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January 15, 2020

**S. 580**

Introduced by Senator Gambrell

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Read the first time March 28, 2019.

**A** **BILL**

TO AMEND CHAPTER 29, TITLE 38, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO THE SOUTH CAROLINA LIFE AND ACCIDENT AND HEALTH INSURANCE GUARANTY ASSOCIATION, SO AS TO DEFINE NECESSARY TERMS, TO PROVIDE THE PURPOSE OF THE CHAPTER, TO ALTER THE APPLICATION OF THE CHAPTER, TO ESTABLISH CERTAIN POWERS AND DUTIES FOR THE ASSOCIATION IN RELATION TO IMPAIRED OR INSOLVENT MEMBER INSURERS, TO PROVIDE THAT THE BOARD OF DIRECTORS OF THE ASSOCIATION MAY CALL AN ASSESSMENT OF THE MEMBERS AND TO PROVIDE CLASSES FOR THE ASSESSMENTS, TO REQUIRE THE ASSOCIATION TO ESTABLISH A PLAN OF OPERATION AND REQUIRE THE PLAN TO CREATE PROCEDURES FOR REMOVING A MEMBER OF THE BOARD UNDER CERTAIN CIRCUMSTANCES AND TO ADDRESS CONFLICTS OF INTEREST, TO PROSCRIBE CERTAIN DUTIES FOR THE DIRECTOR OF THE DEPARTMENT OF INSURANCE TO AID IN THE DETECTION AND PREVENTION OF INSURER IMPAIRMENTS AND INSOLVENCIES, TO PROVIDE THAT NO PERSON MAY USE THE EXISTENCE OF THE SOUTH CAROLINA LIFE AND ACCIDENT AND HEALTH INSURANCE GUARANTY ASSOCIATION FOR THE PURPOSE OF INSURANCE SALES, AND TO REQUIRE THE ASSOCIATION TO PREPARE A DOCUMENT DESCRIBING THE GENERAL PURPOSES AND LIMITATIONS OF THIS CHAPTER.

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

SECTION 1. A. Chapter 29, Title 38 of the 1976 Code is amended to read:

“CHAPTER 29

South Carolina Life and Accident

and Health Insurance Guaranty Association

Section 38‑29‑10. This chapter is known and may be cited as the ‘South Carolina Life and Accident and Health Insurance Guaranty Association Act’.

Section 38‑29‑20. As used in this chapter:

(1) ‘Account’ means any of the three accounts created under Section 38‑29‑50.

(2) ‘Association’ means the South Carolina Life and Accident and Health Insurance Guaranty Association created under Section 38‑29‑50.

(3) ‘Authorized assessment’ or ‘authorized’ when used in the context of assessments means the board of directors has passed a resolution whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(4) ‘Benefit plan’ means a specific employee, union, or association of natural persons benefit plan.

(5) ‘Called assessment’ or ‘called’ when used in the context of assessments means that notice has been issued by the association to the member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(6) ‘Contractual obligation’ means any obligation under covered policies, contracts, or certificates under a group policy or contract, or portion thereof for which coverage is provided pursuant to Section 38‑29‑40.

~~(4)~~(7) ‘Covered policy’ or ‘covered contract’ means any policy or contract or portion of a policy or contract within the scope of Section 38‑29‑40.

(8) ‘Director’ means the Director of the Department of Insurance.

(9) ‘Extra‑contractual claims’ includes claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney’s fees and costs.

(10) ‘Health benefit plan’ means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. ‘Health benefit plan’ does not include:

(a) accident only insurance;

(b) credit insurance;

(c) dental only insurance;

(d) vision only insurance;

(e) Medicare supplement insurance;

(f) benefits for long‑term care, home health care, community‑based care, or any combination thereof;

(g) disability income insurance;

(h) coverage for on‑site medical clinics; or

(i) specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

~~(5)~~(11) ‘Impaired insurer’ means~~:~~

~~(a)~~ ~~an insurer which becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction, or~~

~~(b)~~ ~~an insurer considered by the director or his designee to be unable or potentially unable to fulfill its contractual obligations~~ a member insurer which, after the effective date of this chapter, is not an insolvent insurer but has been placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

~~(6)~~(12) ‘Insolvent insurer’ means a member insurer which, after the effective date of this chapter, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(13) ‘Member insurer’ means ~~any person~~ an insurer or health maintenance organization authorized to transact in this State any kind of insurance to which this chapter applies under Section 38‑29‑40. This includes an insurer or health maintenance organization whose authority to transact business in this State may have been suspended, revoked, not renewed, or voluntarily withdrawn but does not include:

(a) a hospital or medical service organization, whether profit or nonprofit;

(b) a fraternal benefit society;

(c) a mandatory state pooling plan;

(d) a mutual assessment company or other person that operates on an assessment basis;

(e) an insurance exchange;

(f) an organization that has a certificate or license limited to the issuance of charitable gift annuities under Section 38‑5‑20; or

(g) an entity similar to any of the above.

(14) ‘Moody’s Corporate Bond Yield Average’ means the Monthly Average Corporates as published by Moody’s Investors Service, Inc., or any successor thereto.

(15) ‘Owner’ of a policy or contract and ‘policy holder,’ ‘policy owner’ and ‘contract owner’ mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(16) ‘Person’ means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

~~(7)~~(17) ‘Premiums’ means ~~direct gross insurance premiums and annuity considerations collected or written on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders on the direct business. ‘Premiums’ does not include premiums and considerations on contracts between insurers and reinsurers. As used in Section 38‑29‑80, ‘premiums’ means those for the calendar year preceding the determination of impairment~~ amounts or considerations received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. ‘Premiums’ does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided pursuant to Section 38‑29‑40 except that assessable premiums may not be reduced on account of the provisions of Sections 38‑29‑40 relating to interest limitations and limitations with respect to one individual, one participant, and one policy or contract owner. ‘Premiums’ do not include premiums on an unallocated annuity contract or, with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(18) ‘Principal place of business’ means the state in which a natural person who establishes policies or contracts for the direction, control, and coordination of the operations of the entity as a whole primarily exercises that function, determined by the association after consideration of the state in which the:

(a) primary executive and administrative headquarters of the entity is located;

(b) principal office of the chief executive officer of the entity is located;

(c) board of directors conducts the majority of its meetings;

(d) executive or management committee of the board of directors of the entity conducts the majority of its meetings;

(e) management of the overall operations of the entity is directed; and

(f) holding company or controlling affiliate has its principal place of business in the case of a benefit plan by affiliated companies comprising a consolidated corporation.

However, in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state is deemed to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a benefit plan is deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(19) ‘Receivership court’ means the court in the insolvent or impaired insurer’s state with jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

~~(8)~~(20) ‘Resident’ means ~~any~~ a person who resides in this State at the time the impairment ~~is~~ as determined by a court of appropriate jurisdiction and to whom contractual obligations are owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either residents of foreign countries, or residents of United States’ possessions, territories, or protectorates that do not have an association similar to the association created by this chapter, are deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(21) ‘State’ means a state, the District of Columbia, Puerto Rico, and a United States’ possession, territory, or protectorate.

(22) ‘Structured settlement annuity’ means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(23) ‘Supplemental contract’ means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(24) ‘Unallocated annuity contract’ means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Section 38‑29‑30. (1) The purpose of this chapter is to ~~maintain public confidence in the promises of insurers by providing a mechanism for protecting policy owners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, accident and health insurance policies, annuity contracts, and supplemental contracts~~ protect, subject to certain limitations, the persons specified in Section 38‑29‑40(1) against failure in the performance of contractual obligations of certain life, health, and annuity policies, plans, or contracts due to the impairment or insolvency of the member insurer issuing these policies, plans, or contracts. ~~To provide this protection:~~

~~(1)~~ ~~an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages;~~

~~(2)~~ ~~members of the association are subject to assessment to provide funds to carry out the purpose of this chapter; and~~

~~(3)~~ ~~the association is authorized to assist the director, his designee, and the department, in the prescribed manner, in the detection and prevention of insurer impairments.~~

(2) To provide this protection, an association of member insurers is created to pay benefits and continue coverage in the manner provided for in this chapter and the member insurers are subject to an assessment to provide funds to carry out this purpose.

Section 38‑29‑40. ~~(1)~~ ~~This chapter applies to direct life insurance policies, accident and health insurance policies, annuity contracts, and contracts supplemental to life and accident and health insurance policies and annuity contracts issued by persons authorized to transact insurance in this State at any time.~~

~~(2)~~ ~~This chapter does not apply to:~~

~~(a)~~ ~~Any policy or contract or part thereof under which the risk is borne by the policyholder.~~

~~(b)~~ ~~Any policy or contract or part thereof assumed by the impaired insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.~~

~~(c)~~ ~~Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans.~~

~~(d)~~ ~~A policy or contract or part of it to the extent that the assessments required by Section 38‑29‑80 with respect to the policy or contract are preempted by federal or state law.~~

(1)(a) The provisions of this chapter shall provide coverage to a person, regardless of where they reside, excluding nonresident certificate holders under group policies or contracts, who is the beneficiary, assignee, or payee, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under this section.

