CHAPTER 13

Examinations, Investigations, Records, and Reports

ARTICLE 1

General Provisions

**SECTION 38‑13‑10.** Examination of insurers; examination of person or business; acceptance of examination report of insurer prepared by insurance department of another state.

(A) The director or his examiners may conduct an examination under this chapter of an insurer as often as the director or his designee consider appropriate but, at a minimum, shall conduct an examination of every insurer licensed in this State not less frequently than once every five years. When the director or his designee considers it prudent for the protection of policyholders in this State, he may examine or have examined an insurer applying for admission in this State. In scheduling and determining the nature, scope, and frequency of the examinations, the director or his designee shall consider compliance with relevant South Carolina laws and regulations, the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other criteria set forth in the Examiners’ Handbook adopted by the National Association of Insurance Commissioners and in effect when the director or his designee exercises his authority under this subsection.

(B) For purposes of completing an examination of an insurer under this chapter, the director or his designee may examine or investigate a person or his business in a manner considered necessary or material by the director or his designee.

(C) In lieu of an examination under this section of a foreign or an alien insurer licensed in this State, the director or his designee may accept an examination report on the insurer prepared by the insurance department for the insurer’s state of domicile or port‑of‑entry state until January 1, 1994. After that time, the reports may be accepted only if one or both of the following apply:

(1) The insurance department at the time of the examination was accredited under the National Association of Insurance Commissioners’ Financial Regulation Standards and Accreditation Program;

(2) The examination is performed with the participation of one or more examiners who are employed by the accredited insurance department, and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their department.

HISTORY: Former 1976 Code Section 38‑13‑10 [1947 (45) 322; 1952 Code Section 37‑601; 1962 Code Section 37‑601] has no comparable provisions in 1987 Act No. 155; Former 1976 Code Section 38‑5‑1220 [1947 (45) 322; 1948 (45) 1734; 1952 Code Section 37‑281; 1957 (50) 282; 1960 (51) 1646; 1962 Code Section 37‑281] recodified as Section 38‑13‑10 by 1987 Act No. 155, Section 1; 1988 Act No. 357, Section 1; 1992 Act No. 394, Section 1; 1993 Act No. 181, Section 537.

Editor’s Note

2005 Act No. 27, Section 10, provides as follows:

“The Department of Insurance shall review data reported on annual statements by liability insurers including, but not limited to, paid claims, reserves, loss adjustment expenses, and such additional data as the department may require by promulgation of bulletin, to determine savings related to a decrease in litigation and claims paid pursuant to litigation after the effective date of this act. The department may require special reports from insurers to determine if savings are realized as a result of the provisions of this act. The department shall compile a report of savings realized and submit it for General Assembly review upon request. Costs or expenses associated with the compilation of this report of savings shall be paid by the insurers pursuant to the provisions of Chapter 13 of Title 38. The Department of Insurance shall review premium and losses by line of insurance to determine if appropriate adjustments have been made based upon the department estimates of savings realized pursuant to the provisions of this act.”

2005 Act No. 32, Section 14, provides as follows:

“The Department of Insurance shall review data reported on annual statements by liability insurers, including, but not limited to, paid claims, reserves, loss adjustment expenses, and such additional data as the department may require by promulgation of bulletin, to determine savings related to a decrease in litigation and claims paid pursuant to litigation after the effective date of this act. The department may require special reports from insurers to determine if savings are realized as a result of the provisions of this act. The department shall compile a report of savings realized and submit it for General Assembly review upon request. Costs or expenses associated with the compilation of this report of savings shall be paid by the insurers pursuant to the provisions of Chapter 13 of Title 38. The Department of Insurance shall review premium and losses by line of insurance to determine if appropriate adjustments have been made based upon the department estimates of savings realized pursuant to the provisions of this act.”

**SECTION 38‑13‑20.** Examination warrant; conduct of examination; access to books, records, accounts, etc.; refusal to submit to examination; subpoenas, examination under oath; failure to obey subpoena; retaining professionals and specialists as examiners; director’s or designee’s authority.

(A) Upon determining that an examination must be conducted, the director or his designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe South Carolina laws and regulations and those guidelines and procedures set forth in the Examiners’ Handbook adopted by the National Association of Insurance Commissioners. The director also may employ other guidelines or procedures he considers appropriate.

(B) Every person or insurer and his or its officers, directors, and agents from whom information is sought shall provide to the examiners appointed under subsection (A) timely, convenient, and free access at all reasonable hours at his or its offices to all books, records, accounts, papers, documents, and all computer or other recordings relating to the property, assets, business, and affairs of the person or insurer being examined. If the director or his designee considers it necessary to the conduct of the examination, he may require that the person or insurer or his or its agents or affiliated or subsidiary corporations or partnerships furnish the original books and records. The officers, directors, employees, and agents of the insurer or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a person or an insurer by his or its officers, directors, employees, or agents to submit to examination or to comply with a reasonable written request of the examiners is grounds for suspension or revocation of the person’s or insurer’s certificate of authority to engage in the business of insurance in this State. The director or his designee may make the suspension or revocation and the reasons for it public. Proceedings for revocation must be conducted pursuant to Section 38‑5‑140.

(C) The director or his examiners may issue subpoenas, administer oaths, and examine under oath a person as to matters pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the director or his designee may petition a court of competent jurisdiction, and upon proper showing the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(D) When making an examination under Section 38‑13‑10, the director or his designee may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of the retainment must be borne by the insurer which is the subject of the examination together with the expenses of the director or his designee and the expenses and compensation of the director’s assistants. If a domestic insurer has less than one million dollars total capital and surplus as of December 31, 1993, and thereafter, then it must not be assessed the actual examination costs but shall instead pay in accordance with the examination fee schedule in effect as of July 1, 1993. If an insurer determines that its examination fees have not been assessed as provided in this section or that the fees assessed are unreasonable in relation to the examination performed, the insurer may appeal the assessments to the Administrative Law Court. Examination fees must be retained by the department and are considered “other funds”.

(E) Nothing contained in Section 38‑13‑10 limits the authority of the director or his designee to:

(1) terminate or suspend an examination to pursue other legal or regulatory action pursuant to the insurance laws of this State. Findings of fact and conclusions made pursuant to an examination are prima facie evidence in a legal or regulatory action;

(2) use and, if appropriate, make public a final or preliminary examination report, examiner or insurer work papers or other documents, or other information discovered or developed during the course of an examination in the furtherance of a legal or regulatory action which the director or his designee, in his sole discretion, considers appropriate.

HISTORY: Former 1976 Code Section 38‑13‑20 [1947 (45) 322; 1952 Code Section 37‑602; 1962 Code Section 37‑602] has no comparable provisions in 1987 Act No. 155; Former 1976 Code Section 38‑5‑1230 [1947 (45) 322; 1952 Code Section 37‑282; 1960 (51) 1646; 1962 Code Section 37‑282] recodified as Section 38‑13‑20 by 1987 Act No. 155, Section 1; 1990 Act No. 363, Section 1; 1992 Act No. 394, Section 1; 1993 Act No. 181, Section 537; 1994 Act No 497, Section 16.

