**South Carolina General Assembly**

126th Session, 2025-2026

**H. 3934**

**STATUS INFORMATION**

General Bill

Sponsors: Reps. Hardee, Schuessler, McGinnis, King, Sessions, J.L. Johnson, Alexander, Anderson, Atkinson, Bailey, Bannister, Bauer, Bowers, Brewer, Brittain, Burns, Bustos, Calhoon, Caskey, Chapman, Clyburn, Cobb-Hunter, Collins, Chumley, B.J. Cox, B.L. Cox, Crawford, Davis, Dillard, Erickson, Gagnon, Garvin, Gatch, Gibson, Gilliam, Gilliard, Grant, Guest, Guffey, Hager, Hartnett, Hayes, Herbkersman, Hewitt, Hiott, Hixon, Holman, Hosey, J.E. Johnson, Jones, Jordan, Kilmartin, Kirby, Landing, Lawson, Ligon, Lowe, Luck, McCravy, McDaniel, Mitchell, B. Newton, W. Newton, Oremus, Pace, Pedalino, Pope, Rivers, Robbins, Sanders, M.M. Smith, Spann-Wilder, Teeple, Vaughan, Weeks, Wetmore, Whitmire, Williams, Wooten and Yow

Companion/Similar bill(s): 330

Document Path: LC-0031PH25.docx

Introduced in the House on February 6, 2025

Currently residing in the House Committee on **Labor, Commerce and Industry**

Summary: Cost sharing

**HISTORY OF LEGISLATIVE ACTIONS**

 Date Body Action Description with journal page number

 2/6/2025 House Introduced and read first time (House Journal‑page 33)

 2/6/2025 House Referred to Committee on **Labor, Commerce and Industry** (House Journal‑page 33)

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**VERSIONS OF THIS BILL**

[02/06/2025](https://www.scstatehouse.gov/sess126_2025-2026/prever/3934_20250206.docx)

A bill

TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY ADDING SECTION 38‑71‑295 SO AS TO DEFINE TERMS AND TO INCLUDE REFERENCES TO THE FEDERAL INTERNAL REVENUE CODE FOR PURPOSES OF COST SHARING; AND BY ADDING SECTION 38‑71‑2270 SO AS TO DEFINE TERMS AND TO INCLUDE REFERENCES TO THE FEDERAL INTERNAL REVENUE CODE FOR PURPOSES OF COST SHARING.

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 38‑71‑295. (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 covered by a health plan, including a prescription drug, and paid by or on behalf of such enrollee.

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

 (3) “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.

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

 (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.

 (7) “Third‑party administrator” means any person that directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, arranges alternative access to or funding for prescription drugs, or adjusts or settles claims on, residents of this State or residents of another state from offices in this State, in connection with health insurance coverage.

 (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 or third‑party administrator must include any cost‑sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If under federal law, application of this requirement would result in Health Savings Account ineligibility under Section 223 of the federal Internal Revenue Code, this requirement 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 for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this 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 or third‑party administrator may 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, 2026.

 (G) In implementing the requirements of this section, the State only may regulate an insurer 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 21, Chapter 71, Title 38 of the S.C. Code is amended by adding:

 Section 38‑71‑2270. (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 covered by a health plan, including a prescription drug, and paid by or on behalf of such enrollee.

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

 (3) “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.

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

 (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) “Pharmacy benefit 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 aspect of a prescription drug benefit including, but not limited to, the processing and payment of claims for prescription drugs, arranging alternative access to or funding 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, managing or providing data relating to the prescription drug benefit, or the provision of services related thereto;

 (c) performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration, or reporting, or billing service; and

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

 (7) “Pharmacy benefit manager” means any person that, pursuant to a written agreement with an insurer or health plan, either directly or indirectly, provides one or more pharmacy benefit management services on behalf of the insurer or health plan, 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.

 (8) “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, including a health plan administered by a pharmacy benefit manager.

 (C) When calculating an enrollee’s contribution to any applicable cost‑sharing requirement, a pharmacy benefit manager includes 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 for with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of this 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) A pharmacy benefit manager may 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, 2026.

 (G) In implementing the requirements of this section, the State only may regulate an insurer, health plan, or pharmacy benefit manager 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. This act takes effect upon approval by the Governor.

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