(b) The provisions of this chapter shall provide coverage to a person who is the owner of, certificate holder, or enrollee under a policy or contract, other than a structured settlement annuity, and is:

(i) a resident; or

(ii) not a resident, but under all of the following conditions:

(A) the member insurer that issued the policies or contracts is domiciled in this State;

(B) the states in which the persons reside have associations similar to the association created by this chapter;

(C) the person is not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state’s guaranty association law.

(c) The provisions of this chapter shall provide coverage to a person who is a payee or a beneficiary if the payee is deceased under a structured settlement annuity if the payee:

(i) is a resident, regardless of where the contract owner resides;

(ii) is not a resident but the contract owner is a resident; or

(iii) is not a resident but:

(A) the insurer that issued the structured settlement annuity is domiciled in this State; and

(B) the state in which the contract owner resides has an association similar to the association created pursuant to this chapter but the payee and contract owner are not eligible for coverage by the association of the state in which they reside.

(d) The provisions of this chapter shall not provide coverage to a person who:

(i) is a payee of a contract owner resident of this State, if the payee is afforded any coverage by the association of another state; or

(ii) acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 55891(c)(3)(A), regardless of when the transaction occurred.

(e) This chapter is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person may not be provided coverage under this chapter. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter may be construed in conjunction with other state laws to result in coverage by only one association.

(2)(a) This chapter shall provide coverage for policies or contracts of direct, nongroup life insurance, health insurance including health maintenance organization subscriber contracts and certificates, or annuities, for certificates under direct group policies and contracts, and for supplemental contracts to any of these, in each case issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(b) Except as otherwise provided, this chapter does not provide coverage for:

(i) a portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(ii) a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) a portion of a policy or contract, other than a portion, including a rider, that provides long‑term care or any other health insurance benefits, to the extent the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody’s Corporate Bond Yield Average averaged for that same four‑year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(B) on and after the date on which the member insurer becomes an impaired or insolvent insurer, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody’s Corporate Bond Yield Average as most recently available;

(iv) any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;

(v) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self‑funded or uninsured including, but not limited to, benefits payable by an employer, association, or other person under:

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. Section 1002(40);

(B) a minimum premium group insurance plan;

(C) a stop‑loss group insurance plan; or

(D) an administrative services‑only contract;

(vi) a portion of a policy or contract to the extent that it provides for:

(A) dividends or experience rating credits;

(B) voting rights; or

(C) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vii) a portion of a policy or contract to the extent that the assessments required by Section 38‑29‑80 with respect to the policy or contract are preempted by federal or state law;

(viii) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including without limitation:

(A) claims based on marketing materials;

(B) claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) misrepresentations of or regarding policy or contract benefits;

(D) extra‑contractual claims; or

(E) a claim for penalties or consequential or incidental damages;

(ix) a contractual agreement that establishes the member insurer’s obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(x) an unallocated annuity contract;

(xi) a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner’s rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy’s or contract’s interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(xii) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to 42 U.S.C. Chapter 7, Subchapter XVIII, Part C or Part D; 42 U.S.C. Chapter 7, Subchapter XIX; or 42 U.S.C. Chapter 7; or any regulations issued pursuant thereto; or

(xiii) structured settlement annuity benefits to which a payee or beneficiary has transferred his rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of when the transaction occurred before or after such section became effective.

(c) The exclusion from coverage referenced in subitem (iii) of this subsection does not apply to any portion of a policy or contract, including a rider that provides long‑term care or any other health insurance benefits.

(3) The benefits that the association may become obligated to cover may not exceed the lesser of:

(a) the contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) with respect to one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;

(B) for health insurance benefits:

(1) $300,000 for coverages not defined as disability income insurance or health benefit plans or long‑term care insurance, including any net cash surrender and net cash withdrawal values;

(2) $300,000 for disability income insurance and $300,000 for long‑term care insurance;

(3) $500,000 for health benefit plans;

(C) $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(ii) with respect to each payee of a structured settlement annuity or beneficiary if the payee is deceased, $300,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iii) the association is not obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for health benefit plans, in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual or with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(iv) the limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association’s obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(v) for purposes of this chapter, benefits provided by a long‑term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(4) In performing its obligations to provide coverage, the association may not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, or reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract.

Section 38‑29‑50. (1) There is created a nonprofit legal entity to be known as the South Carolina Life and Accident and Health Insurance Guaranty Association. All member insurers are and must remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under the plan of operation established and approved under Section 38‑29‑90 and shall exercise its powers through a board of directors established under Section 38‑29‑60. For purposes of administration and assessment, the association shall maintain three accounts:

(a) the accident and health insurance account;

(b) the life insurance account; and

(c) the annuity account.

(2) The association is under the immediate supervision of the department and is subject to the applicable insurance laws of this State.

Section 38‑29‑60. (1) The board of directors of the association shall consist of not less than five nor more than ~~nine~~ eleven members serving terms as established in the plan of operation. Member insurers shall select the members of the board subject to the director’s approval. Any vacancies on the board must be filled for the remaining period of the term ~~in the manner described in the plan of operation~~ by a person elected by a majority vote of the remaining board members and subject to the approval by the director.

(2) In approving selections or in appointing members to the board, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board may not otherwise be compensated by the association for their services.

Section 38‑29‑70. In addition to the powers and duties enumerated in other sections of this chapter:

~~(1)~~ ~~If a domestic insurer is an impaired insurer, the association may, prior to an order of liquidation or rehabilitation and subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired insurer and approved by the impaired insurer and the director or his designee:~~

~~(a)~~ ~~Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, all the covered policies of the impaired insurer.~~

~~(b)~~ ~~Provide monies, pledges, notes, guarantees, or other means as are proper to effectuate subitem (a) and assure payment of the impaired insurer’s contractual obligations pending action under subitem (a).~~

~~(c)~~ ~~Loan money to the impaired insurer.~~

~~(2)~~ ~~If a foreign or alien insurer is an impaired insurer, the association may prior to an order of liquidation, rehabilitation, or conservation, with respect to the covered policies of residents and subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired insurer and approved by the impaired insurer and the director or his designee:~~

~~(a)~~ ~~Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, the impaired insurer’s covered policies of residents.~~

~~(b)~~ ~~Provide monies, pledges, notes, guarantees, or other means as are proper to effectuate subitem (a) and assure payment of the impaired insurer’s contractual obligations to residents pending action under subitem (a).~~

~~(c)~~ ~~Loan money to the impaired insurer.~~

~~(3)~~ ~~If a domestic insurer is an impaired insurer under an order of liquidation or rehabilitation, the association shall, subject to the approval of the director or his designee:~~

~~(a)~~ ~~Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the impaired insurer’s covered policies.~~

~~(b)~~ ~~Assure payment of the impaired insurer’s contractual obligations.~~

~~(c)~~ ~~Provide money, pledges, notes, guarantees, or other means as are reasonably necessary to discharge its duties. If the association fails to act within a reasonable period of time, the director or his designee has the powers and duties of the association under this chapter with respect to the domestic impaired insurer.~~

~~(4)~~ ~~If a foreign or alien insurer is an impaired insurer under an order of liquidation, rehabilitation, or conservation, the association shall, subject to the approval of the director or his designee:~~

~~(a)~~ ~~Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of residents.~~

~~(b)~~ ~~Assure payment of the impaired insurer’s contractual obligations to residents.~~

~~(c)~~ ~~Provide monies, pledges, notes, guarantees, or other means as are reasonably necessary to discharge its duties. If the association fails to act within a reasonable period of time, the director or his designee has the powers and duties of the association under this chapter with respect to the foreign or alien impaired insurer.~~

~~(5)~~ ~~Liens may be imposed as long as the association:~~

~~(a)~~ ~~In carrying out its duties under items (3) and (4), requests that there be imposed policy liens, contract liens, moratoriums on payments, or other similar means. These liens, moratoriums, or similar means may be imposed if the director or his designee finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the impaired insurer’s contractual obligations or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, moratoriums, or similar means to be in the public interest and approves the specific policy liens, contract liens, moratoriums, or similar means to be used.~~

~~(b)~~ ~~Before being obligated under items (3) and (4) of this section, requests, subject to the approval of the director or his designee, that there be imposed temporary moratoriums or liens on payments of cash values and policy loans.~~

