the option of the insurer may constitute a breach of contract by the physician.

(D) Nothing in this section prohibits an insurer from basing actual compensation to the physician on the insurer’s maximum allowable amount or other contract adjustments, including those stated in the patient’s plan of benefits, or both.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

Library References

Health 939 to 942.

Insurance 2521.

Westlaw Topic Nos. 198H, 217.

C.J.S. Hospitals Sections 3, 21.

**SECTION 38‑59‑230.** Time frame for payment of clean claims; acknowledging receipt of claim; processing of electronic claims by billing service.

(A) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted via paper within forty business days following the later of the insurer’s receipt of the claim or the date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer:

(1) to determine that such claim does not contain any material defect, error, or impropriety; or

(2) to make a payment determination.

(B) An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted electronically within twenty business days following the later of the insurer’s receipt of the claim or the date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer:

(1) to determine that such claim does not contain any material defect, error, or impropriety; or

(2) to make a payment determination.

(C) An insurer shall affix to or on paper claims, or otherwise maintain a system for determining, the date claims are received by the insurer. An insurer shall send an electronic acknowledgement of claims submitted electronically either to the provider or the provider’s designated vendor for the exchange of electronic health care transactions. The acknowledgement must identify the date claims are received by the insurer. If an insurer determines that there is any defect, error, or impropriety in a claim that prevents the claim from entering the insurer’s adjudication system, the insurer shall provide notice of the defect or error either to the provider or the provider’s designated vendor for the exchange of electronic health care transactions within twenty business days of the submission of the claim if it was submitted electronically or within forty business days of the claim if it was submitted via paper. Nothing contained in this section is intended or may be construed to alter an insurer’s ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.

(D) A clearinghouse, billing service, or any other vendor that contracts with a provider to deliver health care claims to an insurer on the provider’s behalf is prohibited from converting electronic claims received from the provider into paper claims for submission to the insurer. A violation of this subsection constitutes an unfair trade practice under Chapter 5, Title 39, and individual providers and insurers injured by violations of this subsection have an action for damages as set forth in Section 39‑5‑140.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

Library References

Insurance 3393 to 3400(2).

Westlaw Topic No. 217.

C.J.S. Insurance Sections 1978, 1981 to 1985, 2210 to 2212, 2321.

**SECTION 38‑59‑240.** Interest on payments later than applicable period; exceptions.

(A) For each clean claim with respect to which an insurer has directed the issuance of a check or the electronic funds transfer later than the applicable period specified in Section 38‑59‑230, the insurer shall pay interest in the same manner and at the same rate set forth in Section 34‑31‑20(A) on the balance due on each claim computed from the twenty‑first or the forty‑first business day, as appropriate, based on the circumstances described in Section 38‑59‑230, up to the date on which the insurer directs the issuance of the check or the electronic funds transfer for payment of the clean claim. At the insurer’s election, interest paid pursuant to this section must be included in the claim payment check or wire transfer or must be remitted periodically, but at least quarterly, in a separate check or wire transfer along with a report detailing the claims for which interest is being paid.

(B) No insurer has an obligation to make any interest payment pursuant to subsection (A):

(1) with respect to any clean claim if within twenty business days of the submission of an original claim submitted electronically or within forty business days of an original claim submitted via paper, a duplicate claim is submitted while the adjudication of the original claim is still in process;

(2) to any participating provider who balance bills a plan member in violation of the participating provider’s agreement with the insurer;

(3) with respect to any time period during which a force majeure prevents the adjudication of claims; or

(4) when payment is made to a plan member.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

Library References

Insurance 3396.

Westlaw Topic No. 217.

C.J.S. Insurance Section 2212.

**SECTION 38‑59‑250.** Initiation of overpayment recovery efforts.

(A)(1) An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least thirty business days prior to engaging in the overpayment recovery efforts, other than for recovery of duplicate payments or other similar adjustments relating to:

(a) claims where a provider has received payment for the same services from another payor whose obligation is primary; or

(b) timing or sequence of claims for the same insured that are received by the insurer out of chronological order in which the services were performed.

(2) The written notice required by this section shall include:

(a) the patient’s name;

(b) the service date;

(c) the payment amount received by the provider;

(d) a reasonably specific explanation of the change in payment; and

(e) if the claim is submitted pursuant to a provider contract that includes an appeals process, the telephone number or a mailing address through which the provider may initiate an appeal, and the deadline by which an appeal must be received.

(B) An insurer may not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by the provider; however, this time limit does not apply to the initiation of overpayment recovery efforts:

(1) based upon a reasonable belief of fraud or other intentional misconduct;

(2) required by a self‑insured plan; or

(3) required by a state or federal government program.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008); 2012 Act No. 243, Section 1, eff September 16, 2012.

Library References

Insurance 3504.

Westlaw Topic No. 217.

C.J.S. Insurance Section 1987.

**SECTION 38‑59‑260.** Application of requirements of article.

The requirements of this article do not apply to claims that are processed under any national account delivery program in which an insurer participates but is not solely responsible for the processing and payment of the claims, or claims for services under a program offered or sponsored by any state or federal governmental entity other than in its capacity as an employer, or both.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

**SECTION 38‑59‑270.** Enforcement; cease and desist orders; penalty; private right of action.

The Department of Insurance shall enforce the provisions of this article. If, after due notice and hearing, the Director of the Department of Insurance or his designee determines that an insurer has failed to meet the obligations imposed by this article, he shall order the insurer to cease and desist from the practice, to correct any errant business practices, and to make any payments due, including applicable interest. If an insurer does not comply with the order within thirty days, the director or his designee may then impose a penalty as provided in Section 38‑2‑10. Nothing in this article may be construed to create a private right of action to enforce the specific provisions of this article.

HISTORY: 2008 Act No. 356, Section 1, eff one year after approval by the Governor (approved June 11, 2008).

Library References

Insurance 1056.

Westlaw Topic No. 217.

C.J.S. Insurance Section 53.