**SECTION 38‑13‑30.** Examination report; copy of report to insurer examined; written rebuttals by insurer; review by, and order of, director; hearings; confidentiality of report work papers, recorded information and documents.

(A) Examination reports must be comprised of only facts appearing upon the books, records, or other documents of the insurer, its agents, or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and the conclusions and recommendations the examiners find reasonably warranted from the facts.

(B) No later than sixty days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the insurer examined with a notice which affords the insurer a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to matters contained in the examination report.

(C) After the expiration of the thirty‑day period allowed for the receipt of written submissions or rebuttals, the director or his designee shall consider and review the report fully with written submissions or rebuttals and relevant portions of the examiner’s work papers and enter an order:

(1) adopting the examination report as filed or with modification or corrections. If the examination report reveals that the insurer is operating in violation of law, regulation, or prior order of the director or his designee, he may order the insurer to take action the director or his designee considers necessary and appropriate to cure the violation;

(2) rejecting the examination report with directions to the examiners to reopen the examination to obtain additional data, documentation, or information and refiling pursuant to subsection (A); or

(3) calling for an investigatory hearing with no less than twenty days’ notice to the insurer to obtain additional documentation, data, information, and testimony.

(D)(1) Orders entered pursuant to subsection (C)(1) must be accompanied by findings and conclusions resulting from the director’s or his designee’s consideration and review of the examination report, relevant examiner work papers, and written submissions or rebuttals. The order must be considered a final administrative decision and may be appealed to the Administrative Law Court as provided by law. The order must be served upon the insurer by certified mail, with a copy of the adopted examination report. Within thirty days of the issuance of the adopted report, the insurer shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(2) A hearing conducted under subsection (C)(3) by the director or his authorized representative must be conducted as a nonadversarial, confidential investigatory proceeding as necessary for the resolution of inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the director’s or his designee’s review of relevant work papers or by the written submission or rebuttal of the insurer. Within twenty days of the conclusion of the hearing, the director or his designee shall enter an order pursuant to subsection (C)(1).

(a) The director may not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the insurer limited to the examiner’s work papers which tend to substantiate assertions set forth in a written submission or rebuttal. The director or his representative may issue subpoenas for the attendance of witnesses or the production of documents considered relevant to the investigation whether under the control of the department, the insurer, or other persons. The documents produced must be included in the record, and testimony taken by the director or his representative must be under oath and preserved for the record. Nothing contained in this section requires the department to disclose information or records which indicate or show the existence or content of an investigation or activity of a criminal justice agency.

(b) The hearing shall proceed with the director or his representative posing questions to the person subpoenaed. After the questions the insurer and the department may present testimony relevant to the investigation. Cross examination may be conducted only by the director or his representative. The insurer and the department may make closing statements and be represented by counsel of their choice.

(E)(1) Upon completion of the examination report under subsection (C)(1), the director or his designee shall hold the content of the examination report as private and confidential information for the thirty‑day period provided for written submissions or rebuttals. Thirty days after the examination report has been submitted to it if the insurer examined has neither notified the director or his designee of its acceptance and approval of the report nor requested to be heard on it, the report must be filed as a public document and is open to public inspection, as long as no court of competent jurisdiction has stayed its publication.

(2) This section does not prohibit the director or his designee from disclosing the content of an examination report, preliminary examination report, or results or related matters to the insurance department of this or another state or country, or law enforcement officials of this or another state or agency of the federal government so long as the agency or office receiving the reports, results, or related matters agrees in writing to hold them confidential and in a manner consistent with Sections 38‑13‑10 through 38‑13‑60.

(3) If the director or his designee determines that regulatory action is appropriate as a result of an examination, he may initiate proceedings or actions provided by law.

(F) All work papers, recorded information, documents, and their copies produced by, obtained by, or disclosed to the director, his designee, or other persons in the course of an examination made under this chapter must be given confidential treatment, are not subject to subpoena, and must not be made public by the director, or other persons, except to the extent provided in subsection (E). Access also may be granted to the National Association of Insurance Commissioners. The parties shall agree in writing before receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the insurer to which it pertains has been obtained or unless ordered by a court of competent jurisdiction. The information may be provided to the consumer advocate as provided in Section 37‑6‑605 pursuant to an appropriate proprietary agreement to ensure confidentiality.

HISTORY: Former 1976 Code Section 38‑13‑30 [1947 (45) 322; 1952 Code Section 37‑603; 1962 Code Section 37‑603] recodified as Section 38‑15‑10 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1260 [1947 (45) 322; 1952 Code Section 37‑283; 1962 Code Section 37‑283] recodified as Section 38‑13‑30 by 1987 Act No. 155, Section 1; 1992 Act No. 394, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑40.** Examiners not to be appointed if conflict of interest exists; exceptions.

(A) No examiner may be appointed by the director if the examiner, directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in a person subject to examination under Section 38‑13‑10. This section does not preclude automatically an examiner from being:

(1) a policyholder or claimant under an insurance policy;

(2) a grantor of a mortgage or similar instrument on the examiner’s residence to a regulated entity if done under customary terms and in the ordinary course of business;

(3) an investment owner in shares of regulated diversified investment companies; or

(4) a settlor or beneficiary or a ‘blind trust’ into which otherwise impermissible holdings have been placed.

(B) Notwithstanding the requirements of this section, the director may retain on an individual basis qualified actuaries, certified public accountants, or other similar individuals who are practicing their professions independently, even though the persons may be employed or retained similarly by persons subject to examination under Section 38‑13‑10.

HISTORY: Former 1976 Code Section 38‑13‑40 [1947 (45) 322; 1952 Code Section 37‑604; 1962 Code Section 37‑604] recodified as Section 38‑15‑20 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1270 [1947 (45) 322; 1952 Code Section 37‑284; 1962 Code Section 37‑284] recodified as Section 38‑13‑40 by 1987 Act No. 155, Section 1; 1992 Act No. 394, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑50.** Insurer to pay cost of examination; civil action to recover costs.

The insurer shall pay the charges incurred in the examination, including the expenses of the director or his designee and the expenses and compensation of his examiners and assistants. The director or his designee promptly shall institute a civil action to recover the expenses of examination against an insurer which refuses or fails to pay.

HISTORY: Former 1976 Code Section 38‑13‑50 [1947 (45) 322; 1948 (45) 1734; 1949 (46) 600; 1952 Code Section 37‑605; 1962 Code Section 37‑605; 1966 (54) 2141; 1975 (59) 318; 1986 Act No. 429, Section 3] recodified as Section 38‑15‑30 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1280 [1947 (45) 322; 1952 Code Section 37‑285; 1962 Code Section 37‑285] recodified as Section 38‑13‑50 by 1987 Act No. 155, Section 1; 1992 Act No. 394, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑60.** Immunity from liability; recovery of attorney fees and costs if prevailing party.