~~(6)~~ ~~The association has no liability under this section for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides by statute or regulation for residents of this State protection substantially similar to that provided by this chapter for residents of other states. In addition, the association has no liability under this chapter for covered policies of a domestic insurer for residents of another state unless the other state has a guaranty association that provides protection to South Carolina residents substantially similar to that provided by this chapter for residents of other states.~~

~~(7)~~ ~~The association may render assistance and advice to the director or his designee, upon his request, concerning rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of an impaired insurer.~~

~~(8)~~ ~~The association has the authority to appear before any court in this State with jurisdiction over an impaired insurer concerning which the association is or may become obligated under this chapter. This authority extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the impaired insurer and the determination of the covered policies and contractual obligations.~~

~~(9)~~ ~~Any person receiving benefits under this chapter is considered to have assigned his rights under the covered policy to the association to the extent of the benefits received because of this chapter whether the benefits are payments of contractual obligations or continuation of coverage. The association may require an assignment to it of these rights by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon that person. The association is subrogated to these rights against the assets of any impaired insurer, and the subrogation rights of the association have the same priority against the assets as that possessed by the person entitled to receive benefits under this chapter.~~

~~(10)~~ ~~The contractual obligations of the impaired insurer for which the association becomes or may become liable are the same as the contractual obligations of the impaired insurer would have been in the absence of an impairment, but the association has no liability with respect to any portion of a covered policy to the extent that the policy’s benefits to any one person exceed an aggregate of three hundred thousand dollars.~~

~~(11)~~ ~~The association may:~~

~~(a)~~ ~~Enter into contracts that are necessary or proper to carry out the provisions and purposes of this chapter.~~

~~(b)~~ ~~Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under Section 38‑29‑80.~~

~~(c)~~ ~~Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.~~

~~(d)~~ ~~Employ or retain persons necessary to handle the financial transactions of the association and to perform other functions as become necessary or proper under this chapter.~~

~~(e)~~ ~~Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.~~

~~(f)~~ ~~Take legal action necessary to avoid payment of improper claims.~~

~~(g)~~ ~~Exercise, for the purposes of this chapter and to the extent approved by the director or his designee, the powers of a domestic life or accident and health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired insurer.~~

(1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the covered policies or contracts of the impaired insurer; and

(b) provide such monies, pledges, loans, notes, guarantees, or other means as are proper and assure payment of the impaired insurer’s pending contractual obligations.

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)(A) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or

(B) assure payment of the contractual obligations of the insolvent insurer; and

(ii) provide monies, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association’s duties; or

(b) provide benefits and coverages in accordance with the following provisions:

(i) with respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(A) with respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty‑five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies and contracts;

(B) with respect to nongroup policies, contracts, and annuities not later than the earlier of the next renewal date, if applicable, under the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) make diligent efforts to provide all known insureds, enrollees or annuitants for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty days’ notice of the termination of the benefits provided;

(iii) with respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of this section, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(iv)(A) in providing the substitute coverage, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates;

(B) alternative or reissued policies or contracts must be offered without requiring evidence of insurability and may not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract;

(C) the association may reinsure any alternative or reissued policy or contract;

(v)(A) alternative policies or contracts adopted by the association are subject to the approval of the director. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency;

(B) alternative policies or contracts must contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged. The association must set the premium in accordance with a table of rates that it adopts. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy or contract was last underwritten;

(C) any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(vi) if the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium must be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk;

(vii) the association’s obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association;

(viii) when proceeding with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Section 38‑29‑40.

(3) Nonpayment of premiums within thirty‑one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association’s obligations under the policy, contract, or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association must provide a report to the liquidator regarding such premium collected by the association. The association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(5) The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

(6) In carrying out its duties, the association may, subject to approval by a court in this State, impose:

(a) permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association’s duties, or that the economic or financial conditions as they affect member insurers are sufficiently averse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(b) temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) The association has no liability for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides by statute or regulation for residents of this State protection substantially similar to that provided by this chapter for residents of other states. In addition, the association has no liability under this chapter for covered policies of a domestic insurer for residents of another state unless the other state has a guaranty association that provides protection to South Carolina residents substantially similar to that provided by this chapter for residents of other states.

(8) A deposit in this State held pursuant to Sections 38‑9‑80 and 38‑9‑90 or otherwise required by the director for the benefit of South Carolina creditors, including policy or contract owners, must be released to the domiciliary receiver upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer in accordance with Section 38‑9‑150. The Association is entitled to a portion of the deposit in an amount equal to the aggregate of policy or contract owners’ claims for which the Association has provided statutory benefits on behalf of the insurer and associated administrative expenses. The amount must be promptly paid to the Association provided such payment does not prejudice the rights of a South Carolina policyholder or creditor of the insurer that is the subject of the liquidation or rehabilitation proceedings. Any amount so paid to the association and retained by it not used in fulfilling the association’s obligations must be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements. The director, the Association, and other necessary parties are authorized to enter into agreements to effectuate the intent of this section.

(9) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, the director shall have the powers and duties of the association under this chapter with respect to the insolvent insurer.

(10) The association may render assistance and advice to the director, upon the director’s request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(11) The association shall have standing to appear or intervene before a court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning that which the association is or may become obligated to cover under this chapter or with jurisdiction over any person or property against that which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the covered policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association also shall have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(12)(a) A person receiving benefits under this chapter is deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations continuation of coverage or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon that person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets as that possessed by the person entitled to receive benefits under this chapter.

(c) The association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts.

(d) If the preceding provisions are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights to, the person must pay to the association the portion of the recovery attributable to the policies or contracts covered by the association.

(13) In addition to the rights and powers elsewhere in this chapter, the association may:

(a) enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(b) sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under Section 38‑29‑80 and to settle claims or potential claims against it;

(c) borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(d) employ or retain such persons necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this chapter;

(e) take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) exercise, for the purposes of this chapter and to the extent approved by the director, the powers of a domestic life insurer, health insurer, or health maintenance organization, but in no case may the association issue policies or contracts other than those issued to perform its obligations under this chapter;

(g) organize itself as a corporation or in other legal form permitted by the laws of the State;

(h) request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request;

(i) unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter; and

(j) take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.

(14) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(15)(a)(i) At any time within one hundred eighty days of the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the association or the National Organization of Life and Health Insurance Guaranty Association (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(ii) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer must make available upon request to the association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings copies of in‑force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and notices of any defaults under the reinsurance contacts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(iii) The following applies to reinsurance contracts assumed by the association:

(A) The association is responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and is responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts, or annuities covered, in whole or in part, by the association. The association may charge policies, contracts, or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and must provide notice and an accounting of these charges to the liquidator.

(B) The association is entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the association, provided that, upon receipt of any such amounts, the association is obliged to pay to the beneficiary under the policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(1) the amount received by the association; and

(2) the excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contract, or annuity less the retention of the insurer applicable to the loss or event.

(C) Within thirty days following the association’s election, the association and each reinsurer under contracts assumed by the association must calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set‑off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due to the association, the receiver must remit the same to the association as promptly as practicable.

(D) If the association or receiver on the association’s behalf, within sixty days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the association, the reinsurer is not entitled to terminate the reinsurance contracts for failure to pay premiums insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by the association, and is not entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due the association.

(b) During the period from the date of the order of liquidation until the election date or until one hundred eighty days after the date of the order of liquidation if the election date does not occur:

(i)(A) the association or the reinsurer does not have any rights or obligations under reinsurance contracts that the association has the right to assume whether for periods prior to or after the date of the order of liquidation; and

(B) the reinsurer, the receiver, and the association shall, to the extent practicable, provide each other data and records reasonably requested;

(ii) provided that once the association has elected to assume a reinsurance contract, the parties’ rights and obligations must be governed pursuant to this section.

(c) If the association does not elect to assume a reinsurance contract by the election date, the association has no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(d) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities also may be transferred by the association, in the case of contracts assumed, subject to the following:

(i) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

(ii) the obligations described in this section no longer apply with respect to matters arising after the effective date of the transfer; and

(iii) notice must be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty days prior to the effective date of the transfer.

(e) The provisions of this section supersede the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver remains entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

(f) Except as otherwise provided in this section, nothing in this section alters or modifies the terms and conditions of any reinsurance contract. Nothing in this section abrogates or limits any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section gives a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section limits or affects the association’s rights as a creditor of the estate against the assets of the estate. Nothing in this section applies to reinsurance agreements covering property or casualty risks.

(16) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

(17) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association’s obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(18) Venue in a suit against the association arising under the chapter is in Richland County. The association may not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

(19) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) in lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, a payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(b) there is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(c) the alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Section 38‑29‑80. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at times and for amounts as the board finds necessary. Payment is due thirty days after written notice to the member insurers and shall accrue interest as set forth in the plan of operation.

