**South Carolina General Assembly**

126th Session, 2025-2026

**H. 3302**

**STATUS INFORMATION**

General Bill

Sponsors: Rep. Garvin

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Introduced in the House on January 14, 2025

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

Summary: Stop Surprise Bills

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

12/5/2024 House Prefiled

12/5/2024 House Referred to Committee on **Labor, Commerce and Industry**

1/14/2025 House Introduced and read first time ([House Journal‑page 159](h:\hj\20250114.docx))

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**VERSIONS OF THIS BILL**

[12/05/2024](https://www.scstatehouse.gov/sess126_2025-2026/prever/3302_20241205.docx)

A bill

TO AMEND THE SOUTH CAROLINA CODE OF LAWS by ENACTing THE “STOP SURPRISE BILLS ACT” BY ADDING SECTION 38‑71‑292 SO AS TO PROHIBIT INSURERS AND HEALTHCARE PROVIDERS FROM ENGAGING IN SURPRISE BILLING; AND BY ADDING SECTION 39‑5‑45 SO AS TO MAKE IT AN UNFAIR TRADE PRACTICE FOR AN INSURER OR HEALTHCARE PROVIDER TO ENGAGE IN THE PRACTICE OF SURPRISE BILLING.

Whereas, it is the goal of the State of South Carolina to protect patients from “surprise bills” from medical providers; and

Whereas, surprise billing occurs when a patient unknowingly receives medical care from an out‑of‑network healthcare provider, either because of emergency treatment or because an out‑of‑network healthcare provider participated in or provided routine, scheduled care without the patient affirmatively choosing the receive out‑of‑network care; and

Whereas, it is against public policy for South Carolina citizens to receive exorbitant and unexpected medical bills, which frequently arrive even before the patient has recovered from the unplanned, emergency health crisis. Now therefore,

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

SECTION 1. This act may be cited as the “Stop Surprise Bills Act.”

SECTION 2. Article 1, Chapter 71, Title 38 of the S.C. Code is amended by adding:

Section 38‑71‑292. (A) “Surprise bill” means a bill for healthcare services, including laboratory services and tests, received by an insured for services rendered by an out‑of‑network healthcare provider at an in‑network facility, during a service or procedure performed by an in‑network provider or during a service or procedure previously approved or authorized by the insurer and the insured did not knowingly elect to obtain services from an out‑of‑network provider. It also includes emergency services rendered at an out of network healthcare provider. “Surprise bill” does not include a bill for healthcare services received by an insured when an in‑network healthcare provider is available to render such services and the insured knowingly elects to obtain services from an out‑of‑network healthcare provider.

(B) No health insurer may impose a coinsurance, copayment, deductible, or other out‑of‑pocket expense for emergency services, including laboratory tests and services, rendered by an out‑of‑network healthcare provider that is greater than the coinsurance, copayment, deductible or other out‑of‑pocket expense that would be imposed if such emergency services were rendered by an in‑network healthcare provider.

(C)(1) If an insured receives emergency services, including laboratory tests and services, from an out‑of‑network healthcare provider, such healthcare provider may bill the insurer directly and the insurer must reimburse the healthcare provider the greatest of the following amounts:

(a) the amount the insured’s healthcare plan would pay for the same services if rendered by an in‑network healthcare provider;

(b) the usual, customary, and reasonable rate for the same services; or

(c) the amount Medicare would reimburse for the same services.

(2) Nothing in this subsection prohibits an insurer and out‑of‑network healthcare provider from agreeing to a greater reimbursement amount.

(D) An insurer may not require prior authorization for the rendering of emergency services, including laboratory tests and services to an insured.

(E) With respect to a surprise bill:

(1) an insured only may be required to pay the applicable coinsurance, copayment, deductible, or other out‑of‑pocket expense that would be imposed for such healthcare services if such services were rendered by an in‑network healthcare provider; and

(2) an insurer must reimburse the out‑of‑network healthcare provider or insured, as applicable, for healthcare services rendered at the in‑network rate under the insured’s healthcare plan as payment in full, unless the insurer and healthcare provider agree otherwise.

(F) It is an unfair trade practice in violation of Chapter 5, Title 39 for any healthcare provider, including a laboratory, to request from an insured payment other than the applicable coinsurance, copayment, deductible, or other out‑of‑pocket expenses that would be imposed for such healthcare services if the services were rendered by an in‑network provider for:

(1) emergency services covered under a healthcare plan and rendered by an out‑of‑network healthcare provider; or

(2) surprise bill, as defined in subsection (A).

(G) Within one year following the effective date of this section, the Department of Insurance must report to the Governor and the General Assembly on the efficacy of dispute resolution practices between providers, including physicians, laboratories, and hospitals and insurers and make recommendations for any changes that should be made based on best practices from surprise billing laws in other states. The Department of Insurance also shall post this information on its agency website.

SECTION 3. Article 1, Chapter 5, Title 39 of the S.C. Code is amended by adding:

Section 39‑5‑45. It is an unfair trade practice pursuant to Section 39‑5‑20 for a healthcare insurer or provider to engage in “surprise billing” as defined in Section 38‑71‑292(A).

SECTION 4. This act takes effect upon approval by the Governor.

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