(A) No cause of action may arise nor may liability be imposed against:

(1) the director, the director’s authorized representatives or his designees, or an examiner appointed by the director for statements made or conduct performed in good faith while carrying out Sections 38‑13‑10 through 38‑13‑40;

(2) a person for communicating or delivering information or data to the director or the director’s authorized representative or examiner pursuant to an examination made under Sections 38‑13‑10 through 38‑13‑40 if the communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(B) This section does not abrogate or modify common law or statutory privilege or immunity enjoyed by a person identified in subsection (A).

(C) A person identified in subsection (A) may receive attorney’s fees and costs if he is the prevailing party in a civil cause of action for libel, slander, or another relevant tort arising out of his activities in carrying out Sections 38‑13‑10 through 38‑13‑40 and the party bringing the action was not justified substantially in doing so. For purposes of this section a proceeding is “substantially justified” if it had a reasonable basis in law or fact at the time that it was initiated.

HISTORY: Former 1976 Code Section 38‑13‑60 [1947 (45) 322; 1952 Code Section 37‑606; 1962 Code Section 37‑606] recodified as Section 38‑15‑40 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1290 [1947 (45) 322; 1952 Code Section 37‑286; 1962 Code Section 37‑286] recodified as Section 38‑13‑60 by 1987 Act No. 155, Section 1; 1992 Act No. 394, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑70.** Investigation of charges; liability for expenses.

Upon his own motion or upon written complaint filed by a citizen of this State that an insurer has violated this title, the director or his designee shall investigate the matter and, if necessary, examine under oath the president and other officers or agents of the insurer and all books, records, and papers of the insurer. If the director or his designee finds upon substantial evidence that a complaint against an insurer is justified, the insurer, in addition to the penalties imposed for violation of this title, is liable for the expenses of the investigation, and the director or his designee shall promptly present the insurer with a statement of the expenses. If the insurer refuses or neglects to pay, the director or his designee is authorized to revoke its license and to bring civil action for the collection of the expenses.

HISTORY: Former 1976 Code Section 38‑13‑70 [1947 (45) 322; 1952 Code Section 37‑607; 1962 Code Section 37‑607] recodified as Section 38‑15‑50 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1240 [1947 (45) 322; 1952 Code Section 37‑287; 1962 Code Section 37‑287] recodified as Section 38‑13‑70 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑80.** Annual statement as to business standing and financial condition.

(A) Every insurer annually shall file with the department by March first, in the form and detail the director or his designee prescribes, a statement showing the business standing and financial condition of the insurer on December thirty‑first of the preceding year, except that upon timely written request by the chief managing agent or officer setting forth reasons why the statement cannot be filed within the time provided, the director or his designee may grant in writing an extension of filing time for not more than thirty days. This statement must conform substantially to the form of statement adopted by the National Association of Insurance Commissioners. Unless the director or his designee provides otherwise, the annual statement is to be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners. The annual statement must be verified by at least two of its principal officers, at least one of whom prepared or supervised the preparation of the annual statement.

(B) The director or his designee may require every insurer to file quarterly reports and additional information considered necessary to enable the director or his designee to carry out his duties under this chapter. The reports and information must be furnished in the time and manner prescribed by the director or his designee.

HISTORY: Former 1976 Code Section 38‑13‑80 [1947 (45) 322; 1952 Code Section 37‑608; 1962 Code Section 37‑608] recodified as Section 38‑15‑60 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1300 [1947 (45) 322; 1952 Code Section 37‑293; 1962 Code Section 37‑293; 1964 (53) 2054; 1972 (57) 2529; 1979 Act No. 25] recodified as Section 38‑13‑80 by 1987 Act No. 155, Section 1; 1988 Act No. 324; 1990 Act No. 367, Section 1; 1993 Act No. 181, Section 537; 2000 Act No. 312, Section 5.

**SECTION 38‑13‑85.** Annual statement to be filed with National Association of Insurance Commissioners; immunity from liability for disseminating information; confidentiality of information.

(a) Every insurer who is authorized to write insurance in this State shall file annually with the National Association of Insurance Commissioners by March first a copy of its annual statement convention blank along with any additional filings prescribed by the director or his designee for the preceding year. The information filed with the National Association of Insurance Commissioners must be in the same format and scope as that required by the director or his designee and must include the signed jurat page and the actuarial certification. Any amendments and addenda to the annual statement filing subsequently filed with the director or his designee also must be filed with the National Association of Insurance Commissioners. Foreign insurers domiciled in a state which has a law substantially similar to this subsection are considered in compliance with this subsection.

(b) In the absence of actual malice, members of the National Association of Insurance Commissioners, their authorized committees, subcommittees, and task forces, their delegates, National Association of Insurance Commissioners’ employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks are acting as agents of the director or his designee under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required by this subsection.

(c) All financial analysis ratios and examination synopses concerning insurers submitted to the department by the National Association of Insurance Commissioners’ Insurance Regulatory Information System are confidential and may not be disclosed by the department.

HISTORY: 1988 Act No. 332; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑90.** Publication of assets and liabilities.

No insurer may publish a statement of its assets and liabilities unless it shows both its assets and liabilities with equal conspicuousness. The statement shall reflect the assets and liabilities as were shown on the last annual statement or subsequent report of examination accepted by the director or his designee unless the director or his designee has given prior written approval to the publishing of a statement as of another date. Any publication purporting to show the capital of the insurer shall exhibit only the amount of capital actually paid in. An insurer or agent violating this section is subject to the penalties provided in Section 38‑2‑10.

HISTORY: Former 1976 Code Section 38‑13‑90 [1947 (45) 322; 1952 Code Section 37‑609; 1962 Code Section 37‑609] recodified as Section 38‑15‑70 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1310 [1947 (45) 322; 1952 Code Section 37‑289; 1958 (50) 1607; 1960 (51) 1646; 1962 Code Section 37‑289] recodified as Section 38‑13‑90 by 1987 Act No. 155, Section 1; 1988 Act No. 374, Section 6; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑100.** Items to be included as liabilities in financial statements.

In any determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include:

(1) The amount of its capital stock outstanding, if any;

(2) The amount, estimated consistent with provisions of the law and rulings of the director or his designee, necessary to pay all its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement;

(3) With reference to life and accident and health insurance and annuity contracts:

(a) the amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted pursuant to Section 38‑9‑180 which are applicable,

(b) reserves for disability benefits, for both active and disabled lives,

(c) reserves for accidental death benefits, and

(d) any additional reserves which may be reasonably required by the director or his designee;

(4) With reference to insurance other than specified in the law and rulings of the director or his designee, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with the law and rulings of the director or his designee; and

(5) Taxes, expenses, and other obligations due or accrued at the date of the statement.