(2) There are ~~three~~ two classes of assessments, as follows:

(a) Class A assessments are made for the purpose of meeting administrative costs and other general expenses not related to a particular impaired insurer.

(b) Class B assessments are made to the extent necessary to carry out the powers and duties of the association under Section 38‑29‑70 with regard to ~~a domestic~~ an insolvent or impaired insurer.

~~(c)~~ ~~Class C assessments are made to the extent necessary to carry out the powers and duties of the association under Section 38‑29‑70 with regard to a foreign or alien impaired insurer.~~

(3) ~~Assessments must be determined as follows:~~ (a) The amount of any Class A~~, Class B, or Class C~~ assessment for each account must be determined by the board ~~based on the amounts necessary to satisfy the obligation of the association under this chapter~~ and may be authorized and called on a pro rata or non pro rata basis. If called on a pro rata basis, the board may provide that the assessment must be credited against future Class B assessments.

~~(b)~~ ~~Class A assessments must be divided equally among all members not to exceed one hundred dollars per assessment. Class C assessments against member insurers for each account must be in the proportion that the premiums received on business in this State by each assessed member insurer on policies covered by each account bear to the premiums received on business in this State by all assessed member insurers.~~

~~(c)~~ ~~Class B assessments for each account must be made separately for each state in which the domestic impaired insurer was authorized to transact insurance at any time, in the proportion that the premiums received on business in that state by the impaired insurer on policies covered by that account bear to those premiums received in all of those states by the impaired insurer. The assessments against member insurers must be in the proportion that the premiums received on business in each of these states by each assessed member insurer on policies covered by each account bear to those premiums received on business in each state by all assessed member insurers.~~

~~(d)~~ ~~Assessments for funds to meet the requirements of the association with respect to an impaired insurer may not be made until necessary to implement the purposes of this chapter. Classification of assessments under subsection (2) of this section and computation of assessments under subsection (3) of this section must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.~~

~~(4)~~ ~~The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. The total of all assessments upon a member insurer for each account may not in any one calendar year exceed four percent of the insurer’s premiums in this State on the policies covered by the account.~~

~~(5)~~ ~~In the event an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth in subsection (4) of this section, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. If the maximum assessment, together with the other assets of the association in either account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this chapter.~~

~~(6)~~ ~~The board may, by an equitable method as established in the plan of operation, refund to member insurers the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from net realized gains and income from investments. Refunds to member insurers must be in proportion to the contribution of the insurer to that account. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.~~

~~(7)~~ ~~It is proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.~~

~~(8)~~ ~~The association shall issue to each insurer paying an assessment under this chapter a certificate of contribution, in a form prescribed by the director or his designee, for the amount so paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in the form and for the amount, if any, and period of time as the director or his designee may approve.~~

(b) The amount of a Class B assessment, except for assessments related to long‑term care insurance, must be allocated for assessment purposes between the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of the Class B assessment for long‑term care insurance written by the impaired or insolvent insurer must be allocated according to a methodology included in the plan of operation and approved by the director. The methodology must provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each account must be in the proportion to the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became insolvent. In the case of an assessment of an impaired insurer, the assessment must be in proportion to the premiums received on business in this State for those calendar years by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this chapter. Classification and computation of assessments under this subsection must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer must pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a)(i) The total of all assessments authorized by the association with respect to a member insurer for each account shall not in one calendar year exceed four percent of that member insurer’s average annual premiums received in this State on the policies and contracts covered by the account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

(ii) If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation must be equal and limited to the higher of the three‑year average annual premiums for the applicable account as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon as permitted by this chapter.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(c) If the maximum assessment for the life or annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then the board shall assess the other accounts for the necessary additional amount, subject to the maximum provided in this section.

(6) The board may, by an equitable method established in the plan of operation, refund to member insurers in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future claims.

(7) It is proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(8) The association must issue to each member insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the director, for the amount of the assessments so paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in the form and for the amount and for a period of five years.

(9)(a ) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess must be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

Section 38‑29‑90. (1) The association shall submit to the department a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments become effective upon the written approval of the director or his designee or thirty days after submission if the plan of operation and any amendments have not been rejected by the director. If the association fails to submit suitable amendments to the plan, the director or his designee shall, after notice and hearing, adopt and promulgate reasonable amendments necessary or advisable to effectuate the provisions of this chapter. These amendments must continue in force until modified by the director or his designee or superseded by amendments submitted by the association and approved by the director or his designee.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

(a) establish procedures for handling the assets of the association~~.~~;

(b) establish the amount and method of reimbursing members of the board of directors under Section 38‑29‑60~~.~~;

(c) establish regular places and times for meetings of the board of directors~~.~~;

(d) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors~~.~~;

(e) establish the procedure whereby selections for the board of directors must be made and submitted to the department director~~.~~;

(f) establish any additional procedures for assessments under Section 38‑29‑80~~.~~;

(g) contain additional provisions necessary or proper for the execution of the powers and duties of the association~~.~~;

(h) establish procedures whereby a member of the board of directors may be removed for cause including a case where a member insurer director becomes an impaired or insolvent insurer;

(i) require the board of directors to establish a policy and procedures for addressing conflicts of interest.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under Section 38‑29‑70~~(11)~~(13)(c) and Section 38‑29‑80, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization must be reimbursed for any payments made on behalf of the association and must be paid for its performance of any function of this association. A delegation under this subsection takes effect only with the approval of both the board of directors and the department director or his designee and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

Section 38‑29‑100. In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The director or his designee:

(a) shall notify the board of directors of the existence of an impaired insurer not later than three days after a determination of impairment is made or he receives notice of impairment~~.~~;

(b) shall, upon request of the board of directors, provide the association with a statement of the premiums ~~in the~~ written in this State and any other appropriate ~~states~~ state for each member insurer~~.~~;

(c) shall, when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to its shareholders, if any. The failure of the insurer to comply promptly with the demand does not excuse the association from the performance of its powers and duties under this chapter.

~~(d)~~ ~~Must, in any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the director or his designee must be appointed conservator.~~

(2) The director or his designee may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the director or his designee may ~~impose the penalties provided in Section 38‑2‑10~~ levy a forfeiture on a member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent of the unpaid assessment per month but may not be less than one hundred dollars a month.

(3) ~~Any action~~ A final action of the board of directors or the association may be appealed to the ~~Administrative Law Court~~ director as provided by law by any member insurer if the appeal is taken within ~~thirty days of the action being appealed~~ sixty days of receipt of notice of the final action being appealed. A final action or order of the director is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this State.

(4) The liquidator, rehabilitator, or conservator of an impaired or insolvent insurer may notify all interested persons of the effect of this chapter.

Section 38‑29‑110. ~~To aid in the detection and prevention of insurer impairments:~~

~~(1)~~ ~~The board of directors shall, upon majority vote, notify the director or his designee of any information indicating a member insurer may be unable or potentially unable to fulfill its contractual obligations.~~

~~(2)~~ ~~The board of directors may, upon majority vote, request that the director or his designee order an examination of a member insurer which the board in good faith believes may be unable or potentially unable to fulfill its contractual obligations. The examination may be conducted as a National association of Insurance Commissioners examination or may be conducted by the director or his designee. The cost of the examination must be paid by the association and the examination report must be treated as are other examination reports. In no event may the examination report be released to the board of directors of the association prior to its release to the public, but this does not excuse the director or his designee from his obligation to comply with item (3) of this section. The director or his designee shall notify the board of directors when the examination is completed. The request for an examination must be kept on file by the department, but it is not open to public inspection prior to the release of the examination report to the public. It must be released at that time only if the examination discloses that the examined insurer is unable or potentially unable to meet its contractual obligations.~~

~~(3)~~ ~~The director or his designee shall report to the board of directors when he has reasonable cause to believe that a member or licensed insurer may be unable or potentially unable to fulfill its contractual obligations.~~

~~(4)~~ ~~The board of directors may, upon majority vote, make reports and recommendations to the director, his designee, and the department upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer. These reports and recommendations are not open to public inspection.~~

~~(5)~~ ~~The board of directors may, upon majority vote, make recommendations to the director, his designee, and the department for the detection and prevention of insurer impairments.~~

~~(6)~~ ~~The board of directors shall, at the conclusion of an insurer impairment in which the association carried out its duties under this chapter or exercised any of its powers under this chapter, prepare a report on the history and causes of the impairment, based on the information available to the association, and submit the report to the department.~~ To aid in the detection and prevention of insurer impairments and insolvencies:

(1) It is the duty of the director:

(a) to notify the commissioners of all the other states and territories of the United States and the District of Columbia within thirty days following an action taken or the date the action occurs, when the director takes any of the following actions against a member insurer:

(i) revocation of license;

(ii) suspension of license; or

(iii) makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders, or creditors;

(b) to report to the board of directors when the director has taken any of the actions set forth in subitem (a) or has received a report from any other director indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner;

(c) to report to the board of directors when the director has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer;

(d) to furnish to the board of directors the National Association of Insurance Commissioners’ (NAIC) Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein must be kept confidential by the board of directors until such time as made public by the director or other lawful authority.

