DISCLAIMER

The South Carolina Legislative Council is offering access to the unannotated South Carolina Code of Laws on the Internet as a service to the public. The unannotated South Carolina Code on the General Assembly's website is now current through the 2010 session. The unannotated South Carolina Code, consisting only of Code text and numbering, may be copied from this website at the reader's expense and effort without need for permission.

The Legislative Council is unable to assist users of this service with legal questions. Also, legislative staff cannot respond to requests for legal advice or the application of the law to specific facts. Therefore, to understand and protect your legal rights, you should consult your own private lawyer regarding all legal questions.

While every effort was made to ensure the accuracy and completeness of the unannotated South Carolina Code available on the South Carolina General Assembly's website, the unannotated South Carolina Code is not official, and the state agencies preparing this website and the General Assembly are not responsible for any errors or omissions which may occur in these files. Only the current published volumes of the South Carolina Code of Laws Annotated and any pertinent acts and joint resolutions contain the official version.

Please note that the Legislative Council is not able to respond to individual inquiries regarding research or the features, format, or use of this website. However, you may notify Legislative Printing, Information and Technology Systems at [LPITS@scstatehouse.gov](mailto:LPITS@scstatehouse.net) regarding any apparent errors or omissions in content of Code sections on this website, in which case LPITS will relay the information to appropriate staff members of the South Carolina Legislative Council for investigation.

CHAPTER 74.

HEALTH INSURANCE POOL

**SECTION 38‑74‑10.** Definitions.

As used in this chapter:

(1) “Pool” means the South Carolina Health Insurance Pool.

(2) “Board” means the board of directors of the pool.

(3) “Insured” means any individual resident of this State who is eligible to receive benefits from any insurer.

(4) “Insurer” means any entity that provides health insurance in this State. For purposes of this section, insurer includes an insurance company, a health maintenance organization, and any other entity providing health insurance which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

(5) “Health insurance” or “health insurance coverage” means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under a hospital or medical service policy or certificate, hospital, or medical service plan contract, or health maintenance organization contract offered by an insurer, except:

(a) coverage only for accident or disability income insurance, or any combination thereof;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers’ compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit‑only insurance;

(g) coverage for on‑site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

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

(iii) such other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness; and

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy, coverage supplement to the coverage provided under Chapter 55, Title 10 of the United States Code.

(6) “Medicare” means Title XVIII of the Social Security Act, 42 USC 1395, et seq., as amended.

(7) “Physician” means any practitioner of the healing arts, other than an insured person or a person related to an insured person, who is legally licensed to perform any service for which benefits are provided by the insurance policy issued by the pool.

(8) “Hospital” means an institution operated pursuant to law under the supervision of a staff of duly licensed physicians which is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the public on a prearranged basis, medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made and provides twenty‑four hour nursing service under the supervision of registered nurses.

(9) “Health maintenance organization” means an organization as defined in Section 38‑33‑20(7).

(10) “Plan of operation” means the plan of operation of the pool, including articles, bylaws, and operating rules adopted by the board.

(11) “Benefits plan” means the coverages to be offered by the pool to eligible persons.

(12) “Department” means the South Carolina Insurance Department.

(13) “Director” means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. Furthermore, the director may bestow upon his designee or deputy director any duty or function required of him by law in managing or supervising the Insurance Department.

(14) “Member” means each insurer participating in the pool.

(15) “Net loss” means the excess of incurred claims plus expenses over the sum of earned premiums, accrued investment income, and other appropriate gains and losses.

(16) “Affiliation period” means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during this period and no premium shall be charged to the participant or beneficiary for any coverage during the period. The period begins on the enrollment date and runs concurrently with any waiting period under the plan.

(17) “Beneficiary” has the meaning given under Section 3( 8) of the Employee Retirement Income Security Act of 1974.

(18) “COBRA continuation provision” means:

(a) Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974, other than Section 609 of the act;

(b) Section 4908B of the Internal Revenue Code of 1986, other than subsection (f)(1) of the section insofar as it relates to pediatric vaccines; or

(c) Title XXII of the Public Health Service Act.

