CHAPTER 73

Property, Casualty, Inland Marine, and Surety Rates and Rate‑making Organizations

ARTICLE 1

General Provisions

**SECTION 38‑73‑10.** Declaration of purpose; construction.

(a) The purposes of this chapter are to:

(1) promote the public welfare by regulating insurance rates to the end that they may not be excessive, inadequate, or unfairly discriminatory and to authorize and regulate cooperative action among insurers in rate making and in other matters within the scope of this chapter;

(2) empower the director or his designee to fix, establish, and promulgate any uniform statistical plan necessary or appropriate to obtain all automobile insurance loss and loss adjustment expense experience, other expense experience, and all other appropriate statistical and financial data from insurers, rating organizations, and advisory organizations engaged in an automobile insurance business in this State to the end that the department shall promulgate the risk classification and territorial plans to be used by all insurers of automobile insurance in this State and in order that the director or his designee may test the risk and territorial differentials previously established against the most recently available loss experience;

(3) provide that investment income accruing to automobile insurers is taken into consideration in the approval of rates or premium charges and in the determination of any net loss incurred by the South Carolina Reinsurance Facility and to make provision for the securing by the department of all necessary or appropriate financial data for purposes of ascertaining and determining the investment income and the profits from realized and unrealized capital gains of each automobile insurer doing business in this State;

(4) provide for reasonable competition for commercial property and casualty insurers of insureds who make large purchases of insurance.

Nothing in this chapter is intended to prohibit or discourage reasonable competition.

(b) This chapter must be liberally interpreted to carry into effect the purposes of this chapter.

HISTORY: Former 1976 Code Section 38‑43‑10 [1947 (45) 322; 1952 Code Section 37‑651; 1962 Code Section 37‑651] recodified as Section 38‑73‑10 by 1987 Act No. 155, Section 1; 1989 Act No. 148, Section 6; 1993 Act No. 181, Section 783; 2000 Act No. 235, Section 5.

**SECTION 38‑73‑20.** Scope of chapter.

(a) This chapter applies to (1) fire and allied lines and inland marine insurance, as defined in Section 38‑73‑310 and (2) casualty insurance, including fidelity, surety, and guaranty bonds, and to all other forms of automobile insurance, in either case on risks located or operations in this State. However, Article 3 and Article 5 of this chapter apply only to the respective classes of insurance as stated in Sections 38‑73‑310 and 38‑73‑410.

(b) This chapter does not apply to:

(1) reinsurance, other than joint reinsurance to the extent stated in Article 15 of this chapter;

(2) insurance of vessels or craft or their cargoes, marine builders’ risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies;

(3) accident and health insurance;

(4) insurance against loss of or damage to aircraft or against liability arising out of the ownership, maintenance, or use of aircraft; or

(5) life insurance.

HISTORY: Former 1976 Code Sections 38‑43‑20 [1947 (45) 322; 1952 Code Section 37‑652; 1962 Code Section 37‑652] and 38‑43‑30 [1947 (45) 322; 1952 Code Section 37‑653; 1962 Code Section 37‑653] recodified as Section 38‑73‑20 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑30.** Insurance subject to dual regulation.

If any kind of insurance, subdivision, or combination thereof or type of coverage subject to this chapter is also subject to regulation by another rate regulatory act of this State or other law of this State, an insurer to which the other act or law and this chapter are otherwise applicable shall file with the department a designation as to which rate regulatory chapter or act or law is applicable to it with respect to that kind of insurance, subdivision, or combination thereof or type of coverage.

HISTORY: Former 1976 Code Section 38‑43‑40 [1947 (45) 322; 1952 Code Section 37‑654; 1962 Code Section 37‑654] recodified as Section 38‑73‑30 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑40.** Recording and reporting of loss and expense experience.