(2) The director may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the director regarding the financial condition of member insurers, insurers, or health maintenance organizations seeking admission to transact business in this State.

(3) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the solvency of any insurer or health maintenance organization seeking to do business in this State. These reports and recommendations may not be considered public documents.

(4) The board of directors may, upon majority vote, notify the director of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of member insurer insolvencies.

Section 38‑29‑120. The association may recommend the appointment of a person to serve as a special deputy to act for the director or his designee and under his supervision in the liquidation, rehabilitation, or conservation of a member insurer.

Section 38‑29‑130. (1) Nothing in this chapter may be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records must be kept of all negotiations and meetings ~~in which the association or its representatives are involved~~ of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 38‑29‑70. Records of these ~~negotiations or~~ meetings must be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection ~~(2)~~ limits the duty of the association to render a report of its activities under Section 38‑29‑140.

(3) For the purpose of carrying out its obligations under this chapter, the association is considered to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to Section 38‑29‑70~~(9)~~(12). All assets of the impaired or insolvent insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection ~~(3)~~, are that proportion of the assets which the reserves that should have been established for those policies bear to the reserve that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) ~~With respect to distributing assets:~~ As a creditor of the impaired or insolvent insurer as established in this section and consistent with Section 38‑27‑530, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association is entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, policy and contract owners, certificate holders, and enrollees of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired or insolvent insurer. In this determination, consideration must be given to the welfare of the ~~policyholders,~~ policy and contract owners, certificate holders, and enrollees of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of assessments levied by the association with respect to the insurer plus interest has been fully recovered by the association.

~~(5)~~ ~~It is a prohibited unfair trade practice for any person to make use in any manner of the protection afforded by this chapter in the sale of insurance.~~

(6) The recovery procedure shall provide that:

(a) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order has a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of items (b), (c), and (d) of this subsection ~~(6)~~.

(b) No such ~~dividend~~ distribution is recoverable if the insurer shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared is liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the impaired insurer to pay the contractual obligations of the impaired insurer.

(e) If any person liable under item (c) is insolvent, all its affiliates that controlled it at the time the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Section 38‑29‑140. The association is subject to examination and regulation by the department. The board of directors shall annually submit to the department, by May first, a financial report for the preceding calendar year in a form approved by the director or his designee and a report of its activities during the preceding calendar year.

Section 38‑29‑150. The association is exempt from payment of all fees and all state, county, and municipal taxes.

Section 38‑29‑160. (1) Unless a longer period has been allowed by the director or his designee, a member insurer, at its option, has the right to show a certificate of contribution as an asset in the form approved by the director or his designee pursuant to Section 38‑29‑80(8) at percentages of the original face amount approved by the director or his designee, for calendar years as follows:

one hundred percent for the calendar year of issuance;

eighty percent for the first calendar year after the year of issuance;

sixty percent for the second calendar year after the year of issuance;

forty percent for the third calendar year after the year of issuance;

twenty percent for the fourth calendar year after the year of issuance;

zero percent for the fifth calendar year after the year of issuance and thereafter.

(2) The insurer may offset the amount written off by it in a calendar year under subsection (1) against its premium, ~~(~~or income~~)~~,tax liability to this State accrued with respect to business transacted in that year.

(3) Any sums acquired by refund, pursuant to Section 38‑29‑80(6), from the association which have previously been written off by contributing insurers and offset against premium (or income) taxes as provided in subsection (2) of this section and are not then needed for purposes of this chapter must be paid by the association to the department and by him deposited with the State Treasurer for credit to the general fund of this State.

Section 38‑29‑170. There is no liability on the part of, and no cause of action of any nature may arise against, any member insurer or its agents or employees, the association’s agents or employees, members of the board of directors, or the director or his representatives for any action taken or omission by them in the authorized performance of their powers and duties under this chapter. This section does not relieve the association of any of its ~~liability~~ statutory obligations. The immunity extends to the participation in an organization of one or more state associations of similar purposes and to such organization, its agents, and employees.

Section 38‑29‑180. All proceedings in which the impaired or insolvent insurer is a party in any court in this State must be stayed ~~sixty~~ one hundred eighty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on default the association may apply to have the judgment set aside by the same court that made the judgment and must be permitted to defend against the suit on the merits.

Section 38‑29‑190. For domestic insolvencies, the court shall fix a date, not less than four months from the date of the order, as the last day for the filing of claims, together with proper proofs thereof, with the association and shall prescribe the notice that must be given to insureds and claimants of the date. Prior to the date fixed the court may extend the time for the filing of claims.

Section 38‑29‑200. (1) No person, including a member insurer, agent, or affiliate of a member insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or social media, or in any other way, an advertisement, announcement, or statement, written or oral, which uses the existence of the South Carolina Life and Accident and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter. However, this section shall not apply to the South Carolina Life and Accident and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

(2) Within one hundred eighty days of July 1, 2019, the association shall prepare a summary document describing the general purposes and current limitations of the chapter and complying with this section. This document must be submitted to the director for approval. At the expiration of the sixtieth day after the date on which the director approves the document, a member insurer may not deliver a policy or contract to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder, or enrollee at the time of delivery of the policy or contract. The document must be made available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document must be revised by the association as amendments to the chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

(3) The document shall contain a clear and conspicuous disclaimer on its face. The director shall establish the form and content of the disclaimer. The disclaimer shall:

(a) state the name and address of the South Carolina Life and Health Insurance Guaranty Association and insurance department;

(b) prominently warn the policy owner, contract owner, certificate holder, or enrollee that the South Carolina Life and Health Insurance Guaranty Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this State;

(c) state the types of policies or contracts for which guaranty funds will provide coverage;

(d) state the member insurer and its agents are prohibited by law from using the existence of the South Carolina Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

(e) state that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the South Carolina Life and Health Insurance Guaranty Association when selecting an insurer or health maintenance organization;

(f) explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter; and

(g) provide other information as directed by the director including, but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state’s public records law.

(4) A member insurer shall retain evidence of compliance for so long as the policy or contract for which the notice is given remains in effect.

Section 38‑29‑210. This chapter must be liberally construed to effect the purpose under Section 38‑29‑30 which constitutes an aid and guide to interpretation.”

B. The amendments made by this act do not apply to a member insurer that has been placed on an order of rehabilitation or liquidation before the July 1, 2019.

SECTION 2. Article 3, Chapter 79, Title 38 of the 1976 Code is amended to read:

“Article 3

South Carolina Medical Malpractice Liability

Joint Underwriting Association

Section 38‑79‑110. As used in this article:

(1) “Accumulated deficit” means the amount that the association’s and the fund’s liabilities exceed their assets, as reported in the association’s and fund’s respective most recently reported financial statements on June 30, 2019.

(2) “Association” means any joint underwriting association established by the General Assembly in 1987 and managed and operated pursuant to the provisions of this article.

(3) “Fund” means the Patients’ Compensation Fund.

(4) “Future deficit” means any deficit accumulated by the association and fund after the most recently reported financial statements as of June 30, 2019.

~~(2)~~(5) “Licensed health care providers” means physicians and surgeons, nurses, oral surgeons, dentists, pharmacists, ~~chiropractors,~~ podiatrists, hospitals, nursing homes, or any similar major category of licensed health care providers. The term ‘licensed health care provider’ also includes blood centers which collect, process, and distribute blood to hospitals and physicians for the care of patients if these blood centers as of July 1, 1997, were insured with the Joint Underwriting Association.

~~(3)~~(6) “Medical malpractice insurance” means medical professional liability insurance or insurance protection against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering or failing to render professional service by any licensed physician, licensed health care provider, or hospital.

~~(4)~~(7) “Net‑direct premiums” means gross direct premiums written on ~~bodily injury liability insurance, other than automobile liability insurance, homeowners liability insurance, and farmowners liability insurance, including the liability component of multiple peril package policies, as~~ medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, and any other type of professional liability insurance covering risks of licensed health care providers and facilities as determined and computed by the director or his designee, less return premiums or the unused or unabsorbed portions of premium deposits. The net‑direct premium calculation does not include premiums written by the fund.