(19) “Church plan” has the meaning given the term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

(20) “Creditable coverage” means, with respect to an individual, coverage of the individual under:

(a) a group health plan;

(b) health insurance;

(c) Part A or B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55, Title 10 of the United States Code;

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool, including the South Carolina Health Insurance Pool;

(h) a health plan offered under Chapter 89, Title 5 of the United States Code;

(i) a public health plan, as defined in regulations;

(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or

(k) Title XXI of the Social Security Act (State Children’s Health Insurance Program).

The term does not include coverage consisting only of those benefits excepted from the definition of health insurance.

A period of creditable coverage is not counted if, after such period and before the enrollment date, there was a sixty‑three day period during all of which the individual was not covered under any creditable coverage. However, in determining whether there has been continuous coverage, no period must be taken into account during which the individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period.

Periods of creditable coverage with respect to an individual must be established through presentation of certifications as described in Section 38‑71‑850(D) or in a manner specified in regulations.

(21) “Employee” has the meaning given the term under Section 3(6) of the Employee Retirement Income Security Act of 1974.

(22) “Enrollment date” means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for the enrollment.

(23) “Federally defined eligible individual” means an individual:

(a) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage is eighteen or more months;

(b) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan or health insurance coverage offered in connection with one of these plans;

(c) who is not eligible for coverage under a group health plan, part A or part B of Title XVIII of the Social Security Act, or a state plan under Title XIX of the Social Security Act or any successor program and who does not have other health insurance coverage;

(d) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(e) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected the coverage; and

(f) who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program.

(24) “Governmental plan” has the meaning given the term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of the government.

(25) “Group health insurance coverage” means, in connection with a group health plan, health insurance offered by an insurer in connection with the plan.

(26) “Group health plan” means an employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(27) “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan. The term includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year unless the State elects to regulate the coverage as coverage issued to small employers as defined in Section 38‑71‑1330.

(28) “Medical care” means amounts paid for:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(b) amounts paid for transportation primarily for and essential to medical care referred to in subitem (a); and

(c) amounts paid for insurance covering medical care referred to in subitems (a) and (b).

(29) “Participant” has the meaning given the term under Section 3(7) of the Employee Retirement Income Security Act of 1974.

(30) “Preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date. Genetic information may not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the information.

(31) “Waiting period” means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(32) “Qualified TAA eligible individual” means an individual who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986.

**SECTION 38‑74‑20.** South Carolina health insurance pool.

(A) There is created a nonprofit entity to be known as the South Carolina Health Insurance Pool. All insurers authorized to issue or provide health insurance in this State on or after the effective date of this chapter are members of the pool.

(B) The director or his designee shall give notice to all insurers of the time and place for the initial organizational meetings. The pool members shall select five directors to sit on the board. The Governor shall appoint three directors to the board. One must be appointed to represent consumers and two must be appointed to represent businesses, other than the insurance industry. In the event of a tie vote of the board on any matter, the issue must be presented to the director for his approval or disapproval. The selection of the administering insurer is subject to approval by the director. The board shall include, to the extent possible, at least two domestic insurance companies selling health insurance in South Carolina, including the domestic company selling the largest amount of health insurance.

(C) If, within sixty days of the organizational meeting the board is not selected, the director shall appoint the initial board.

(D) The board shall submit to the director or his designee a plan of operation for the pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The director or his designee shall approve the plan of operation provided it is determined to be suitable to assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of pool gains or losses on an equitable basis. The plan of operation is effective upon approval in writing by the director or his designee consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit a suitable plan of operation within one hundred twenty days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the department, after notice and hearing, shall promulgate reasonable regulations necessary to effectuate the provisions of this chapter. The regulations shall continue in force until modified by the department or superseded by a plan submitted by the board and approved by the director or his designee.