HISTORY: Former 1976 Code Section 38‑13‑100 [1947 (45) 322; 1952 Code Section 37‑610; 1962 Code Section 37‑610] recodified as Section 38‑15‑80 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1320 [1958 (50) 1608; 1962 Code Section 37‑289.1] recodified as Section 38‑13‑100 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑110.** Treatment of contingent debts or liabilities in financial statements.

Contingent debts or liabilities of domestic insurers must be set forth in financial statements in the following manner:

(1) in the event a contingent liability or surplus certificate liability is in the form of certain borrowings provided for under Section 38‑19‑610 and the borrowings are made by a domestic mutual insurer insuring properties only, then the obligation of the corporation or association must be shown as a footnote on any published financial statement of the corporation or association;

(2) in the event a contingent liability or surplus certificate liability of the corporation is in connection with a domestic mutual assessment association or other form of domestic mutual insurer having issued and in force policies containing an assessment provision for either life insurance or property insurance, then the liability must be set forth as a footnote on any published financial statement of the corporation or association;

(3) in the event that a domestic mutual insurer has outstanding or is issuing a contract that does not contain an assessment provision, then the statement of assets and liabilities shall show as a part of the liabilities the face amount of the liability, with a footnote explaining that payment of the liability must be made out of the surplus earnings of the insurer and, in the event of dissolution of the corporation or association, is a junior liability to the claims of the policyholders but a senior liability to the distribution of any remaining assets to policyholders; and

(4) in the event there is a contingent liability or a surplus certificate liability outstanding in connection with any domestic capital stock insurance corporation, the full face amount of the liability must be separately stated as a part of the surplus of the insurer and is considered to be a junior liability to policyholders’ reserves and claimants’ liabilities but is considered a senior liability, either in the event of dissolution or for statement purposes, to that which otherwise would be a liability to the stockholders.

HISTORY: Former 1976 Code Section 38‑13‑110 [1947 (45) 322; 1952 Code Section 37‑611; 1962 Code Section 37‑611] recodified as Section 38‑15‑90 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1330 [1958 (50) 1611; 1962 Code Section 37‑289.2] recodified as Section 38‑13‑110 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑120.** Record of business done; inspection by Director or designee.

All companies doing any kind of insurance business in this State shall make and keep a full and correct record of the business done by them, showing the number, date, term, amount insured, premiums, and the person to whom issued of every policy or certificate of renewal. This information must be furnished to the director or his designee on demand, and the original books or record must be open to the inspection of the director or his designee on demand. These records must be kept for a minimum of five years.

HISTORY: Former 1976 Code Section 38‑13‑120 [1947 (45) 322; 1952 Code Section 37‑612; 1962 Code Section 37‑612] recodified as Section 38‑15‑90 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1210 [1947 (45) 322; 1952 Code Section 37‑290; 1962 Code Section 37‑290] recodified as Section 38‑13‑120 by 1987 Act No. 155, Section 1; 1988 Act No. 357, Section 2; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑130.** Records of losses and claims.

Every insurer doing business in this State shall maintain a record of losses paid under its policies and notices as provided in its policies which may normally result in claim or loss. The records must be maintained until the next regular examination by an insurance department or for a period of five years from the date of payment of the loss or receipt of the notice.

HISTORY: Former 1976 Code Section 38‑13‑130 [1947 (45) 322; 1952 Code Section 37‑613; 1962 Code Section 37‑613] recodified as Section 38‑15‑100 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1340 [1956 (49) 1740; 1962 Code Section 37‑290.1] recodified as Section 38‑13‑130 by 1987 Act No. 155, Section 1; 1988 Act No. 357, Section 3; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑140.** Refusal to exhibit records; false statements; confidentiality of replies.

A person who has in his possession or control any books, accounts, or papers of a company licensed under this title shall exhibit them to the director or to any deputy, actuary, accountant, or person acting with or for the director. A person who refuses, on demand, to exhibit any books, accounts, or papers or knowingly or wilfully makes a false statement in regard to them is guilty of a misdemeanor and, upon conviction, must be fined in the discretion of the court or imprisoned for not more than three years, or both. All replies are strictly confidential except for the purposes of prosecution for any false or fraudulent statement made to the director or his designee.

HISTORY: Former 1976 Code Section 38‑13‑140 [1947 (45) 322; 1952 Code Section 37‑614; 1962 Code Section 37‑614] has no comparable provisions in 1987 Act No. 155; Former 1976 Code Section 38‑5‑1370 [1947 (45) 322; 1952 Code Section 37‑291; 1962 Code Section 37‑291] recodified as Section 38‑13‑140 by 1987 Act No. 155, Section 1; 1993 Act No. 184, Section 210; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑150.** Returns of reinsurance by insurers; effect of refusal.

Every insurer shall file a return, on a form and at times prescribed by the director or his designee, showing all reinsurance or cessions of risk or liability contracted for or effected by it, whether by issue of policy, entry, or bordereau, general participation agreement, excess loss reinsurance, or in any manner whatsoever, upon property located in this State or covering, whether specified or otherwise, any risk or liability upon property so located. The return must be certified by the oath of its president and secretary, if a company of the United States, and, if a company of a foreign country, by the oath of its managers in the United States as to reinsurance or cessions effected through its branch office in the United States and by the oath of its president and secretary or by officers corresponding thereto, at its home office, wherever located, as to reinsurance or cessions contracted for or effected through the foreign office. The refusal of an insurer to file the required return is presumptive evidence that it is guilty of violating the provisions of Section 38‑9‑190.

HISTORY: Former 1976 Code Section 38‑13‑150 [1947 (45) 322; 1952 Code Section 37‑615; 1962 Code Section 37‑615] has no comparable provision in 1987 Act No. 155; Former 1976 Code Section 38‑5‑1350 [1947 (45) 322; 1952 Code Section 37‑292; 1962 Code Section 37‑292] recodified as Section 38‑13‑150 by 1987 Act No. 155, Section 1; 1988 Act No. 374, Section 7; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑160.** Director or designee may require special reports; confidentiality of replies.

The director or his designee may require any authorized insurer or its officers to answer any inquiry in relation to its transactions, condition, or any connected matter necessary to the administration of the insurance laws of the State. Every corporation or person must reply in writing to the inquiry promptly and truthfully, and the reply must be verified, if required by the director or his designee, by the individual or by the officer or officers of a corporation as he designates. These replies are strictly confidential.

HISTORY: Former 1976 Code Section 38‑13‑160 [1947 (45) 322; 1952 Code Section 37‑616; 1962 Code Section 37‑616] has no comparable provisions in 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑5‑1360 [1947 (45) 322; 1952 Code Section 37‑294; 1962 Code Section 37‑294] recodified as Section 38‑13‑160 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑170.** Penalties for making or aiding in making false statement.

If an insurer, in its annual or other statement required by law, wilfully misstates the facts, the insurer and the person signing the statement and any person aiding, abetting, or participating in the making of the statement are guilty of a felony, and upon conviction, must be fined not more than two thousand dollars or imprisoned not more than five years, or both. The insurer, upon conviction, forfeits its right to do business in this State.