The department may promulgate statistical plans, reasonably adapted to each of the rating systems on file with the department, which may be modified from time to time and which must be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in Sections 38‑73‑330 and 38‑73‑430, as the case may be. The plans may also provide for the recording and reporting of expense experience items which are specially applicable to this State and are not susceptible of determination by a prorating of countrywide expense experience. In promulgating these plans, the department shall give due consideration to the rating systems on file with it and, in order that such plans may be as uniform as is practicable among the several states, to the form of the plans used for rating systems in other states. The department may designate one or more rating organizations or other agencies to assist him in gathering the experience and making compilations thereof. These compilations must be made available, subject to plans promulgated by the department, to insurers and rating organizations.

HISTORY: Former 1976 Code Section 38‑43‑50 [1947 (45) 322; 1952 Code Section 37‑655; 1962 Code Section 37‑655; 1974 (58) 2718] recodified as Section 38‑73‑40 by 1987 Act No. 155, Section 1; 1989 Act No. 148, Section 7; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑50.** Interchange of rating plan data.

Reasonable regulations and plans may be promulgated by the department for the interchange of data necessary for the application of rating plans.

HISTORY: Former 1976 Code Section 38‑43‑60 [1947 (45) 322; 1952 Code Section 37‑656; 1962 Code Section 37‑656] recodified as Section 38‑73‑50 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑60.** Consultation with other states.

In order to further uniform administration of rate regulatory laws, the director or his designee and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers, and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

HISTORY: Former 1976 Code Section 38‑43‑70 [1947 (45) 322; 1952 Code Section 37‑657; 1962 Code Section 37‑657] recodified as Section 38‑73‑60 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑70.** Regulations.

The department may make reasonable regulations necessary to effect the purposes of this chapter.

HISTORY: Former 1976 Code Section 38‑43‑80 [1947 (45) 322; 1952 Code Section 37‑658; 1962 Code Section 37‑658]; Section 38‑43‑90 [1960 (51) 1646; 1962 Code Section 37‑658.1; 1969 (56) 239; 1972 (57) 2750] recodified as Section 38‑73‑70 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑80.** Withholding or giving false or misleading information.

No person or organization may wilfully withhold information from or knowingly give false or misleading information to the director or his designee, any statistical agency designated by the director or his designee, any rating organization, or any insurer which will affect the rates or premiums chargeable under this chapter. A violation of this section subjects the one guilty of the violation to the penalties provided in Chapter 2 of this title.

HISTORY: Former 1976 Code Section 38‑43‑100 [1947 (45) 322; 1952 Code Section 37‑659; 1962 Code Section 37‑659] recodified as Section 38‑73‑80 by 1987 Act No. 155, Section 1; 1988 Act No. 374, Section 40; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑90.** Examinations of rating organizations, advisory groups, and other organizations.

The director or his designee shall, at least once in five years, make or cause to be made an examination of each rating organization licensed in this State as provided in Section 38‑73‑1230. The director or his designee may, as often as he considers advisable, make or cause to be made an examination of each advisory organization referred to in Section 38‑73‑1510 and of each group, association, or other organization referred to in Section 38‑73‑1710. The reasonable costs of the examination must be paid by the rating organization, advisory organization, or group, association, or other organization examined upon presentation to it of a detailed account of the costs. The officers, manager, agents, and employees of these rating organizations, advisory organizations, or groups, associations, or other organizations may be examined at any time under oath and shall exhibit all books, records, accounts, documents or agreements governing their method of operation. These examinations are subject to the provisions of Sections 38‑13‑40 to 38‑13‑60. In lieu of an examination the director or his designee may accept the report of an examination made by the insurance supervisory official of another state pursuant to the laws of that state.

HISTORY: Former 1976 Code Section 38‑43‑110 [1947 (45) 322; 1952 Code Section 37‑660; 1962 Code Section 37‑660] recodified as Section 38‑73‑90 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑110.** Suspension of license.

The director or his designee may suspend the license of any rating organization or insurer which fails to comply with an order of the director or his designee within the time limited by the order or any extension thereof which the director or his designee may grant. The director or his designee may not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal therefrom has expired or, if an appeal has been taken, until the order has been affirmed. The director or his designee may determine when a suspension of license becomes effective and it remains in effect for the period fixed by him unless he modifies or rescinds the suspension or until the order upon which the suspension is based is modified, rescinded, or reversed.