(E) In its plan the board shall:

(1) establish procedures for the handling and accounting of assets and monies of the pool;

(2) select an administering insurer in accordance with Section 38‑74‑40 and establish procedures for filling vacancies on the board of directors;

(3) establish procedures for the collection of assessments from all members to provide for claims incurred or estimated to be incurred under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments must be established by the board, pursuant to Section 38‑74‑50. Assessment occurs at the end of each fiscal year. The board may provide also for interim assessments against members of the pool if necessary to assure the financial capability of the pool. Assessments are due and payable within thirty days of receipt of the assessment notice;

(4) develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

(F) The pool has the general powers granted under the laws of this State to insurance companies licensed to transact accident and health insurance including, but not limited to, the specific authority to:

(1) enter into contracts necessary to carry out the provisions of this act, including the authority, with the approval of the director or his designee, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal actions necessary or proper for recovery of assessments for, on behalf of, or against pool members;

(3) take legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(4) establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

(5) assess members of the pool in accordance with the provisions of this act;

(6) subject to the approval of the director or his designee, issue policies of insurance in accordance with the requirements of this chapter;

(7) appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the pool, policy, and other contract design, and any other function within the authority of the pool;

(8) borrow money to effect the purposes of this act. Notes or other evidence of indebtedness of the pool not in default are legal investments for domestic insurers and may be carried as admitted assets. The pool may not borrow money unless there is a net loss of the operation of the pool which exhausts the assessments of the pool for that year. No money may be borrowed in excess of the loss after assessments have been exhausted. No more than three million dollars may be borrowed in any one year, and the total amount borrowed at any one time may not exceed five million dollars. The members of the pool are responsible for any debt which is incurred by the pool;

(9) cause to be audited on an independent basis every two years the finances of the pool and submit the report of audit to the department who shall submit it to the Chairman of the Senate Finance Committee and the Chairman of the House Ways and Means Committee with recommendations on the operations of the pool.

(G) In addition to its general powers, the board may take measures to contain insurance costs subject to the approval of the director or his designee, including, but not limited to:

(1) provide for and employ cost containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective;

(2) design, utilize, contract, or otherwise arrange for delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, or other limited network provider arrangements.

**SECTION 38‑74‑30.** Eligibility for pool coverage.

(A) A person who is a resident of this State for thirty days, except that for a federally defined eligible individual or a Qualified TAA eligible individual, there shall not be a thirty‑day requirement, and his newborn child is eligible for pool coverage:

(1) upon providing evidence of any of the following actions by an insurer on an application for health insurance comparable to that provided by the pool submitted on behalf of the person:

(a) a refusal to issue the insurance for health reasons;

(b) a refusal to issue the insurance except with a reduction or exclusion of coverage for a preexisting health condition for a period exceeding twelve months, unless it is determined that the person voluntarily terminated his or did not seek any health insurance coverage before being refused issuance except with a reduction or exclusion for a preexisting health condition, and then seeks to be eligible for pool coverage after the health condition develops. This determination must be made by the board;

(c) a refusal to issue insurance coverage comparable to that provided by the pool except at a rate exceeding one hundred fifty percent of the pool rate; or

(2) if the individual is a federally defined eligible individual or a Qualified TAA eligible individual, as defined in Section 38‑74‑10, who is and continues to be a resident of this State; or

(3) if the individual is under the age of sixty‑five and covered under Medicare Parts A and B for reasons other than age.

(B) A person whose health insurance coverage is terminated involuntarily for any reason other than nonpayment of premium may apply for coverage under the plan but shall submit proof of eligibility according to subsection (A) of this section. If proof is supplied and if coverage is applied for within sixty days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage is the date of termination of the previous coverage. Waiting period and preexisting condition exclusions are waived to the extent to which similar exclusions, if any, have been satisfied under the prior health insurance coverage. The waiver does not apply to a person whose policy has been terminated or rescinded involuntarily because of a material misrepresentation.

(C) A person who is paying a premium for health insurance comparable to the pool plan in excess of one hundred fifty percent of the pool rate or who has received notice that the premium for a policy would be in excess of one hundred fifty percent of the pool rate may make application for coverage under the pool. The effective date of coverage is the date of the application, or the date that the premium is paid if later, and any waiting period or preexisting condition exclusion is waived to the extent to which similar exclusions, if any, were satisfied under the prior health insurance plan. Benefits payable under the pool plan are secondary to benefits payable by the previous plan. The board shall require an additional premium for coverage effected under the plan in this manner notwithstanding the premium limitation stated in Section 38‑74‑60.