HISTORY: Former 1976 Code Section 38‑13‑170 [1947 (45) 322; 1952 Code Section 37‑617; 1962 Code Section 37‑617] has no comparable provisions in 1987 Act No. 155; Former 1976 Code Section 38‑5‑1380 [1947 (45) 322; 1952 Code Section 37‑295; 1956 (49) 1834; 1962 Code Section 37‑295] recodified as Section 38‑13‑170 by 1987 Act No. 155, Section 1; 1993 Act No. 184, Section 66; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑180.** Insurance reserve fund defined.

For purposes of Sections 38‑13‑190 and 38‑13‑200, “insurance reserve fund” or “funds” means the insurance reserve funds administered by the State Fiscal Accountability Authority to provide liability and property insurance, as authorized under Section 1‑11‑140, Chapter 7 of Title 10, and the regulations prescribed by the State Fiscal Accountability Authority.

HISTORY: Former 1976 Code Section 38‑5‑840 [En, 1983 Act No. 151, Part II, Section 55] recodified as Section 38‑13‑180 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 537.

Code Commissioner’s Note

At the direction of the Code Commissioner, references in this section to the offices of the former State Budget and Control Board, Office of the Governor, or other agencies, were changed to reflect the transfer of them to the Department of Administration or other entities, pursuant to the directive of the South Carolina Restructuring Act, 2014 Act No. 121, Section 5(D)(1), effective July 1, 2015.

**SECTION 38‑13‑190.** Commissioner to examine affairs and methods of operations of insurance reserve fund; reports of findings.

(1) At the end of each three years of operation, and at any other time considered prudent, the director or his designee shall examine the affairs of the insurance reserve funds and make findings and recommendations as provided by this section. For purposes of examination, the director or person making the examination has free access to all relevant records, books, and papers in the possession of any person or entity and may summon, administer oaths to, and examine as witnesses any persons in relation to matters relevant to the examination.

(2) The director or his designee shall examine all methods of operation of the insurance reserve funds to determine whether the funds are being administered in accordance with sound insurance practices and in the best interest of the State. Following the examination, the director or his designee shall prepare a report for submission, through the State Fiscal Accountability Authority, to the Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate containing his findings and conclusions and any recommendations to improve the efficiency, effectiveness, and overall operation of the funds.

HISTORY: Former 1976 Code Section 38‑5‑850 [1983 Act No. 151, Part II, Section 55] recodified as Section 38‑13‑190 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 537.

Code Commissioner’s Note

At the direction of the Code Commissioner, references in this section to the offices of the former State Budget and Control Board, Office of the Governor, or other agencies, were changed to reflect the transfer of them to the Department of Administration or other entities, pursuant to the directive of the South Carolina Restructuring Act, 2014 Act No. 121, Section 5(D)(1), effective July 1, 2015.

**SECTION 38‑13‑200.** Penalty for refusal to be examined under oath.

Any person or entity having possession or control of any records, books, or papers relevant to an insurance reserve fund examination who fails or refuses to be examined under oath is guilty of a misdemeanor and upon conviction must be punished by a fine of not more than ten thousand dollars or imprisonment for not more than one year and is subject to suspension or revocation of any insurance licenses issued by the director or his designee.

HISTORY: Former 1976 Code Section 38‑5‑860 [En, 1983 Act No. 151, Part II, Section 55] recodified as Section 38‑13‑200 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 537.

ARTICLE 3

Reports of Loss and Expense Experience

**SECTION 38‑13‑300.** Regulations requiring insurer to report its loss and expense experience and other data.

The director may require insurers licensed to write property or casualty insurance in the State to record and report loss and expense experience and any other data necessary to determine whether rates are excessive, inadequate, or unfairly discriminatory. The director or his designee may designate one or more statistical agents, organizations, or advisory organizations to gather and compile this experience and data. In addition, the director may require each insurer licensed to write property and casualty insurance in this State, as a supplement to its annual statement, to submit a report on a form furnished by the department showing the insurer’s direct writings in this State and the United States and any information required by Sections 38‑13‑310 and 38‑13‑320.

The director may adopt data disclosure requirements developed by the National Association of Insurance Commissioners. If adopted, the NAIC disclosure requirements must be deemed to be in full compliance with the reporting requirements of Sections 38‑13‑300 through 38‑13‑360.

HISTORY: 1987 Act No. 166, Section 11; 1993 Act No. 181, Section 537; 1997 Act No. 68, Section 2.

**SECTION 38‑13‑310.** Supplemental report.

The supplemental report required by Section 38‑13‑300 may include, but is not limited to, the following types of insurance written by the insurer:

(a) political subdivision liability insurance reported separately in the following categories:

(1) municipalities;

(2) school districts;

(3) other political subdivisions;

(b) public official liability insurance;

(c) dram shop liability insurance;

(d) day care center liability insurance;

(e) labor, fraternal, or religious organizations liability insurance;

(f) errors and omissions liability insurance;

(g) officers and directors liability insurance reported separately as follows:

(1) nonprofit entities;

(2) for‑profit entities;

(h) products liability insurance;

(i) medical malpractice insurance;

(j) attorney malpractice insurance;

(k) architects and engineers malpractice insurance; and

(l) motor vehicle insurance reported separately for commercial and private passenger vehicles as follows:

(1) motor vehicle liability insurance first‑party benefits;

(2) motor vehicle bodily injury liability insurance;

(3) motor vehicle property liability insurance;

(4) uninsured motorist insurance; and

(5) underinsured motorist insurance.

HISTORY: 1987 Act No. 166, Section 12; 1993 Act No. 181, Section 537; 1997 Act No. 68, Section 3.

**SECTION 38‑13‑320.** Data in supplemental report.

The supplemental report may include, but is not limited to, the following data both as to this State and the United States for the previous year ending on December thirty‑first:

(a) direct premiums written,

(b) direct premiums earned,

(c) net investment income, including net realized capital gains and losses, using appropriate estimates where necessary,

(d) incurred claims, developed as the sum of the following (the report shall include data for each of the following categories used to develop the sum of incurred claims):

(1) dollar amount of claims closed with payment, plus

(2) dollar amount of payments on claims still open, plus

(3) reserves for reported claims at the end of the current year, minus

(4) reserves for reported claims at the end of the previous year, plus

(5) reserves for incurred but not reported claims at the end of the current year, minus

(6) reserves for incurred but not reported claims at the end of the previous year, plus

(7) loss adjustment expenses for claims closed, plus

(8) reserves for loss adjustment expense at the end of the current year, minus

(e) actual incurred expenses allocated separately to loss adjustment, commissions, other acquisition costs, advertising, general office expenses, taxes, licenses and fees, and all other expenses;

(f) net underwriting gain or loss;

(g) net operation gain or loss, including net investment income;

(h) the number and dollar amount of claims closed with payment, by year incurred and the amount reserved for them;

(i) the number of claims closed without payment and the dollar amount reserved for those claims;

(j) federal income tax recoverable; and

(k) any other information requested by the director or his designee.