HISTORY: Former 1976 Code Section 38‑43‑130 [1947 (45) 322; 1952 Code Section 37‑662; 1962 Code Section 37‑662] recodified as Section 38‑73‑110 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑120.** Hearing as prerequisite to imposition of penalty or suspension of license.

No penalty may be imposed and no license may be suspended or revoked except upon a written order of the director or his designee, stating his findings, made after a hearing held upon not less than thirty days’ written notice to the person or organization specifying the alleged violation.

HISTORY: Former 1976 Code Section 38‑43‑140 [1947 (45) 322; 1952 Code Section 37‑663; 1962 Code Section 37‑663] recodified as Section 38‑73‑120 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑130.** Hearing procedure; judicial review.

Any insurer or rating organization aggrieved by any order or decision of the director or his designee made without a hearing may, within thirty days after notice of the order to the insurer or organization, make written request to the Administrative Law Court for a hearing. The Administrative Law Court shall hear the party or parties within twenty days after receipt of the request and shall give not less than ten days’ written notice of the time and place of the hearing. Within fifteen days after the hearing the Administrative Law Court shall affirm, reverse, or modify the previous action, specifying his reasons therefor. Pending the hearing and decision thereon the director or his designee may suspend or postpone the effective date of his previous action.

HISTORY: Former 1976 Code Section 38‑43‑150 [1947 (45) 322; 1952 Code Section 37‑664; 1962 Code Section 37‑664] recodified as Section 38‑73‑130 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

ARTICLE 2

Property and Casualty Insurance Personal Lines Modernization Act

**SECTION 38‑73‑210.** Article title and application.

This article is known as the “Property and Casualty Insurance Personal Lines Modernization Act” and applies only to personal lines insurance.

HISTORY: 2004 Act No. 290, Section 1, eff July 29, 2004.

**SECTION 38‑73‑220.** Approval process for rate level changes.

(A) Except as provided in subsection (B), overall average rate‑level increases or decreases, for all coverages combined, of seven percent above or below the insurer’s rates then in effect may take effect without prior approval on a file and use basis with respect to rates for fire, allied lines, and homeowner’s insurance policies. The seven percent cap does not apply on an individual insured basis.

(B) Notwithstanding another provision of this chapter, for any policies governed by this section, filings that produce rate‑level changes within the limitation specified in subsection (A) become effective without prior approval. No more than two rate increases within the limitation specified in subsection (A) may be implemented during any twelve‑month period and the second rate‑increase filing in the twelve‑month period is subject to prior approval.

(C) A rate increase or decrease falling within the limitation in subsection (B) may become effective not less than thirty days after the date of the filing with the director. The filing is considered to meet the requirements of this chapter. If the director finds that this filing is not in compliance with this chapter, he shall issue a written order specifying in detail the provisions with which the insurer has not complied and state a reasonable period in which the filing is considered no longer effective. An order by the director pursuant to this section that is issued more than thirty days from the date on which the director received the rate filing is on a prospective basis only and does not affect any contract issued or made before the effective date of the order.

(D) Rate filings falling outside the limitation specified in subsection (B) are subject to the prior approval of the director. The director shall approve or disapprove these filings in accordance with the provisions of Sections 38‑73‑960 and 38‑73‑990.

HISTORY: 2004 Act No. 290, Section 1, eff July 29, 2004; 2006 Act No. 332, Section 8, eff June 1, 2006.

**SECTION 38‑73‑230.** Declaration of competitive line; factors considered; hearings before Administrative Law Court.

(A) The director may declare a line of insurance competitive by providing public notice on the department website and in major newspapers in South Carolina of the intention of declaring a market competitive in sixty days. A separate notice must be sent to the Consumer Advocate. A report that provides the support for that declaration must be available upon request and posted on the department’s website. A party may send a request to the department requesting a public hearing before the Administrative Law Court. If a public hearing is requested, the department shall cooperate in establishing a hearing.