(D)(1) The waiting period and preexisting condition exclusions are waived for a federally defined eligible individual.

(2) The waiting period and preexisting condition exclusions are waived for a Qualified TAA eligible individual if the individual maintained creditable coverage for an aggregate period of three months as of the date on which the individual seeks to enroll in pool coverage, not counting any period prior to a sixty‑three‑day break in coverage.

(E) A person not eligible for pool coverage is one who meets any one of the following criteria:

(1) a person who has coverage under health insurance comparable to that offered by the pool from an insurer or any other source except a person who would be eligible under subsection (C) of this section;

(2) a person who is eligible for health insurance comparable to that offered by the pool from an insurer or any other source except a person who would be eligible for pool coverage under Section 38‑74‑30(A)(1)(b), 38‑74‑30(A)(1)(c), 38‑74‑30(A)(2), or 38‑74‑30(A)(3);

(3) a person who at the time of pool application is eligible for health care benefits under state Medicaid or eligible for health care benefits under Medicare and age sixty‑five or older;

(4) a person having terminated coverage in the pool unless twelve months have lapsed since termination unless termination was because of ineligibility, except that this item shall not apply with respect to an applicant who is a federally defined eligible individual;

(5) a person on whose behalf the pool has paid out one million dollars in benefits;

(6) inmates of public institutions and persons eligible for public programs, except that this item shall not apply with respect to an applicant who is a federally defined eligible individual;

(7) a person who fails to maintain South Carolina residency.

(F) A person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

**SECTION 38‑74‑40.** Administration of pool.

(A) The board shall select an insurer through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which includes:

(1) the insurer’s proven ability to handle accident and health insurance;

(2) the efficiency of the insurer’s claim‑paying procedures;

(3) an estimate of total charges for administering the plan;

(4) the insurer’s ability to administer the pool in a cost‑efficient manner;

(B)(1) The administering insurer shall serve for a period of three years subject to removal for cause.

(2) At least one year prior to the expiration on each three‑year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three‑year period. Selection of the administering insurer for the succeeding period must be made at least six months prior to the end of the current three‑year period.

(C)(1) The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

(2) The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings must be made on a periodic basis as determined by the board.

(3) The administering insurer shall perform all necessary functions to assure timely payment of benefits to a covered person under the pool including:

(a) making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission must be made;

(b) evaluating the eligibility of each claim for payment by the pool.

(4) The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report are determined by the board.

(5) Following the close of each fiscal year, the administering insurer shall determine the net loss for the year and report this information to the board and the department on a form prescribed by the commissioner.

(6) The administering insurer is paid as provided in the plan of operation for its expenses incurred in the performance of its services.

**SECTION 38‑74‑50.** Insurer’s assessment.

(A) Each insurer’s assessment is determined by multiplying the net loss of pool operation by a fraction, the numerator of which equals that insurer’s total premium and subscriber contract charges for health insurance written in the State during the preceding calendar year, and the denominator of which equals the total of all health premiums and subscriber contract charges written by all insurers in the State during the preceding calendar year. Health insurance premiums that are less than an amount determined by the board to justify the cost of collection are not considered for purposes of determining assessments.

(B) If assessments exceed the net loss of pool operation, the excess must be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, “future losses” includes reserves for incurred but not reported claims.

(C)(1) Each member’s proportion of participation in the pool is determined annually by the board based on annual statements and other reports considered necessary by the board and filed by the member with it.

(2) Any deficit incurred by the pool may be recouped by assessments apportioned under subsection (A) of this section by the board among members.

(D) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member 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 members in a manner consistent with the basis for assessments set forth in subsection (A) of this section. The member receiving abatement or deferment shall remain liable to the pool for the deficiency for four years.

