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Summary: Pharmacy insurance benefits cost-sharing

**HISTORY OF LEGISLATIVE ACTIONS**

 Date Body Action Description with journal page number

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**VERSIONS OF THIS BILL**

[12/11/2024](https://www.scstatehouse.gov/sess126_2025-2026/prever/100_20241211.docx)

A bill

TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY ADDING SECTION 38‑71‑292 AND SECTION 38‑71‑820 BOTH SO AS TO DEFINE TERMS AND OUTLINE THE APPLICABILITY AND REQUIREMENTS FOR COST SHARING FOR INSURERS; BY ADDING SECTION 38‑71‑2270 SO AS TO DEFINE TERMS AND OUTLINE THE APPLICABILITY AND REQUIREMENTS FOR COST SHARING FOR PHARMACY BENEFIT MANAGERS; AND BY AMENDING SECTION 38‑71‑2200, RELATING TO DEFINITIONS CONCERNING PHARMACY BENEFITS MANAGERS, SO AS TO MAKE CONFORMING CHANGES.

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

SECTION 1. Article 1, Chapter 71, Title 38 of the S.C. Code is amended by adding:

 Section 38‑71‑292. (A) As used in this section:

 (1) “Cost sharing” means any copayment, coinsurance, deductible, or other similar charges required of an enrollee for a healthcare service, including a prescription drug, covered by a health plan, and paid by or on behalf of such enrollee.

 (2) “Enrollee” means any individual entitled to healthcare services from an insurer.

 (3) “Health plan” means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

 (4) “Healthcare service” means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

 (5) “Insurer” means an entity subject to the insurance laws and rules of insurance in this State or subject to the jurisdiction of the director that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services under a health plan in this State.

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

 (B) The annual limitation on cost sharing provided for under 42 U.S.C. Section 18022(c)(1) applies to all healthcare services covered under any health plan offered or issued by an insurer in this State.

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

 (D) Subsection (C) does not apply to a prescription drug for which there is a medically appropriate generic equivalent, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process, or as specified in Section 39‑24‑30(A).

 (E) An insurer shall not directly or indirectly set, alter, implement, or condition the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

 (F) This section applies with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2027.

 (G) In implementing the requirement of this section, the State shall only regulate an insurer or health benefit plan to the extent permissible under applicable law.

 (H) The director or his designee may promulgate rules and regulations as it deems necessary to implement this section.

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

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

 (1) “Cost sharing” means any copayment, coinsurance, deductible, or other similar charges required of an enrollee for a healthcare service, including a prescription drug, covered by a health plan, and paid by or on behalf of such enrollee.

 (2) “Enrollee” means any individual entitled to health care services from an insurer.

 (3) “Health plan” means a policy, contract, certification, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

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

 (5) “Insurer” means an entity subject to the insurance laws and rules of insurance in this State or subject to the jurisdiction of the director, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services under a health plan in this State.

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

 (B) The annual limitation on cost sharing provided for under 42 U.S.C. Section 18022(c)(1) applies to all healthcare services covered under any health plan offered or issued by an insurer in this State.

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

 (D) Subsection (C) does not apply to a prescription drug for which there is a medically appropriate generic equivalent, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process, or as specified in Section 39‑24‑30 (A).

 (E) An insurer shall not directly or indirectly set, alter, implement, or condition the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

 (F) This section applies with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2027.

 (G) In implementing the requirement of this section, the State shall only regulate an insurer or health benefit plan to the extent permissible under applicable law.

 (H) The director or his designee may promulgate rules and regulations as it deems necessary to implement this section.

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

 Section 38‑71‑2270. (A) The annual limitation on cost sharing provided for under 42 U.S.C. Section 18022(c)(1) applies to all healthcare services covered under any health plan offered or issued by an insurer in this State, including a health benefit plan administered by a pharmacy benefits manager.

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

 (C) Subsection (B) does not apply to a prescription drug for which there is a medically appropriate generic equivalent, unless the enrollee has obtained access to the brand name prescription drug through prior authorization, a step therapy protocol, the insurer's exceptions and appeals process, or as specified in Section 39‑24‑30 (A).

 (D) An insurer shall not directly or indirectly set, alter, implement, or condition the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

 (E) This section applies with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2027.

 (F) In implementing the requirement of this section, the State shall only regulate an insurer or health benefit plan to the extent permissible under applicable law.

SECTION 4. Section 38‑71‑2200 of the S.C. Code is amended to read:

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

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

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

 (a) receiving payments for pharmacist services;

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

 (c) both receiving and making payments.

 (3) “Cost sharing” means any copayment, coinsurance, deductible, or other similar charges required of an enrollee for a healthcare service, including a prescription drug, covered by a health plan, and paid by or on behalf of such enrollee.

 (4) “Enrollee” means any individual entitled to healthcare services from an insurer.

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

 (4)(6) “Healthcare insurer” means an entity that provides health insurance coverage in this State as defined in Section 38‑71‑670(7) and Section 38‑71‑840(16)subject to the insurance laws and rules of insurance in this State or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services under a health plan in this State.

 (7) “Healthcare service” means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

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

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

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

 (b) disbursing or distributing rebates;

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

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

 (e) developing formularies;

 (f) designing prescription benefit programs; or

 (g) advertising or promoting services.

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

 (7)(11) “Pharmacist” has the same meaning as provided in Section 40‑43‑30.

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

 (9)(13) “Pharmacy” has the same meaning as provided in Section 40‑43‑30.

 (14) “Pharmacy benefits management service” means:

 (a) negotiating the price of prescription drugs, including negotiating and contracting for direct or

indirect rebates, discounts, or other price concessions;

 (b) managing any aspects of a prescription drug benefit including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs, or the provision of services related thereto;

 (c) performance of any administrative, managerial, clinical, pricing, financial, reimbursement, or billing services; and

 (d) such other services as the department may define in regulation.

 (10)(15) “Pharmacy benefits manager” means an entity that contracts with pharmacists or pharmacies on behalf of an insurer, third‑party administrator, or the South Carolina Public Employee Benefit Authority to:

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

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

 (c) negotiate rebates with manufacturers for drugs paid for or procured as described in this articlea person who, pursuant to a written agreement with a healthcare insurer or health benefit plan, third‑party administrator, or the South Carolina Public Employee Benefit Authority, either directly or indirectly provides one or more pharmacy benefits management services on behalf of the healthcare insurer, health benefit plan, third‑party administrator, or the South Carolina Public Employee Benefit Authority, and any agent, contractor, intermediary, affiliate, subsidiary, or related entity of such person who facilitates, provides, directs, or oversees the provision of the pharmacy benefit management services.

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

 (12) “Pharmacy Services Administrative Organization” (PSAO) means an entity that has contracted with pharmacy clients in the State to conduct business on their behalf with third‑party payers or pharmacy benefits managers. PSAOs provide administrative services to pharmacies and negotiate and enter into contracts with third‑party payers or pharmacy benefits managers on behalf of pharmacies.

 (13) “Specialized delivery drug” means a prescription drug that meets a majority of the following criteria, as set forth by the manufacturer, FDA, or other applicable law or regulatory body and:

 (a) requires special handling or storage;

 (b) requires complex and extended patient education or counseling;

 (c) requires intensive monitoring;

 (d) requires clinical oversight; or

 (e) requires product support services; and the drug is used to treat chronic and complex, or rare medical conditions:

 (i) that can be progressive; or

 (ii) that can be debilitating or fatal if left untreated or undertreated.

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

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