HISTORY: 1987 Act No. 166, Section 13; 1993 Act No. 181, Section 537; 1997 Act No. 68, Section 4.

**SECTION 38‑13‑340.** Review of supplemental reports.

The department shall annually compile and review reports submitted by insurers pursuant to this article by order of the director to determine the appropriateness of premium rates for property and casualty insurance in this State. Any findings and filings of the department must be published, provided to the General Assembly, and made available to any interested insured or citizen, subject to the cost of copying. If the director or his designee finds at any time that any rate is excessive, inadequate, or unfairly discriminatory, he shall issue an order withdrawing its approval. The order shall specify reasons for withdrawal of approval and must be furnished to each affected insurer and rating organization. Any such order is effective not less than sixty days from its issuance unless an affected insurer meets the burden of showing that the rate is fair and appropriate.

HISTORY: 1987 Act No. 166, Section 15; 1993 Act No. 181, Section 537; 1997 Act No. 68, Section 5.

**SECTION 38‑13‑350.** Filing of required information.

Each insurance company shall file all of the information required under Sections 38‑13‑300 through 38‑13‑360 with the department as a prerequisite to obtaining permission to write coverage, to continue to do business, or to file for rate increases.

HISTORY: 1987 Act No. 166, Section 16; 1993 Act No. 181, Section 537.

**SECTION 38‑13‑360.** Penalty for failure to comply with provisions of article.

Each insurer who fails to comply with the terms of Sections 38‑13‑300 through 38‑13‑350 shall pay a civil penalty of a fine of twenty thousand dollars and thereafter a fine of one thousand dollars daily until the named sections of the article are complied with.

HISTORY: 1987 Act No. 166, Section 17; 1993 Act No. 181, Section 537.

ARTICLE 5

Report Disclosing Acquisitions and Dispositions of Assets, and Ceded Reinsurance Agreements.

**SECTION 38‑13‑400.** Report disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions; when due; confidentiality.

(A) Effective January 1, 1995, each insurer domiciled in this State and, effective July 1, 2006, each health maintenance organization domiciled in this State, shall file a report with the director or his designee disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements, unless these acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the director or his designee for review, approval, or information purposes pursuant to other provisions of the insurance laws, regulations, or other requirements.

(B) The report required in subsection (A) is due within fifteen days after the end of the calendar month in which any of the foregoing transactions occur.

(C) All reports obtained by or disclosed to the director or his designee, pursuant to this section or Section 38‑13‑410 or 38‑13‑420 must be given confidential treatment and are not subject to subpoena and may not be made public by the director, his designee, or any other person, except to insurance departments of other states, without the prior written consent of the insurer or health maintenance organization to which it pertains, unless the director or his designee, after giving the insurer or health maintenance organization that is affected notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public is best served by the publication of the reports, then the director or his designee may publish all or any part of them in the manner as the director or his designee considers appropriate.

HISTORY: 1994 Act No. 372, Section 1; 2006 Act No. 332, Section 3, eff June 1, 2006.

**SECTION 38‑13‑410.** Exceptions to reporting requirements; material acquisitions or dispositions defined; information to be disclosed; report to be on nonconsolidated basis; exceptions.

(A) Acquisitions or dispositions of assets may not be reported pursuant to Section 38‑13‑400 if the acquisitions or dispositions are not material. For purposes of this section and Sections 38‑13‑400 and 38‑13‑420, a material acquisition or the aggregate of any series of related acquisitions during any thirty‑day period, or disposition or the aggregate of any series of related dispositions during any thirty‑day period is one that is nonrecurring and not in the ordinary course of business and involves more than five percent of the total admitted assets as reported in the most recent annual statement of the insurer or health maintenance organization as filed with the director or his designee.

(B)(1) Asset acquisitions subject to this section and Sections 38‑13‑400 and 38‑13‑420 include each purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or health maintenance organization or the acquisition of materials for that purpose.

(2) Asset dispositions subject to this section and Sections 38‑13‑400 and 38‑13‑420 include each sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment (whether for the benefit of creditors or otherwise), abandonment, destruction, or other disposition.

(C)(1) The following information must be disclosed in any report of a material acquisition or disposition of assets:

(a) date of the transaction;

(b) manner of acquisition or disposition;

(c) description of the assets involved;

(d) nature and amount of the consideration given or received;

(e) purpose of, or reason for, the transaction;

(f) manner by which the amount of consideration was determined;

(g) gain or loss recognized or realized as a result of the transaction; and

(h) names of the persons from whom the assets were acquired or to whom they were disposed.

(2) An insurer and a health maintenance organization shall report material acquisitions and dispositions on a nonconsolidated basis unless the insurer or health maintenance organization is part of a consolidated group of insurers or health maintenance organizations which utilize a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer’s or health maintenance organization’s reserves and the insurer or health maintenance organization ceded substantially all of its direct and assumed business to the pool. An insurer or a health maintenance organization is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer or a health maintenance organization has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer’s or health maintenance organization’s capital and surplus.

HISTORY: 1994 Act No. 372, Section 1; 2006 Act No. 332, Section 4, eff June 1, 2006.

**SECTION 38‑13‑420.** Exceptions to reporting requirements; material nonrenewals, cancellations, or revisions of ceded reinsurance agreements defined; information to be disclosed; report to be on nonconsolidated basis; exceptions.

(A) Nonrenewals, cancellations, or revisions of ceded reinsurance agreements may not be reported pursuant to Section 38‑13‑400 if the nonrenewals, cancellations, or revisions are not material. For purposes of this section and Sections 38‑13‑400 and 38‑13‑410, a material nonrenewal, cancellation, or revision is one that affects, for property and casualty business, including accident and health business when written as such, more than fifty percent of an insurer’s or health maintenance organization’s ceded written premium, or, for life, annuity, and accident and health business, more than fifty percent of the total reserve credit taken for business ceded, on an annualized basis as indicated in the insurer’s or health maintenance organization’s most recently filed annual statement. However, a filing is not required if the insurer’s or health maintenance organization’s ceded written premium or the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of direct plus assumed written premium or ten percent of the statutory reserve requirement before any cession, respectively.

(B) Subject to the criteria outlined in subsection (A) of this section, a report must be filed without regard to which party has initiated the nonrenewal, cancellation, or revision of ceded reinsurance whenever one or more of the following conditions exist:

(1) the entire cession has been canceled, nonrenewed, or revised and ceded indemnity and loss adjustment expense reserves after any nonrenewal, cancellation, or revision represent less than fifty percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation, or revision not occurred;

(2) an authorized or accredited reinsurer has been replaced on an existing cession by an unauthorized reinsurer; or

(3) collateral requirements previously established for unauthorized reinsurers have been reduced; e.g., the requirement to collateralize incurred but not reported (IBNR) claim reserves has been waived with respect to one or more unauthorized reinsurers newly participating in an existing cession.

