**South Carolina General Assembly**

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Summary: Fair Claims Accountability Act

**HISTORY OF LEGISLATIVE ACTIONS**

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

 1/14/2025 House Introduced and read first time (House Journal‑page 246)

 1/14/2025 House Referred to Committee on **Labor, Commerce and Industry** (House Journal‑page 246)

 2/5/2025 Scrivener's error corrected

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**VERSIONS OF THIS BILL**

[12/12/2024](https://www.scstatehouse.gov/sess126_2025-2026/prever/3566_20241212.docx)

[02/05/2025](https://www.scstatehouse.gov/sess126_2025-2026/prever/3566_20250205.docx)

A bill

TO AMEND THE SOUTH CAROLINA CODE OF LAWS by ENACTing THE “FAIR CLAIMS ACCOUNTABILITY ACT” BY ADDING SECTION 37‑4‑305 SO AS TO ESTABLISH THE HEALTHCARE CLAIMS CONSUMER ASSISTANCE PROGRAM (“H‑CAP”) AND TO PROVIDE THAT A HEALTH PLAN OR INSURER IN THIS STATE MAY NOT WRONGFULLY DENY OR INSUFFICIENTLY COVER A VALID CONSUMER INSURANCE CLAIM.

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

SECTION 1. This act may be cited as the “Fair Claims Accountability Act.”

SECTION 2. Chapter 4, Title 37 of the S.C. Code is amended by adding:

 Section 37‑4‑305. (A)(1) The Healthcare Claims Consumer Assistance Program (“H‑CAP”) is established within the Department of Consumer Affairs to provide support for consumers, including prospective consumers, of health insurance and to customer assistance programs and public and private health insurance assistance programs.

 (2) The services provided by H‑CAP may include:

 (a) assisting consumers with filing complaints and appeals with a group health plan, health insurance carrier, or independent review organization and providing information about the internal and external appeal and grievance processes of a group health plan, health insurance carrier, or independent review organization;

 (b) assisting consumers and health plans or insurers to settle health insurance conflicts, disputed claims, and claim denials;

 (c) collecting, tracking, and quantifying inquiries regarding health insurance and problems encountered by consumers;

 (d) educating consumers on their rights and responsibilities with respect to health insurance coverage;

 (e) assisting consumers with obtaining health insurance coverage by providing information, referrals, or other assistance;

 (f) assisting with obtaining federal health insurance premium tax credits under Section 368 of the United States Internal Revenue Code of 1986, as amended; and

 (g) providing information to the public about the services of H‑CAP through a comprehensive outreach program and a toll‑free telephone number.

 (B) All health plans and insurers in this State are required to place a prominent, plain‑language notice about H‑CAP assistance on the front page of all health insurance explanation of benefits, denials, or other plan‑related communications.

 (C) The Department of Consumer Affairs is authorized to contract with a nonprofit, independent health insurance consumer assistance entity, which may not be a health plan or insurer or affiliate thereof, to operate the consumer assistance program.

 (D) The H‑CAP shall work with the department to fulfill the data collection and reporting requirements set forth in this section.

 (E) It is unlawful for a health plan or insurer in this State to wrongfully deny or insufficiently cover a valid consumer insurance claim. The department is authorized to take disciplinary measures, including the imposition of civil penalties and awarding of damages against injured consumers, against a licensee when the department determines that the licensee has committed an act or omission constituting grounds for disciplinary action, as specified. The department also may refer violations to the Attorney General for civil enforcement under South Carolina consumer protection and insurance laws.

 (F) In the event that the department or a court finds that a health plan or insurer has wrongfully denied or insufficiently covered a valid consumer insurance claim:

 (1) The health plan or insurer is automatically liable to pay the policyholder double the amount it is found to have wrongfully denied or insufficiently covered plus all reasonable attorney’s fees incurred to pursue a regulatory complaint or litigation for the pursuit of action against the health plan or insurer.

 (2) The department or a court may assess an additional amount in damages to the health plan or insurer, the entirety of which must be paid to the policyholder, if the department or a court assesses that the harm to the policyholder caused by the wrongful claim denial is severe. When assessing an additional amount in damages against a health plan or insurer, the department or a court shall determine the appropriate amount in damages payable to the policyholder based on one or more factors, as applicable, including:

 (a) the nature, scope, and gravity of the violation;

 (b) the severity of the potential harm to the policyholder in terms of loss of life, loss of health, emotional distress, or financial harm;

 (c) the nature and extent to which the plan cooperated with the department;

 (d) the nature and extent to which the plan aggravated or mitigated any injury or damage caused by the violation; and

 (e) the nature and extent to which the plan has taken corrective action to ensure the violation will not recur.

 (G)(1) The department, after appropriate notice and opportunity to remedy violations, is authorized to issue a civil penalty of up to twenty‑five thousand dollars for each violation to a health plan or insurer in this State, who wrongfully denied a valid consumer insurance claim or insufficiently covers a valid consumer insurance claim.