**SECTION 38‑74‑60.** Major medical expense coverage.

(A)(1) Except as provided in Section 38‑74‑60(B), the pool shall offer major medical expense coverage to every eligible person. The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations must be established by the board and approved by the director taking into consideration the advice and recommendations of the pool members.

(2) In establishing and reviewing the pool’s major medical expense coverage, the board shall take into consideration the levels of health insurance provided in the State and medical and economic factors considered appropriate and promulgate benefit levels, deductibles, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the State. At least one policy form of coverage must be comparable to comprehensive health insurance coverage offered in the individual market in this State or to the standard health insurance plan as defined in Section 38‑71‑1330.

(B) The pool shall offer Medicare supplemental health insurance coverage to each person who is under age sixty‑five covered under Medicare Parts A and B for reasons other than age. The benefit plans to be offered must include Medicare supplement plan A and plan C.

(C) The pool shall provide a choice of health insurance coverage to all eligible individuals.

(D)(1) Premium rates charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

(2) The board shall determine the standard risk rate for major medical expense coverage by taking into account the individual standard rate charged by the five largest insurers offering individual coverages in the State comparable to the pool coverage. If five insurers do not offer comparable coverage, the standard risk rate must be established using reasonable actuarial techniques and must reflect anticipated experience and expenses for coverage. Rates initially established for pool coverage are two hundred percent of rates established as applicable for individual standard risks. Rates subsequently established must provide fully for the expected costs of claims and expenses of operation taking into account investment income and any other cost factors but may not exceed two hundred percent of rates established as applicable for individual standard risks subject to the limitations described in this section. All rates and rate schedules must be submitted to the director or his designee for approval.

(3) Premium rates charged for Medicare supplemental insurance coverage may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Rates established must provide fully for the expected costs of claims and expenses of operation taking into account investment income and any other cost factors.

(E) Except as provided in Section 38‑74‑30(B), (C), and (D), pool coverage excludes charges or expenses incurred during the first six months following the effective date of coverage as to any condition which during the six‑month period immediately preceding the effective date of coverage:

(1) had manifested itself in a manner so as to cause an ordinarily prudent person to seek diagnosis, care, or treatment; or

(2) for which medical advice, care, or treatment was recommended or received as to the condition.

(F)(1) A benefit otherwise payable under pool coverage for covered expenses must be reduced by all amounts paid or payable for the same expenses through any other health insurance or health coverage and by all hospital and medical expense benefits paid or payable under any workers’ compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The insurer or the pool has a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

**SECTION 38‑74‑70.** Immunity.

(A) Neither the participation in the pool as members, the establishment of rates, forms, or procedures nor any other joint or collective action required by this chapter may be the basis of any legal action, criminal or civil liability, or penalty against the pool or any of its members.

(B) There is no liability on the part of, and no cause of action of any nature may arise against, a member insurer or its agents or employees, the pool’s agents, employees, or board of directors, or the director, his designees or his representatives, for any act or omission in the performance of their powers and duties under this chapter. This section does not relieve the pool of any of its liability.

**SECTION 38‑74‑80.** Tax exemption and credits.

The pool established pursuant to this chapter is exempt from all taxes and assessments. Any member subject to tax liability imposed by any state statute may take credit for any assessment paid to the pool in the previous year against its premium or income tax payable. The tax credit is in addition to any other tax credits to which the member may be entitled pursuant to South Carolina law, but the credit may not reduce the member’s tax liability below zero. Any unused credit may be carried forward three years. The credits are subject to the provisions of Section 38‑7‑120(c). The members are responsible for any loss of the operation of the pool, including any loss in excess of assessments paid to the pool. This State is not responsible for any loss of the operation of the pool, and no state funds may be used to defray any loss. If the total assessment for all members of the pool exceeds ten million dollars in any one year, the credit for any member shall be limited to the amount determined by multiplying the member’s assessment by a fraction, the numerator of which equals ten million dollars and the denominator of which equals the total assessment in the year for all members of the pool.

**SECTION 38‑74‑90.** Director of Department of Insurance; promulgation of regulations.

The Director of the Department of Insurance may promulgate regulations necessary or appropriate to carry out the provisions of this chapter.