**A** **BILL**

TO AMEND CHAPTER 57 OF TITLE 38 OF THE 1976 CODE, RELATING TO INSURANCE TRADE PRACTICES, BY ADDING SECTION 38‑57‑190, TO PROVIDE THAT TERMS AND CONDITIONS OF HEALTH CARE CONTRACTS ISSUED BY HEALTH INSURANCE ISSUERS THAT PROVIDE HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL, SMALL GROUP, OR LARGE GROUP MARKET DO NOT DISCRIMINATE UNREASONABLY AGAINST OR AMONG HEALTH CARE PROVIDERS WILLING AND QUALIFIED TO MEET THE TERMS AND CONDITIONS OF PARTICIPATION ESTABLISHED BY A HEALTH INSURANCE ISSUER OR OTHERWISE PROHIBIT OR LIMIT PARTICIPATION BY A PROVIDER WHO IS WILLING TO ACCEPT AN ISSUER’S TERMS AND CONDITIONS FOR PARTICIPATION IN THE PROVISION OF HEALTH CARE SERVICES; BY ADDING SECTION 38‑71‑450, TO PROVIDE THAT INDIVIDUAL HEALTH INSURANCE POLICIES OR CERTIFICATES OF COVERAGE MAY PROVIDE FOR WELLNESS CREDITS OR DISCOUNTS AND TO DEFINE WELLNESS CREDITS OR DISCOUNTS; AND BY ADDING SECTION 38‑71‑815, TO PROVIDE THAT GROUP HEALTH INSURANCE POLICIES OR CERTIFICATES OF COVERAGE MAY PROVIDE FOR WELLNESS CREDITS OR DISCOUNTS AND TO DEFINE WELLNESS CREDITS OR DISCOUNTS.

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

SECTION 1. Chapter 57, Title 38 of the 1976 Code is amended by adding:

“Section 38‑57‑190. (A) As used in this section:

(1) ‘Exclusive agreement clause’ means a provision in a health care contract that:

(a) prohibits, or grants an issuer an option to prohibit, the participating provider from contracting with another third party payor to provide health care services;

(b) requires, or grants an issuer an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other third party payor; or

(c) any other contract provision when the purpose or effect of the provision is to require a provider to provide all, or substantially all, of his services to the issuer’s health care network.

(2) ‘Health care contract’ or ‘contract’ means a contract entered into, materially amended, or renewed between a health insurance issuer and a participating provider for the delivery of health care services.

(3) ‘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.

(4) ‘Health insurance coverage’ means as defined in Sections 38‑71‑670(6) and 38‑71‑840(14).

(5) ‘Health insurance issuer’ or ‘issuer’ means an entity that provides health insurance coverage in this State as defined in Sections 38‑71‑670(7) and 38‑71‑840(16).

(6) ‘Most favored nation clause’ means a provision in a health care contract that:

(a) prohibits, or grants an issuer an option to prohibit, the participating provider from contracting with another third party payor to provide health care services at a rate that is equal to or lower than the payment specified in the contract;

(b) requires, or grants an issuer an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other third party payor at a rate that is equal to or lower than the payment specified in the contract;

(c) requires, or grants an issuer an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other third party payor at a rate that is equal to or lower than the payment specified in the contract;

(d) requires, or grants an issuer an option to require, the participating provider to disclose, directly or indirectly, the participating provider’s contractual rates with other third party payors;

(e) requires, or grants an issuer an option to require, the un‑negotiated adjustment by the issuer of the participating provider’s contractual rate to equal the lowest rate the provider has agreed to charge any other third party payor; or

(f) requires, or grants an issuer an option to require, the participating provider to charge another third party payor a rate that is equal to or more than the reimbursement rate specified in the contract.

(7) ‘Participating provider’ means a provider who provides covered health care services to an insured or a member pursuant to a contract with a health insurance issuer.

(8) ‘Physician’ means a doctor of medicine or doctor of osteopathic medicine licensed by the South Carolina Board of Medical Examiners.

(9) ‘Provider’ means a physician, hospital, or other person properly licensed, certified, or permitted, where required, to furnish health care services.

(B) This section applies to a health insurance issuer that provides health insurance coverage in the individual, small group, or large group market.

(C)(1) The terms and conditions of health care contracts shall not discriminate unreasonably against or among health care providers willing and qualified to meet the terms and conditions of participation established by a health insurance issuer or otherwise prohibit or limit participation by a provider who is willing to accept an issuer’s terms and conditions for participation in the provision of health care services.

(2) Differences in prices among providers based on individual negotiations with such providers, market conditions, patient mix, method of payment, or price differences among providers in different geographical areas shall not be deemed discrimination.

(D) No health insurance issuer shall:

(1) offer to a provider a health care contract that includes an exclusive agreement clause or a most favored nation clause;

(2) enter into a health care contract with a provider that includes an exclusive agreement clause or a most favored nation clause;

(3) amend or renew an existing health care contract previously entered into with a provider to include an exclusive agreement clause or a most favored nation clause; or

(4) enforce an existing health care contract previously entered into with a provider that includes an exclusive agreement clause if the contract remains in place without amendment or renewal two years following enactment of this act.

(E)(1)(a) Nothing in this section may be construed to prohibit a health insurance issuer from asking a participating provider to disclose the provider’s contractual rates with another third party payor or from using information thereby obtained in evaluating and carrying out its rights and duties under a policy of health insurance coverage to the extent otherwise permitted under law.

(b) Notwithstanding subitem (a), a health insurance issuer is prohibited from making use of information, however obtained, regarding a provider’s contractual rates with another third party payor for the purposes of negotiating its own participating provider rates or contract terms with a provider.