(B) The following factors must be considered by the director for purposes of determining if a reasonable degree of competition exists in a particular line of insurance:

(1) the number of insurers or groups of affiliated insurers providing coverage in the market;

(2) measures of market concentration and changes of market concentration over time;

(3) ease of entry and the existence of financial or economic barriers that could prevent new firms from entering the market;

(4) the extent to which any insurer or group of affiliated insurers controls all or a portion of the market;

(5) whether the total number of companies writing the line of insurance in this State is sufficient to provide multiple options;

(6) the availability of insurance coverage to consumers in the markets by specific geographic area, by line of insurance, and by class of risk; and

(7) the opportunities available to consumers in the market to acquire pricing and other consumer information.

Each factor must indicate a competitive market in order for a determination that there is a competitive market to be made.

(C) The director shall monitor the degree and continued existence of competition in this State on an on‑going basis. The director may utilize existing relevant information, analytical systems, and other sources, or rely on a combination of them. Activities may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors, or in any other appropriate manner.

(D) An affected person or organization may make a written request to the director or his designee to initiate a hearing to determine whether a particular line of insurance continues to be competitive. The request for hearing must specify the grounds to be relied upon by the applicant. Within thirty days after the receipt of the request, the director or his designee shall transmit the request for hearing to the Administrative Law Court.

HISTORY: 2004 Act No. 290, Section 1, eff July 29, 2004.

**SECTION 38‑73‑240.** Rate filings where line declared competitive; Consumer Advocate review of certain filings.

(A) In a line of insurance declared competitive, each insurer shall file with the director all rates, supplementary rate information, and supporting information for competitive markets at least thirty days before the proposed effective date. The director or his designee may give written notice, within thirty days of the receipt of the filing, that additional time is needed, not to exceed thirty days from the date of the notice, to consider the filing. Upon written application of the insurer, the director or his designee may authorize rates to be effective before the expiration of the waiting period or an extension of it. A filing is considered to meet the requirements of this chapter and to become effective unless disapproved pursuant to this section by the director or his designee before the expiration of the waiting period or an extension of it. Residual market mechanisms or advisory organizations may file residual market rates.

(B) The filing is considered in compliance with the filing provisions of this section unless the director or his designee informs the insurer within ten days after receipt of the filing as to what supplementary rate information or supporting information is required to complete the filing.

(C) An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense‑constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by this chapter.

(D) All rates, supplementary rate information, and any supporting information filed pursuant to this chapter is open to public inspection after the filing becomes effective.

(E) With respect to applications for rate increases for fire, allied lines, and homeowner’s insurance that exceed the seven percent cap as provided for in Section 38‑73‑260(A) and if an applicant insurer had earned premiums in this State in the previous calendar year of more than ten million dollars for the line or type of insurance for which the rate increase is sought, the director or his designee shall provide a copy of the filing to the Consumer Advocate or, in the alternative, shall direct the insurer to provide a copy simultaneously to the Consumer Advocate. Within ten business days of the receipt of the filing, the Consumer Advocate may request from the insurer additional information. A copy of the request must be served on the director or his designee. Within ten business days of the receipt of the information sought, the Consumer Advocate shall inform the insurer and the director if, in his opinion, the filing is not in compliance with this chapter and specify in detail the reason for his opinion. If the filing is accepted by the director and becomes effective, the Consumer Advocate, upon good cause shown, may request a hearing before the Administrative Law Court. An order of the administrative law judge issued pursuant to the provisions of this section is on a prospective basis only and does not affect any contract issued or made before the effective date of the order.

HISTORY: 2004 Act No. 290, Section 1, eff July 29, 2004; 2006 Act No. 332, Section 9, eff June 1, 2006.

**SECTION 38‑73‑250.** Rate filings where line declared noncompetitive.

(A) If the director or his designee determines that competition does not exist in a line of insurance and issues a ruling to that effect pursuant to Section 38‑73‑230, the rates applicable to insurance sold in that market must be regulated pursuant to Section 38‑73‑260. The director may simply declare a line of insurance noncompetitive and release a report providing the support for that decision. The decision may be appealed to the Administrative Law Court. The market is considered not competitive during the appeal process.

(B) A rate filing in effect at the time the director or his designee determines that competition does not exist pursuant to Section 38‑73‑230 must be considered to be in compliance with the laws of this State unless disapproved pursuant to the procedures and rating standards contained in Section 38‑73‑260 applicable to noncompetitive markets.