Section 38‑79‑120. (1) A joint underwriting association (association) is created, ~~consisting of all insurers authorized to write within this State, on a direct basis, bodily injury liability insurance, other than automobile bodily injury liability insurance, homeowners liability insurance, and farmowners liability insurance, including insurers covering such peril in multiple peril package policies. Every such insurer is and must remain a member of the association as a condition of its authority to continue to transact such kind of insurance in this State.~~ containing as members all insurers authorized to write and report net‑direct written premiums for medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers. Membership also includes foreign and domestic risk retention groups and captive insurers authorized to write and report net‑direct written premiums for medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risk of licensed health care providers, and authorized to do business in accordance with the provisions of this title. The South Carolina Insurance Reserve Fund is not a member of the association. Each insurer described above is and must remain a member of the association as a condition of the authorization to transact the sale of insurance in this State. The membership of the association shall continue as members in the South Carolina Medical Malpractice Association upon its creation as provided in Section 38‑79‑300.

(2) The purpose of the association is to ~~provide medical malpractice insurance~~ ensure the availability of medical malpractice and other types of professional liability insurance for health care providers on a self‑supporting basis to the fullest extent possible. The intent of the General Assembly in enacting this section is to eliminate the accumulated deficit of the association and of the fund and to transition the association over time to a market of last resort so that it is no longer in competition with the private market. Specifically, the General Assembly does not intend that the South Carolina Joint Underwriting Association or any successor in interest offer rates that are competitive to the private market.

~~(3)~~ ~~The association must be called into operation at any time that the department finds and declares the existence of an emergency because of the unavailability of medical malpractice liability insurance, or the unavailability of medical malpractice liability insurance on a reasonable basis through normal channels, in respect to all or any one or more of the major categories of licensed health care providers listed in item (2) of Section 38‑79‑110.~~

Section 38‑79‑125. (1) As of January 1, 2020, all insurers authorized to write on a direct basis bodily injury liability insurance, other than automobile bodily injury insurance, homeowners liability insurance, an insurer which insures only churches and their property, and farmowners liability insurance including monoline farm liability insurance, including insurers covering such peril in multiple peril package policies and bodily injury insurance, must pay an assessment equal to their proportional share of twenty percent of the accumulated deficit of the association as contained in their most recently reported financial statements as of June 30, 2019 as determined by the director. Each insurer’s share of the assessment must be calculated based upon the net‑direct written premiums for the insurer’s liability lines as identified in this subsection on the most recent year preceding the effective date of this section. All money collected from this assessment must be applied to the accumulated deficit of the association. Each insurer may pay the assessment in one lump sum or, at the insurer’s option, in equal installments over a period not to exceed five years. The assessment may be incorporated into the rate filings of the insurer. Upon satisfaction of the assessment, each insurer may withdraw as members of the association upon submission of:

(a) an application for withdrawal in the format prescribed by the director or his designee;

(b) evidence that it has not written any medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers in the consecutive five years preceding the insurer’s withdrawal application; and

(c) certification by the association and the director or his designee that all obligations to the association have been fully satisfied.

(2) The director may set the date on which the insurer’s withdrawal becomes effective by order.

(3) Insurers writing medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers are not eligible to withdraw from membership in the association.

Section 38‑79‑130. The association, pursuant to the provisions of this article and the approved plan of operation in respect to medical malpractice insurance, has the power on behalf of its members to:

(1) issue, or cause to be issued, policies of insurance to applicants including incidental coverages including, but not limited to, premises or operations liability coverage on the premises where services are rendered, all subject to limits of liability as specified in the plan of operation but not to exceed ~~two hundred thousand~~ one million dollars for each claim under one policy and ~~six hundred thousand~~ three million dollars for all claims under one policy in any one year; provided, however, that the association may offer ~~policies up to one million dollars for each claim under one policy and three million dollars~~ higher limits per claim and for all claims under one policy in any one year only upon approval of the board of the association and with the written ~~concurrence of the Board of Governors of the South Carolina Patients’ Compensation Fund~~ approval of the director;

(2) underwrite medical malpractice insurance and to adjust and pay losses with respect to it or to appoint service companies to perform those functions; and

(3) cede and assume reinsurance.

Section 38‑79‑140. (1) The association must operate pursuant to a plan of operation which shall provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance and may contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of the members to defray losses and expenses, commissions arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of insurance to be provided by the association. The plan of operation must be amended within thirty days following the merger provided for in Section 38‑79‑300. The amended plan must address the orderly and expeditious winding down of the Patients’ Compensation Fund.

(2) The plan of operation shall provide that any profit achieved by the association must be added to the reserves of the association or returned to the policyholders as a dividend. If there is no accumulated deficit, any profit achieved by the association must be added to the reserves of the association.

(3) ~~The plan of operation becomes effective and operative no later than thirty days after the declaration of any emergency by the department.~~ The approved plan of operation may make provisions for combining insurers under common ownership or management into groups for voting, assessment, and all other purposes and may provide that no more than one of the officers or employees of a group may serve as a director at any one time.

(4) Amendments to the plan of operation may be made by the directors of the association with the approval of the director or his designee or must be made at the direction of the director or his designee after due notice and public hearing.

Section 38‑79‑150. Any licensed health care provider ~~in a category in which the department has declared an emergency exists~~ is entitled to apply to the association for coverage. The application may be made on behalf of the applicant by a licensed agent or broker authorized in writing by the applicant. If the association determines that the applicant meets the underwriting standards of the association as set forth in the approved plan of operation and there is no unpaid, uncontested premium due from the applicant for any prior insurance of the same kind, the association, upon receipt of the premium, or a portion thereof as prescribed by the plan of operation, shall cause to be issued a policy of medical malpractice liability insurance for a term of one year.

The rates, rating plans, rating rules, rating classifications, territories, and policy forms applicable to insurance written by the association and the statistical and experience data relating thereto are subject to this article and to those provisions of Chapter 73 of this title which are not inconsistent with the purposes and provisions of this article.

Section 38‑79‑160. ~~The director or his designee shall obtain complete statistical data in respect to medical malpractice losses and reparation costs as well as all other costs or expenses which underlie or are related to medical malpractice liability insurance. He shall promulgate any statistical plan he considers necessary for the purpose of gathering data referable to loss and loss adjustment expense experience and other expense experience. When a statistical plan is promulgated all members of the association shall adopt and use it. The director or his designee shall also obtain statistical data in respect to the costs of compensating or rehabilitating victims of medical malpractice without respect to insurance for purposes of studying the feasibility or desirability of alternative medical malpractice compensation systems and estimating the impact of medical malpractice loss and insurance costs upon other compensation and insurance systems such as workers’ compensation and accident and health insurance. He may require from any person obtaining insurance through the association loss, claim, or expense data. This information or data is confidential and the physician‑patient privilege must be preserved.~~ Reserved.

Section 38‑79‑170. In respect to the structuring of rates for medical malpractice liability insurance and the determination of the profit or loss of the association in respect to that insurance, due consideration must be given by the director or his designee to all investment income.

Section 38‑79‑180. ~~Within a time that the director or his designee directs, the association shall submit, for the approval of the director or his designee, an initial filing, in proper form, of policy forms, classifications, rates, rating plans, and rating rules applicable to medical malpractice liability insurance to be written by the association. In the event the director or his designee disapproves the initial filing, in whole or in part, the association shall amend the filing, in whole or in part, in accordance with the direction of the director or his designee. If the director or his designee is unable to approve the filing or amended filing, within the time specified, he shall promulgate the policy forms, classifications, rates, rating plans, and rules to be used by the association in making rates for and writing the insurance.~~ The association shall submit, for the approval of the director or his designee, all policy forms, classifications, rates, rating plans, or rules applicable to its insurance product offerings to customers in this State. Such filings must be submitted for approval to the director no less than sixty days prior to their intended effective date. The director may extend the time for his review by an additional sixty days to allow the department sufficient time to evaluate the proposed form, classification, rate, rating plan, or rule to be used by the association. Rates must be actuarially sound, self supporting, and may not be excessive, inadequate, or unfairly discriminatory.

Section 38‑79‑190. (1) The board of directors shall specify whether policy forms and the rate structure must be on a ‘claims‑made’ or ‘occurrence’ basis and coverage may be provided by the association only on the basis specified by the board of directors. The board of directors shall specify the ‘claims‑made’ basis only if the contract makes provision for residual ‘occurrence’ coverage upon the retirement, death, disability, or removal from the State of the insured. Provision may be made for a premium charge allocable to any such residual ‘occurrence’ coverage and the premium charges for the residual coverage must be segregated and separately maintained for such purpose which may include the reinsurance of all or a part of that portion of the risk.

(2) The policy may not contain any limitation in relation to the existing law in tort as provided by the statute of limitations of the State of South Carolina.