(2) Nothing in this section may be construed so as to prohibit a health insurance issuer and a provider from negotiating payment rates and performance‑based contract terms that would result in the issuer receiving a rate that is as favorable, or more favorable, than the rates negotiated between a provider and any other issuer.

(F) Notwithstanding any other provisions of this title or any other applicable law or regulation, a single prohibited act is a violation of this section.

(G)(1) The director or his designee at any time may examine an issuer to enforce this section. The expense of examination must be paid by the health insurance issuer. If an issuer determines that the fees assessed are unreasonable in relation to the examination performed, the issuer may appeal the assessments to the administrative law judge division. Examination fees must be retained by the department and are considered ‘other’ funds.

(2) A health insurance issuer who violates this section is subject to the penalties as provided in this chapter and Section 38‑2‑10.

(3) If the director or his designee finds that an issuer is participating in a pattern of unfair competition, the director or his designee may impose a fine of up to two hundred thousand dollars.

(H) A violation of this section constitutes an unfair trade practice under Chapter 5, Title 39, and individual providers and issuers injured by violations of this section have an action for damages as set forth in Section 39‑5‑140.”

SECTION 2. Subarticle 1, Article 3, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑450. (A) As used in this section:

(1) ‘Health insurance coverage’ means as defined in Section 38‑71‑670(6).

(2) ‘Health insurance issuer’ or ‘issuer’ means an entity that provides health insurance coverage in this State as defined in Section 38‑71‑670(7).

(B)(1) Any rate, rating schedule, or rating manual for an individual health insurance policy or certificate of coverage may provide for wellness credits or discounts.

(2) A wellness credit or discount provided by an issuer is presumed to be appropriate if there is a correlation between the reduction in health risk and the amount of the discount or credit offered unless credible data demonstrates otherwise or unless such wellness credit or discount requires the covered person to incur costs to qualify for the wellness credit or discount which equal or exceed the value of the wellness credit or discount.

(3) A wellness credit or discount shall be effective for a covered person on an annual basis unless a longer period is otherwise provided for in the policy or certificate of coverage.

(C) Each health insurance issuer shall include notice of the availability, eligibility criteria, and the range of each wellness credit or discount in the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons. The notice must provide a plain language description of all available wellness credits or discounts and the terms and conditions of eligibility and participation. The notice must specify what evidence or proof the covered person or applicant must present to obtain and maintain the wellness credit or discount.

(D)(1) For purposes of this section, a wellness credit or discount includes:

(a) an appropriate refund of premiums paid in the last calendar or policy year;

(b) premium discounts; or

(c) a reduction or waiver of otherwise applicable copayments or deductibles.

(2) A wellness credit or discount may be offered in return for demonstrative maintenance or improvement of the covered person’s health status or enrollment in or adherence to approved programs of health promotion and disease prevention.

(E) The director or his designee may at any time request documentation of and actuarial support for wellness credits or discounts and a copy of the notice of availability furnished to covered persons from a health insurance issuer to determine the reasonableness of any discounts or refunds offered by the issuer. An issuer shall provide this documentation upon request to the director or his designee.

(F) This section applies to health insurance coverage offered by a health insurance issuer that is delivered, issued for delivery, or renewed in this State and which provides health insurance coverage in the individual market.”

SECTION 3. Subarticle 1, Article 5, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑815. (A) As used in this section:

(1) ‘Health insurance coverage’ means as defined in Section 38‑71‑840(14).

(2) ‘Health insurance issuer’ or ‘issuer’ means an entity that provides health insurance coverage in this State as defined in Section 38‑71‑840(16). The term includes the state health plan.

(3) ‘State health plan’ means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.

(B)(1) Any rate, rating schedule, or rating manual for a group health insurance policy or certificate of coverage may provide for wellness credits or discounts.

(2) A wellness credit or discount provided by an issuer is presumed to be appropriate if there is a correlation between the reduction in health risk and the amount of the discount or credit offered unless credible data demonstrates otherwise or unless such wellness credit or discount requires the covered person to incur costs to qualify for the wellness credit or discount which equal or exceed the value of the wellness credit or discount.

(3) A wellness credit or discount shall be effective for a covered person on an annual basis unless a longer period is otherwise provided for in the policy or certificate of coverage.

(C) Each health insurance issuer shall include notice of the availability, eligibility criteria, and the range of each wellness credit or discount in the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons. The notice must provide a plain language description of all available wellness credits or discounts and the terms and conditions of eligibility and participation. The notice must specify what evidence or proof the covered person or applicant must present to obtain and maintain the wellness credit or discount.

(D)(1) For purposes of this section, a wellness credit or discount includes:

(a) an appropriate refund of premiums paid in the last calendar or policy year;

(b) premium discounts; or

(c) a reduction or waiver of otherwise applicable copayments or deductibles.

(2) A wellness credit or discount may be offered in return for demonstrative maintenance or improvement of the covered person’s health status or enrollment in or adherence to approved programs of health promotion and disease prevention.

(E) The director or his designee may at any time request documentation of and actuarial support for wellness credits or discounts and a copy of the notice of availability furnished to covered persons from a health insurance issuer to determine the reasonableness of any discounts or refunds offered by the issuer. An issuer shall provide this documentation upon request to the director or his designee.

(F) This section applies to health insurance coverage offered by a health insurance issuer, including the state health plan, that is delivered, issued for delivery, or renewed in this State and which provides health insurance coverage in the group market.”

SECTION 4. The department may promulgate regulations necessary for implementation 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. Unless otherwise specified, this act takes effect upon approval by the Governor. SECTION 1 of this act takes effect one hundred eighty days after approval by the Governor. SECTIONS 2 and 3 of this act apply to health insurance coverage offered by a health insurance issuer, including the state health plan, that is delivered, issued for delivery, renewed, or entered into on or after December 31, 2013.

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