Subject to the materiality criteria outlined in subsection (A) of this section, for purposes of items (2) and (3), a report must be filed if the result of the revision affects more than ten percent of the cession.

(C)(1) The following information must be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) effective date of the nonrenewal, cancellation, or revision;

(b) the description of the transaction with an identification of the initiator of the transaction;

(c) purpose of, or reason for, the transaction; and

(d) if applicable, the identity of the replacement reinsurers.

(2) An insurer and a health maintenance organization are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer or health maintenance organization is part of a consolidated group of insurers or health maintenance organizations which utilizes a pooling arrangement or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer’s or health maintenance organization’s reserves and the insurer or health maintenance organization ceded substantially all of its direct and assumed business to the pool. An insurer or a health maintenance organization is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer or health maintenance organization has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer’s or health maintenance organization’s capital and surplus.

HISTORY: 1994 Act No. 372, Section 1; 2006 Act No. 332, Section 5, eff June 1, 2006.

ARTICLE 7

Examinations, Investigations, and Reports of the Department of Employment and Workforce

**SECTION 38‑13‑700.** Periodic examination of unemployment compensation fund; duties of director.

(A) At least every five years, or upon request pursuant to Section 38‑13‑710, the director must conduct an examination of the unemployment compensation fund administered by the Department of Employment and Workforce. Examinations scheduled by the director must include at least a detailed accounting of the revenue and expenditures of the fund and an analysis of the current and future solvency of the fund.

(B) In scheduling and determining the nature, scope, and frequency of examinations, the director shall consider compliance with relevant federal and South Carolina laws and regulations, the results of previous examinations, changes in management, and reports of the audits performed by the Legislative Audit Council.

(C) For purposes of completing an examination of an insurer under this article, the director may examine or investigate the Department of Employment and Workforce in a manner considered necessary or material by the director.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

**SECTION 38‑13‑710.** Who may request examination; contents of request.

(A) An examination of the unemployment compensation fund may be initiated upon the request of either:

(1) the Chairman of the Senate Labor, Commerce and Industry Committee or the Chairman of the Senate Finance Committee and the President Pro Tempore; or

(2) the Chairman of the House of Representatives Labor, Commerce and Industry Committee or the Chairman of the House of Representatives Ways and Means Committee and the Speaker of the House of Representatives.

(B) The request must describe the issues upon which the requestor would like for the examination to focus.

(C) The director must consult with the requestors to determine the appropriate scope of the examination.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

**SECTION 38‑13‑720.** Free access to books, records, and other materials relating to examination; powers of director.

(A) The Department of Employment and Workforce must provide timely, convenient, and free access to all books, records, accounts, papers, documents, and computer or other recordings relating to the subject of the examination. If the director considers it necessary to the conduct of the examination, he may require that the Department of Employment and Workforce furnish the original books and records. The Executive Director of the Department of Employment and Workforce shall facilitate the examination and aid in the examination.

(B) The director may issue subpoenas, administer oaths, and examine under oath a person as to matters pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the director may petition a court of competent jurisdiction, and upon proper showing the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(C) When making an examination pursuant to this article, the director may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of the retainment must be borne by the Department of Employment and Workforce. Examination fees must be retained by the department and are considered “other funds”.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

**SECTION 38‑13‑730.** Verification of data provided by department; sample data testing.

In addition to any other recognized and appropriate examination methodologies, when conducting an examination, the department must utilize sample data testing to verify the accuracy of information provided by the Department of Employment and Workforce.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

**SECTION 38‑13‑740.** Examination reports; contents; submission to General Assembly; availability on Internet websites.

The results of each examination must be compiled in a report. Examination reports must be comprised of only facts appearing on the books, records, or other documents maintained by the Department of Employment and Workforce and as ascertained from the testimony of the executive director and any other employees examined concerning the subject of the examination, and the conclusions and recommendations of the director that he finds warranted from the facts. The reports must be submitted to the General Assembly, the Review Committee, and the Governor, and made available on the Internet websites maintained by the Department of Insurance and the Department of Employment and Workforce.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

**SECTION 38‑13‑750.** Conflict of interest prohibited.

The director may not assign an examiner that has a conflict of interest.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

**SECTION 38‑13‑760.** Department to pay charges.

The Department of Employment and Workforce shall pay the charges incurred in the examination, including the expenses of the director and the expenses and compensation of his examiners and assistants.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

**SECTION 38‑13‑770.** Inquiries regarding administration of unemployment compensation fund; prompt written reply.

The director may require the Department of Employment and Workforce to answer any inquiry in relation to the administration of the unemployment compensation fund. The Executive Director of the Department of Employment and Workforce must promptly reply in writing.

HISTORY: 2010 Act No. 146, Section 117, eff March 30, 2010.

ARTICLE 8

Own Risk and Solvency Assessment

**SECTION 38‑13‑810.** Purpose; application; findings.

Section effective January 1, 2018.

(A) The purpose of this article is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment (ORSA) and provide guidance and instructions for filing an ORSA Summary Report with the insurance director of this State.

(B) The requirements of this article apply to all insurers domiciled in this State unless exempt pursuant to Section 38‑13‑860.

(C) The General Assembly finds and declares that an ORSA Summary Report contains confidential and sensitive information related to an insurer or insurance group’s identification of risks material and relevant to the insurer or insurance group filing the report. This information includes proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of the General Assembly that:

(1) an ORSA Summary Report, including all documents, materials, or other information related to its preparation, is a confidential document filed with the director and only may be shared as stated in this article;

(2) an ORSA Summary Report will be used to assist the director in the performance of his duties; and

(3) in no event may an ORSA Summary Report and its accompanying documents be subject to public disclosure.

(D) Nothing in this section prohibits an order from a court of competent jurisdiction requiring an insurance company that is subject to this article to produce an ORSA Summary Report.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

Code Commissioner’s Note

At the direction of the Code Commissioner in 2017, in (A), “this article” was substituted for “this act” to correct a clerical error.

**SECTION 38‑13‑820.** Definitions.

Section effective January 1, 2018.

For purposes of this article, the term:

(1) “Director” means the Director of the Department of Insurance.

(2) “Insurance group” means insurers and affiliates included within an insurance holding company system.

(3) “Insurer” has the same meaning as set forth in Section 38‑1‑20, except the term does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(4) “Own Risk and Solvency Assessment” or “ORSA” means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group’s current business plan, and the sufficiency of capital resources to support those risks.

(5) “ORSA Guidance Manual” means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA Guidance Manual is effective on January first of the following calendar year in which the changes have been adopted by the NAIC.

(6) “ORSA Summary Report” means a confidential high‑level summary of an insurer or insurance group’s ORSA.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑830.** Risk management framework.

Section effective January 1, 2018.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑840.** Insurers required to conduct ORSA on no less than an annual basis.

Section effective January 1, 2018.

Subject to Section 38‑13‑860, an insurer, or the insurance group of which the insurer is a member, regularly shall conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA must be conducted no less than annually but also when significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member occur.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑850.** ORSA Summary Reports.