 (2) The department is authorized to issue additional penalties to the health plan or insurer if it is found to be continuously violating coverage laws in this State.

 (3) When assessing penalties against a health plan or insurer, the department shall determine the appropriate amount of the penalty for each violation of this section based upon one or more factors including, but not limited to, the following:

 (a) the nature, scope, and gravity of the violation;

 (b) the good or bad faith of the health plan or insurer;

 (c) the health plan or insurer’s history of violations;

 (d) the wilfulness of the violation;

 (e) whether the violation is an isolated incident;

 (f) the nature and extent to which the health plan or insurer cooperated with the department;

 (g) the nature and extent to which the health plan or insurer aggravated or mitigated any injury or damage caused by the violation;

 (h) the nature and extent to which the health plan or insurer has taken corrective action to ensure the violation will not recur;

 (i) the financial status of the health plan or insurer including reserves, financial solvency, revenues in excess of expenditures and other factors relating to the financial status of the domestic corporation and any parent company, subsidiary, affiliate, or other financially connected entity, if any;

 (j) the financial cost of the health care service that was denied, delayed, or modified, including whether the penalty is commensurate with or exceeds the avoided cost based on the number of enrollees estimated to be affected;

 (k) the number of enrollees estimated to be affected;

 (l) the frequency of the violation based on the number of days for a continuous violation or the estimated number of incidents with potential harm to enrollees;

 (m) the severity of the potential harm in terms of loss of life, loss of health, emotional distress, or financial harm to the enrollee; and

 (n) the amount of the penalty necessary to deter similar violations in the future.

 (H) The department, after appropriate notice and opportunity to remedy violations, by order, may suspend or revoke any license issued to a health plan or insurer, or assess administrative penalties if the department determines that the licensee has committed any of the acts or omissions constituting a violation of this section.

 (I) Beginning January 1, 2026, and every year thereafter, the penalty amounts specified in this section must be adjusted based on whichever is the higher of:

 (1) the average rate of change in premium rates for the individual and small group markets, weighted by enrollment since the previous adjustment; or

 (2) adjustment based on inflation.

 (J)(1) The department shall keep records of wrongful claim denials brought to H‑CAP and require private health plans and insurers to disclose data on denied claims to the department including, but not limited to:

 (a) number, percentage, and type of denied claims; and

 (b) number, percentage, and type of wrongfully denied claims.

 (2) The department shall require private health plans and insurers to provide required data in a machine‑readable file.

 (3) The department is authorized to investigate health plans and insurers for violations of coverage laws.

 (4) If upon review a health plan or insurer is found to be in violation of coverage laws in more than the median percentage of wrongful denials in the previous year, the department shall review violations considering one or more factors enumerated in subsection (G)(3). The department shall report these violations to the Attorney General, Governor, and the majority and minority leaders of both chambers of the General Assembly.

 (K)(1) Beginning on January 1, 2026, and every year thereafter, the department is required to report to the state Attorney General, Governor, and minority and majority leaders in both chambers of the General Assembly, and publish a report to its public website, with data on:

 (a) number and type of denied claims, including raw numbers and numbers as a percent of total claims;

 (b) number and type of wrongfully denied claims, including raw numbers and numbers as a percent of total claims;

 (c) number and type of denied claim appeals reported to H‑CAP;

 (d) of denied claims appeals brought to H‑CAP, the number, type, and percentage of denied claims that are found to be wrongful by each health plan or insurer;

 (e) information and outcomes of any investigations conducted by the department for health plan or insurer violations of coverage laws; and

 (f) the department shall post the report on their website in a machine‑readable format.

 (2) The department annually shall assess data reporting requirements and update health plan and insurer data reporting requirements based on the department’s needs to fulfill the requirements of this section.

 (L) This State has a compelling interest in protecting privacy and the protection of personal information. In administering this section, state and local agencies, businesses, and any other entity, may only request data necessary to administer this section and retain it only as required to administer and achieve the purposes of this section. Any personal information or data collected or obtained in the course of administering this section may be shared only in a manner that has been deidentified and aggregated to the greatest extent allowable while still in compliance with federal eligibility requirements and every allowable effort must be made to revoke access to such data should programs be eliminated or should there be an ineligibility determination. Personal information or data collected or obtained in the course of administering this section may not be otherwise disclosed without the informed consent of the individual, a warrant signed by a state judge or federal judge, lawful court order administered within South Carolina or a lawful federal court order, or subpoena administered within South Carolina or federal subpoena, or unless otherwise required by federal or state statute. Personal information or data may be considered deidentified if it cannot reasonably be used to infer information about, or otherwise be linked to, a particular individual or household.

 (M) The department shall promulgate rules and regulations to meet the requirements of this section.

SECTION 3. 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 4. This act takes effect upon approval by the Governor.

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