(C) An insurer having a rate filing in effect at the time the director determines that competition does not exist pursuant to Section 38‑73‑240 may be required to furnish supporting information within thirty days of a written request by the director or his designee.

HISTORY: 2004 Act No. 290, Section 1, eff July 29, 2004.

**SECTION 38‑73‑260.** Approval process for rate level changes; Consumer Advocate review of certain filings.

(A) Except as provided in subsection (B), overall average rate‑level increases or decreases, for all coverages combined, of seven percent above or below the insurer’s rates then in effect may take effect without prior approval on a file and use basis with respect to rates for fire, allied lines, and homeowner’s insurance policies. The seven percent cap does not apply on an individual insured basis.

(B) Notwithstanding another provision of this chapter, for any policies governed by this section, filings that produce rate‑level changes within the limitation specified in subsection (A) become effective without prior approval. No more than two rate increases within the limitation specified in subsection (A) may be implemented during a twelve‑month period and the second rate increase filing in the twelve‑month period is subject to prior approval.

(C) A rate increase or decrease falling within the limitation in subsection (B) may become effective not less than thirty days after the date of the filing with the director. The filing is considered to meet the requirements of this chapter. If the director finds that this filing is not in compliance with this chapter, he shall issue a written order specifying in detail the provisions with which the insurer has not complied and state a reasonable period in which the filing is considered no longer effective. An order by the director pursuant to this section that is issued more than thirty days from the date on which the director received the rate filing is on a prospective basis only and does not affect a contract issued or made before the effective date of the order.

(D) Rate filings falling outside the limitation specified in subsection (B) are subject to the prior approval of the director or his designee. The director or his designee shall approve or disapprove these filings pursuant to the provisions of Sections 38‑73‑960 and 38‑73‑990.

(E) With respect to applications for rate increases for fire, allied lines, and homeowner’s insurance that exceed the seven percent cap as provided in subsection (A) and if an applicant insurer had earned premiums in this State in the previous calendar year of more than ten million dollars for the line or type of insurance for which the rate increase is sought, the director or his designee shall provide a copy of the filing to the Consumer Advocate or, in the alternative, shall direct the insurer to provide a copy simultaneously to the Consumer Advocate. Within ten business days of the receipt of the filing, the Consumer Advocate may request from the insurer additional information. A copy of the request must be served on the director or his designee. Within ten business days of the receipt of the information sought, the Consumer Advocate shall inform the insurer and the director if, in his opinion, the filing is not in compliance with this chapter and specify in detail the reason for his opinion. If the filing is accepted by the director and becomes effective, the Consumer Advocate, upon good cause shown, may request a hearing before the Administrative Law Court. An order of the administrative law judge issued pursuant to the provisions of this section is on a prospective basis only and does not affect any contract issued or made before the effective date of the order.

(F)(1) Nothing in this section prevents the director or his designee from considering the impact on individual territories or individual insureds when determining whether the rate is excessive, inadequate, or unfairly discriminatory. Rate level increases or decreases falling within the limitation specified in this subsection must comply with the requirements of this chapter prohibiting rate increases from being excessive, inadequate, or unfairly discriminatory.

(2) With respect to fire, allied lines, and homeowner’s rates, the director or his designee shall specifically review all rate filings made on or after June 1, 2007, to ensure that each insurer’s rates for policies that exclude wind coverage reflect a discount commensurate with that insurer’s previously filed surcharge for policies that include wind coverage.

(3) This subsection does not apply to private passenger automobile insurance nor to insurance against liability arising out of the ownership, maintenance, or the use of:

(a) an individual private passenger automobile as defined in Section 38‑77‑30(5.5)(a); or

(b) property having wheels.

HISTORY: 2004 Act No. 290, Section 1, eff July 29, 2004; 2006 Act No. 332, Section 10, eff June 1, 2006; 2007 Act No. 78, Section 8, eff June 11, 2007, applicable to taxable years beginning after December 31, 2006.