Section effective January 1, 2018.

(A) Upon the director’s request, and no more than once each year, an insurer shall submit to the director an ORSA Summary Report or a combination of reports that contain the information described in the ORSA Guidance Manual, applicable to the insurer and/or the insurance group of which it is a member. Notwithstanding a request from the director, if the insurer is a member of an insurance group, the insurer shall submit the reports required by this subsection if the director is the lead state director of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(B) The reports must include a signature of the insurer or insurance group’s chief risk officer or other executive having responsibility for the oversight of the insurer’s enterprise risk management process attesting to the best of his belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer’s board of directors or other appropriate committees.

(C) An insurer may comply with subsection (A) by providing the most recent and substantially similar reports provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. A report in a language other than English must be accompanied by a translation of that report into the English language.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑860.** Exemptions.

Section effective January 1, 2018.

(A) An insurer is exempt from the requirements of this article if the:

(1) insurer has annual direct written and unaffiliated assumed premiums, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than five hundred million dollars; and

(2) insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premiums including international direct and assumed premiums, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than one billion dollars.

(B) If an insurer qualifies for exemption pursuant to item (1) of subsection (A), but the insurance group of which the insurer is a member does not qualify for exemption pursuant to item (2) of subsection (A), the ORSA Summary Report that is required pursuant to Section 38‑13‑850 must include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for a combination of insurers provided the combination of reports includes every insurer within the insurance group.

(C) If an insurer does not qualify for exemption pursuant to item (1) of subsection (A), but the insurance group of which it is a member qualifies for exemption pursuant to item (2) of subsection (A), the only ORSA Summary Report that may be required pursuant Section 38‑13‑850 is the report applicable to that insurer.

(D) An insurer that does not qualify for exemption pursuant to subsection (A) may apply to the director for a waiver from the requirements of this article based upon unique circumstances. In deciding whether to grant the insurer’s request for waiver, the director may consider the type and volume of business written, ownership and organizational structure, and any other factor the director considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the director shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer’s request for a waiver.

(E) Notwithstanding the exemptions stated in this section, the director may require an insurer to maintain a risk management framework, conduct an ORSA, and file an ORSA Summary Report:

(1) based on unique circumstances including, but not limited to, the type and volume of business written, ownership, and organizational structure, federal agency requests, and international supervisor requests;

(2) if the insurer has risk‑based capital for a company action level event as set forth in Section 38‑9‑330, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in Section 38‑5‑120 or otherwise exhibits qualities of a troubled insurer as determined by the director.

(F) If an insurer that qualifies for an exemption pursuant to subsection (A) subsequently no longer qualifies for that exemption due to premium changes as reflected in the insurer’s most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer has one year following the year the threshold is exceeded to comply with the requirements of this article.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑870.** Preparation of ORSA Summary Report; review; requests for information.

Section effective January 1, 2018.

(A) The ORSA Summary Report must be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection (B). Documentation and supporting information must be maintained and made available upon examination or upon request by the director.

(B) The review of the ORSA Summary Report and additional requests for information must be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑880.** Confidentiality.

Section effective January 1, 2018.

(A) Documents, materials, or other information, including the ORSA Summary Report, in the possession or control of the department that are obtained by, created by, or disclosed to the director or another person under this article, are recognized by this State as being proprietary and to contain trade secrets. All such documents, materials, or other information are confidential by law and privileged, are not subject to Section 30‑4‑10, subpoena, discovery, and are not admissible as evidence in a private civil action. However, the director is authorized to use the documents, materials, or other information in furtherance of a regulatory or legal action brought as a part of the director’s official duties. The director may not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(B) The director or a person who received documents, materials, or other ORSA‑related information, through examination or otherwise, while acting under the authority of the director or with whom such documents, materials, or other information are shared pursuant to this article may not be permitted or required to testify in a private civil action concerning confidential documents, materials, or information subject to subsection (A).

(C) To assist in the performance of his regulatory duties, the director:

(1) may, upon request, share documents, materials, or other ORSA‑related information, including the confidential and privileged documents, materials, or information subject to subsection (A), including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of a supervisory college as defined in Section 38‑21‑10(10), with the NAIC and with any third‑party consultants designated by the director, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA‑related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(2) may receive documents, materials, or other ORSA‑related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade‑secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of a supervisory college as defined in Section 38‑21‑10(10) and from the NAIC, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(3) shall enter into a written agreement with the NAIC or a third‑party consultant governing sharing and use of information provided pursuant to this article, consistent with this subsection that:

(a) specifies procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third‑party consultant pursuant to this article, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers, provided, the agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA‑related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(b) specifies that ownership of information shared with the NAIC or a third‑party consultant pursuant to this article remains with the director and that the NAIC’s or a third‑party consultant’s use of the information is subject to the direction of the director;

(c) prohibits the NAIC or third‑party consultant from storing the information in a permanent database after the underlying analysis is completed;

(d) requires prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third‑party consultant pursuant to this article is subject to a request or subpoena to the NAIC or a third‑party consultant for disclosure or production;

(e) requires the NAIC or a third‑party consultant to consent to intervention by an insurer in a judicial or administrative action in which the NAIC or a third‑party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third‑party consultant pursuant to this article; and

(f) provides for the insurer’s written consent in the case of an agreement involving a third‑party consultant.

(D) The sharing of information and documents by the director pursuant to this article does not constitute a delegation of regulatory authority or rulemaking. The director is solely responsible for the administration, execution, and enforcement of the provisions of this article.

(E) No waiver of an applicable privilege or claim of confidentiality in the documents, proprietary, and trade‑secret materials or other ORSA‑related information may occur as a result of disclosure of this ORSA‑related information or documents to the director under this section or as a result of sharing authorized in this article.

(F) Documents, materials, or other information in the possession or control of the NAIC or a third‑party consultant pursuant to this article are:

(1) confidential by law and privileged;

(2) not subject to Section 30‑4‑10;

(3) not subject to subpoena; and

(4) not subject to discovery or admissible as evidence in a private civil action.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑890.** Penalties.

Section effective January 1, 2018.

An insurer who, without just cause, fails to timely file the ORSA Summary Report shall, after notice and hearing, pay a penalty of one thousand dollars for each day’s delay, to be recovered by the director. The penalty funds recovered must be paid into the General Revenue Fund of this State. The maximum penalty under this section is thirty thousand dollars. The director may reduce the penalty if the insurer demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the insurer.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

**SECTION 38‑13‑900.** Effective date.

Section effective January 1, 2018.

The requirements of this article become effective on January 1, 2018. The first filing of an ORSA Summary Report must take place in 2018 pursuant to Section 38‑13‑850.

HISTORY: 2017 Act No. 48 (S.254), Section 1, eff January 1, 2018.

Code Commissioner’s Note

At the direction of the Code Commissioner in 2017, in (A), “this article” was substituted for “this act” to correct a clerical error.