(3) The policy form whether on a ‘claims‑made’ or ‘occurrence’ basis may not require as a condition precedent to settlement or compromise of any claim the consent or acquiescence of the insured. However, such settlement or compromise may never be held or considered to be an admission of fault or wrongdoing by the insured.

(4) The premium rate charged for either or both ‘claims‑made’ or ‘occurrence’ coverage must be at rates established on an actuarially sound basis, including consideration of trends in the frequency and severity of losses, ~~and must be calculated to be self supporting~~. After the accumulated deficit has been eliminated, the association must function as a residual market mechanism. After that time, the association may not offer rates competitive with the admitted market but the rates for policies issued by the association must be adequate and established at a level that permits the association to operate as a self‑sustaining mechanism.

Section 38‑79‑200. The association is authorized to provide a rate increase or assessment on association policyholders which is subject to the approval of the director or his designee.

Section 38‑79‑210. (1) Any operating deficit sustained by the association in any year must be recouped~~, pursuant to the plan of operation and the rating plan then in effect, by one or both~~ ~~of the following procedures:~~

~~(1)~~ ~~An assessment upon the policyholders which may not exceed one additional annual premium at the then current rate.~~

~~(2)~~ by a rate increase applicable prospectively approved by the director or his designee pursuant to the provisions of Section 38‑79‑180.

Section 38‑79‑220. ~~Effective after the initial year of operation, rates, rating plans, and rating rules, and any provision for recoupment through policyholder assessment or premium rate increase, must be based upon the association’s loss and expense experience and investment income, together with any other information based upon such experience and income as the director or his designee considers appropriate. The resultant premium rates must be on an actuarially sound basis and must be calculated to be self‑supporting.~~

~~In the event that sufficient funds are not available for the sound financial operation of the association, pending recoupment as provided in Section 38‑79‑210, all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner provided for in Section 38‑79‑230. Any such contribution must be reimbursed to the members following recoupment as provided in Section 38‑79‑210.~~ (1) All members of the association, excluding companies who have withdrawn from the association pursuant to 38‑79‑125, must contribute to the elimination of the association and fund’s accumulated deficit. Beginning on January 1, 2020, a uniform assessment of not less than two percent and not more than six percent, as determined by the board and approved by the director, of net direct written premium must be assessed against each member of the association in order to eliminate the accumulated deficits of the association and the fund. Association members must be notified of the assessment at least sixty days prior to each year‑end. After each quarter during the year following notification of the assessment, each member of the association must remit an amount equal to the assessment percentage of the previous quarter’s direct written premiums. Monies derived from this assessment and collected must be distributed by the association to the accumulated deficits of the association and fund as determined appropriate by the director. A member may directly recover any or all of the assessment directly from policyholders. Amounts recouped under this section are not premium and are not subject to premium taxes, fees, or commissions. If one deficit is eliminated before the other, all subsequent monies collected must be distributed to the remaining deficit until it is eliminated. Assessments must cease when both accumulated deficits have been fully eliminated or on December 31, 2035, or whichever occurs first. Funds received by the association under this section will not be considered revenue or considered part of their operating income and will only be used to reduce the accumulated deficit.

(2) Beginning on January 1, 2020, a surcharge on premium may be assessed on association policyholders up to the assessment percentage amount on members in any given year pursuant to the provisions of Section 38‑79‑220 as determined by the association’s board and approved by the director. Association policyholders will be notified of the surcharge percentage at least sixty days prior to each year‑end. Surcharges levied under this section are not premiums and are not subject to premium tax, any fees, or any commissions. Monies derived from this assessment and collected under this section must be distributed by the association to the accumulated deficits of the association and fund as determined appropriate by the director. Should one deficit be eliminated before the other deficit, all subsequent monies collected shall be distributed to the remaining deficit until it is eliminated. This surcharge shall cease when the accumulated deficits of both the association and the fund have been fully eliminated or on December 31, 2035, whichever occurs first. Funds received by the association under this section will not be considered revenue or considered part of their operating income and will only be used to reduce the accumulated deficit.

(3) Each member shall remit to the association payment in full of its assessed amount under this section within thirty days of the end of each quarter. If a member fails to remit its assessed amount by the deadline, the association shall report the failure to the director or designee who may immediately take action to suspend or revoke such insurer’s certificate of authority to transact the business of insurance in the State of South Carolina or issue a fine on that member until such time as the association certifies to the director or his designee that such assessment has been paid in full. The issuance of a fine, suspension, or revocation of an insurer’s certificate of authority to transact business in the State of South Carolina shall not affect the right of the association to proceed against such insurer in any court for any remedy provided by law or contract to the association, including the right to collect such insurer’s assessment. In addition to any other remedy, the association may offset assessments due from an insurer against any amounts in any account of such delinquent insurer. By mailing payment of its allocated amount of assessment, as provided herein, a member shall not waive any right it may have to contest the computation of its allocated amount of assessment. Such contest shall not, however, toll the time within which assessments must be paid or the report to be made to the director or his designee or affect or impede any action to be taken by the director or his designee upon receipt of such report.

(4) Beginning January 1, 2020, all surplus lines insurance producers or brokers placing insurance through nonadmitted insurers shall collect from the insured and remit to the department to be distributed to the association and fund a nonadmitted policy surcharge on all premiums for all insurance written by such surplus lines insurance producer or broker for a policy from a nonadmitted insurer for any and all medical malpractice risks in this State. By procuring or selling medical malpractice insurance in this State from a nonadmitted insurer, each surplus lines insurance producer or broker placing insurance through a nonadmitted insurer agrees to be bound by the provisions of this chapter and to collect and remit the nonadmitted policy surcharge provided for herein.

(a) The nonadmitted policy surcharge must be a percentage of the total policy premium, but the nonadmitted policy surcharge shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the nonadmitted policy surcharge must be treated the same as failure to pay premium. ‘Total policy premium’ includes taxes and commissions.

(b) The nonadmitted policy surcharge percentage must be the same percentage as the assessment that has been approved by the board and director as applied to the insurers writing medical malpractice insurance, medical professional liability insurance, hospital professional liability insurance, or any other type of professional liability insurance in this State covering the professional liability risks of licensed health care providers as described in section 38‑79‑220.

(5) Within thirty days of the end of the quarter, surplus lines insurance producers or brokers placing insurance through nonadmitted insurers shall remit to the department all nonadmitted policy surcharges collected in the preceding quarter. Surplus lines insurance producers or brokers placing insurance through nonadmitted insurers may designate another surplus lines insurance producer or broker that actually procured the insurance from the nonadmitted carrier to collect and remit the nonadmitted policy surcharges.

(6) Each insured in this State who directly procures or renews insurance with a nonadmitted insurer on medical malpractice insurance other than insurance procured through a surplus lines licensee, must be subject to the nonadmitted policy surcharge which must be paid by the insured according to the procedures provided for premium taxes in Chapter 45 of this Title.

Monies derived from the nonadmitted policy surcharge collected under this section must exclusively be used to reduce the accumulated deficits of the association and fund by equal amounts unless the director or his designee determines that different proportions are appropriate. Once the accumulated deficit of the association or the fund is eliminated, whichever occurs first, all subsequent monies collected through the assessment shall exclusively be used to reduce the remaining deficit until it has also been eliminated. The nonadmitted policy surcharge must continue until the surcharge provided in subsection (1) is eliminated.

(7) The accumulated deficits of the association and the fund have accrued and persisted over a period of decades and being partially attributable to state agencies or institutions or their employees, until the director determines that the accumulated deficits of the association and the fund have been eliminated, he may receive appropriations that are explicitly provided for purposes of reducing the accumulated deficits of the association and fund.

Section 38‑79‑230. ~~All insurers which are members of the association shall participate in its writings, expenses, profits, and losses in the proportion that the net direct premiums of each member (excluding that portion of premiums attributable to the operation of the association) written during the preceding calendar year bear to the aggregate net direct premiums written in this State by all members of the association. Each insurer’s participation in the association must be determined annually on the basis of the net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer with the department. The assessment of a member insurer, after hearing, may be ordered deferred in whole or in part upon application by the insurer if, in the opinion of the director or his designee, payment of the assessment may render the insurer insolvent or in danger of insolvency or otherwise may leave the insurer in a condition that further transaction of the insurer’s business may be hazardous to its policyholders, creditors, members, subscribers, stockholders, or the public. If payment of an assessment against a member insurer is deferred by order of the director or his designee in whole or in part, the amount by which the assessment is deferred must be assessed against other member insurers in the same manner as provided in this section. In the order of deferral or in subsequent orders as may be necessary, the director or his designee shall prescribe a plan by which the assessment deferred must be repaid to the association by the impaired insurer with interest at the six‑month treasury bill rate adjusted semiannually. Profits, dividends, or other funds of the association to which the insurer is otherwise entitled may not be distributed to the impaired insurer but must be applied toward repayment of any assessment until the obligation has been satisfied. The association shall distribute the repayments, including interest on them, to the other member insurers on the basis on which assessments were made.~~ Beginning on January 1, 2021, an additional one percent surcharge on premium must be assessed on association policyholders. The premium surcharge must increase by one additional percentage point annually until it reaches ten percent and does not sunset. Surcharges levied under this section are not premium and therefore not subject to premium taxes, fees, or commissions. Surcharges may not be considered when evaluating whether rates are excessive, adequate, or unfairly discriminatory.