**SECTION 38‑73‑270.** Consumer information system.

The director shall utilize, develop, or cause to be developed, a consumer information system which provides and disseminates price and other relevant information on a readily available basis to purchasers of homeowner’s, private passenger nonfleet automobile, or property insurance for personal, family, or household needs. The director may utilize, develop, or cause to be developed, a consumer information system which provides and disseminates price and other relevant information on a readily available basis to purchasers of insurance for commercial risks and personal risks not otherwise specified. The activity may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors, or in another appropriate manner. As necessary and appropriate, the director, insurers, advisory organizations, statistical agents, and other persons or organizations involved in conducting the business of insurance in this State, pursuant to the provisions of this chapter, shall cooperate in the development and utilization of a consumer information system.

HISTORY: 2004 Act No. 290, Section 1, eff July 29, 2004; 2006 Act No. 332, Section 11, eff June 1, 2006.

ARTICLE 3

Fire and Allied Lines and Inland Marine Insurance Rates

**SECTION 38‑73‑310.** Scope of article.

This article applies only to fire and allied lines and inland marine insurance, on risks located in this State. Inland marine insurance includes insurance (a) defined by statute or by interpretation thereof, (b) if not so defined or interpreted, defined by ruling of the director or his designee, or (c) as established by general custom of the business as inland marine insurance. This article does not apply to automobile insurance nor to insurance against liability arising out of the ownership, maintenance, or use of motor vehicles.

HISTORY: Former 1976 Code Section 38‑43‑310 [1947 (45) 322; 1952 Code Section 37‑671; 1962 Code Section 37‑671] recodified as Section 38‑73‑310 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑320.** Insurance subject to both this article and Article 5.

If any kind of insurance, subdivision, or combination thereof or type of coverage subject to this article is also subject to regulation under Article 5 of this chapter, an insurer to which both articles are otherwise applicable shall file with the department a designation as to which regulatory article shall be applicable to it with respect to that kind of insurance, subdivision, or combination thereof or type of coverage.

HISTORY: Former 1976 Code Section 38‑43‑320 [1947 (45) 322; 1952 Code Section 37‑672; 1962 Code Section 37‑672] recodified as Section 38‑73‑320 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑325.** Absence of credit information.

Absence of credit information may be used by an insurer for underwriting purposes only if the insurer presents information satisfactory to the director that the absence is related to the risk.

HISTORY: 2004 Act No. 290, Section 5, eff July 29, 2004.

**SECTION 38‑73‑330.** Making of rates.

Rates must be made in accordance with the following provisions:

(1) Manual, minimum, and class rates, rating schedules, or rating plans must be made and adopted, except in the case of specific inland marine rates on risks specially rated.

(2) Rates may not be excessive, inadequate, or unfairly discriminatory. Due consideration must be given for installation and maintenance of nationally recognized hazard reducing systems.

(3) Due consideration must be given to past and prospective loss experience within and outside this State, to the conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers, to past and prospective expenses, both countrywide and those specially applicable to this State, and to all other relevant factors within and outside this State, and in the case of fire insurance rates consideration must be given to the experience of the fire insurance business during a period of not less than the most recent five‑year period for which the experience is available.

Except to the extent necessary to meet the provisions of item (2) of this section, uniformity among insurers in any matters within the scope of this section is neither required nor prohibited. Rates made in accordance with this section may be used subject to the provisions of this chapter.

HISTORY: Former 1976 Code Section 38‑43‑330 [1947 (45) 322; 1952 Code Section 37‑673; 1962 Code Section 37‑673; 1975 (59) 192] recodified as Section 38‑73‑330 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑340.** Rate filings required.

Every insurer shall file with the department, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans and except as to exempt commercial policies, every manual, minimum, or class rate, rating schedule or rating plan, and every other rating rule and every modification of any of these which it proposes to use. The filing exemption shall not apply to loss cost filings by advisory or rating organizations. Every filing shall state the proposed effective date and shall indicate the character and extent of coverage contemplated. Specific inland marine rates on risks specially rated, made by a rating organization, must be filed with the department.