Section 38‑79‑240. Every member of the Association is bound by the approved plan of operation of the Association, including any amendments made, and by any other rules the board of directors of the Association lawfully prescribes.

Section 38‑79‑250. (1) ~~If the authority of an insurer to transact bodily injury liability insurance, other than automobile, homeowners, or farmowners, in this State terminates for any reason its obligations as a member of the association nevertheless continue until all its obligations have been fulfilled and the director or his designee has so found and certified to the board of directors.~~ If any member insurer ceases writing business in this State, voluntarily or involuntarily, or by order or authority of the director, the insurer shall continue to be a member of the association until all of its obligations have been satisfied and the director has certified the satisfaction to the association’s board.

(2) If a member insurer merges into, acquires, or consolidates with another insurer ~~authorized to transact such insurance in this State or another insurer authorized to transact such insurance in this State has reinsured the insurer’s entire general liability business in this State, both the insurer and its successor or assuming reinsurer, as the case may be, are liable for the insurer’s~~ transacting business subject to this article or if any other insurer or entity has reinsured or assumed a member insurer’s entire liability business in this State, the surviving insurer, acquiring insurer, its legal successor, or its assuming reinsurer nonetheless remains liable for the member insurer’s obligations in respect to the association.

(3) Any unsatisfied net liability of any insolvent member of the association must be assumed by and apportioned among the remaining members in the same manner in which assessments or gain and loss are apportioned and the association shall thereupon acquire and have all rights and remedies allowed by law ~~in~~ on behalf of the remaining members against the estate or funds of the insolvent insurer for funds due the association.

(4) The State is not responsible for any costs, expenses, liabilities, judgments, or other obligations of the association.

Section 38‑79‑260. (1) The provisions of this section only apply until January 1, 2020.

(2) The association is governed by a board of thirteen directors, all of whom must be appointed by the Governor. The Governor shall appoint five health care providers after consultation with the South Carolina Medical Association, the South Carolina Dental Association, and the South Carolina Health Alliance; four insurance representatives after consultation with the insurance industry; one consumer representative who is unaffiliated with the insurance or health care industries or the medical or legal professions; and two licensed insurance agents or brokers. The professional associations listed and the insurance industry may nominate qualified individuals to the Governor for his consideration. The Governor may also receive nominations for appointments to the board from any other individual, group, or association. Notices of vacancies on the board must be published in newspapers of general statewide circulation. The director or his designee shall serve as an ex officio member of the board. The board shall develop a plan of operation which is subject to the approval of the director or his designee as provided in this article. The plan of operation shall provide for staggered terms of the members of the board. The approved plan of operation of the association may make provision for combining insurers under common ownership or management into groups for voting, assessment, and all other purposes and may provide that not more than one of the officers or employees of a group may serve as a director at any one time. The board shall elect a chairman and other necessary officers for two‑year terms. A vacancy must be filled for the unexpired portion of the term only. The Governor may receive recommendations from any individual, group, or association for any vacancy on the board. The board must meet at the call of the chairman or a majority of the members of the board, but in any event it must meet at least once a year.

Section 38‑79‑280. ~~The association shall file in the office of the department annually, by March first, a statement which contains information with respect to its transactions, condition, operations, and affairs during the preceding year.~~ The association shall file a financial statement with the department by March first of each year detailing its transactions, financial condition, operations, and affairs during the previous calendar year. In addition, the director may require the association to file quarterly financial statements with the department on the fifteenth of May, August, and November of each year. The statement shall contain such matters and information as are prescribed by the director or his designee and must be ~~in the form he directs~~ prepared in the format the director prescribes. The director or his designee may~~, at any reasonable time,~~ require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

Section 38‑79‑290. The director or his designee shall ~~make~~ conduct an examination into the financial condition and affairs of the association at least annually and shall file a report thereon with the department, the Governor, and the General Assembly. The expenses of the examination must be paid by the association. The director or his designee may accept an audit of the association performed by a qualified public accounting firm in lieu of conducting his own examination.

Section 38‑79‑300. (A) Effective on January 1, 2020, the Patients’ Compensation Fund provided for in Article 5 of this chapter shall merge with and into the South Carolina Joint Underwriting Association. The surviving entity is the Joint Underwriting Association and must be renamed and referred to here after as the South Carolina Medical Malpractice Association. The South Carolina Medical Malpractice Association shall assume all obligations and responsibilities of the Patients’ Compensation Fund, while retaining all obligations and responsibilities of the Joint Underwriting Association. However, the accumulated obligations and deficits of the former Joint Underwriting Association and the Patients’ Compensation Fund must be separately accounted for until such time as the director determines each of them is fully eliminated.

(B) On January 1, 2020, the board of the Patients’ Compensation Fund shall, with oversight of the Department of Insurance, exercise due diligence in providing for the orderly and expeditious winding down of the Patients’ Compensation Fund. All outstanding affairs and existing contractual obligations of the Patients’ Compensation Fund shall contemporaneously become the responsibility of the South Carolina Medical Malpractice Association on January 1, 2020. After January 1, 2020, the Patients’ Compensation Fund shall cease to exist except as required by law for purposes of winding down its affairs.

(C) The Board of Directors of the South Carolina Medical Malpractice Association must:

(1) be appointed within sixty days of the effective date of this section, and is authorized to enter into contracts for the management of the South Carolina Medical Malpractice Association in accordance with governing law;

(2) have the right to attend any regular or special meeting of the Board of Directors of the Joint Underwriting Association or the Board of Governors of the Patients’ Compensation Fund, but shall have no vote at these meetings;

(3) replace the existing board of the Joint Underwriting Association as provided for in Section 38‑79‑260;

(4) consist of eleven members all appointed by the Governor, as follows:

(a) four medical providers after consultation with the South Carolina Medical Association, the South Carolina Hospital Association, the South Carolina Nurses Association, and the South Carolina Dental Association;

(b) four representatives from the medical malpractice insurance industry representing member companies of the association after consultation with the three largest members;

(c) two consumer representatives; and

(d) one independent insurance agent or broker not affiliated with any of the three medical malpractice insurance companies already represented on the board; and

(e) the director of the Department of Insurance, who serves ex‑officio and does not have any voting privileges.

(5) elect other necessary officers for two‑year terms after the accumulated deficits of the South Carolina Joint Underwriting Association and the Patients’ Compensation Fund are eliminated. The director or his designee shall serve as chairman of the board.

(D) Upon consultation with and consent of the director, the board of the South Carolina Medical Malpractice Association:

(1) must select a person or firm for the administration and management of the South Carolina Medical Malpractice Association using a competitive bidding process;

(2) is responsible for the negotiation of the administrator’s contract including, without limitation, compensation, fees, and the length of the contract; and

(3) shall have the authority to terminate or retain the administrator.

(E) Each member of the board of the South Carolina Medical Malpractice Association shall serve a term of four years; however, any board member may be reappointed for up to two additional four‑year terms. The professional associations listed and the insurance industry may nominate qualified individuals to the Governor for his consideration. The Governor also may receive nominations for appointments to the board from any other individual, group, or association. The South Carolina Medical Malpractice Association and director must publicize all board vacancies to the general public. A vacancy must be filled for the unexpired portion of the term only. The Board of the South Carolina Medical Malpractice Association Board must meet at the call of the chairman or a majority of the members of the board, but in any event it must meet at least once a year. Any board members of the Joint Underwriting Association or the Patients’ Compensation Fund serving at the time of this enactment may be reappointed by the Governor to the Board of the South Carolina Joint Underwriting Association. The prior service of a board member on the Board of the Joint Underwriting Association or Patients’ Compensation Fund does not count toward the term limits on members of the Board of the South Carolina Medical Malpractice Association.

(F) Each member of the board of the South Carolina Medical Malpractice Association has a fiduciary relationship to the organization and must discharge his duties accordingly.”

SECTION 3. Article 5, Chapter 79, Title 38 of the 1976 Code is amended by adding:

“Section 38‑79‑400. This article must be repealed upon the merger of the Patients’ Compensation Fund for benefit of licensed health care providers into the South Carolina Joint Underwriting Association as provided for in Section 38‑79‑300 on January 1, 2020.”

SECTION 4. 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 5. This act takes effect upon approval by the Governor.

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