HISTORY: Former 1976 Code Section 38‑43‑340 [1947 (45) 322; 1952 Code Section 37‑674; 1962 Code Section 37‑674] recodified as Section 38‑73‑340 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 2000 Act No. 235, Section 6; 2002 Act No. 300, Section 2, eff January 1, 2003.

ARTICLE 5

Casualty and Surety Rates

**SECTION 38‑73‑410.** Scope of article.

This article applies only to casualty insurance, including fidelity, surety, and guaranty bonds, and to all other forms of automobile insurance, on risks or operations in this State.

HISTORY: Former 1976 Code Section 38‑43‑410 [1947 (45) 322; 1952 Code Section 37‑681; 1962 Code Section 37‑681] recodified as Section 38‑73‑410 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑420.** Insurance subject to both this article and Article 3.

If any kind of insurance, subdivision, or combination thereof or type of coverage subject to this article is also subject to regulation under Article 3 of this chapter, an insurer to which both articles are otherwise applicable shall file with the department a designation as to which regulatory article shall be applicable to it with respect to that kind of insurance, subdivision, or combination thereof or type of coverage.

HISTORY: Former 1976 Code Section 38‑43‑420 [1947 (45) 322; 1952 Code Section 37‑682; 1962 Code Section 37‑682] recodified as Section 38‑73‑420 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑425.** Absence of credit information.

Absence of credit information may be used by an insurer for underwriting purposes only if the insurer presents information satisfactory to the director that the absence is related to the risk.

HISTORY: 2004 Act No. 290, Section 6, eff July 29, 2004.

**SECTION 38‑73‑430.** Making of rates.

Rates must be made in accordance with the following provisions:

(1) Due consideration must be given to past and prospective loss experience within and outside this State, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers, to past and prospective expenses, both countrywide and those specially applicable to this State, and to all other relevant factors within and outside of this State.

(2) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of the insurer or group with respect to any kind of insurance or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

(3) Risks may be grouped by classifications for the establishment of rates and minimum premiums, and classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring any variations in hazards or expense provisions, or both, that can be demonstrated to have a probable effect upon losses or expenses.

(4) Rates may not be excessive, inadequate, or unfairly discriminatory.

(5) Due consideration must be given to assessments for purposes such as the guaranty fund, wind and hail joint underwriting association, and similar mechanisms.

Except to the extent necessary to meet the provisions of item (4) of this section, uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

HISTORY: Former 1976 Code Section 38‑43‑430 [1947 (45) 322; 1952 Code Section 37‑683; 1962 Code Section 37‑683] recodified as Section 38‑73‑430 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 2004 Act No. 315, Section 1, eff October 12, 2004.

**SECTION 38‑73‑440.** Certain factors may not be considered in determining automobile insurance rates.

In determining the premium rates to be charged on automobile insurance, it is unlawful to consider race, religion, national origin, or economic status.

HISTORY: Former 1976 Code Section 38‑37‑360 [1962 Code Section 37‑591.16; 1974 (58) 2718] recodified as Section 38‑73‑440 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑470.** Disposition of uninsured motorist premium.

Two dollars of the yearly premium for uninsured motorist coverage is directed to be paid to the South Carolina Department of Motor Vehicles to be allocated in the manner provided in Section 56‑10‑552 on a quarterly basis. Interest earned by the “Uninsured Fund” must be retained by that fund. There is no requirement for an insurer or an agent to offer underinsured motorist coverage at limits less than the statutorily required bodily injury or property damage limits.

HISTORY: Former 1976 Code Section 56‑9‑840 [1962 Code Section 46‑750.33:1; 1971 (57) 854; 1974 (58) 2718] recodified as Section 38‑73‑470 by 1987 Act No. 155, Section 1; Reenacted, 1991 Act No. 11, Section 1; 1993 Act No. 181, Section 787; 1993 Act No. 181, Section 783; 1997 Act No. 154, Section 3; 2002 Act No. 324, Section 9, eff July 1, 2002; 2012 Act No. 264, Section 1, eff June 18, 2012; 2016 Act No. 275 (S.1258), Section 10, eff July 1, 2016.

Editor’s Note

2002 Act No. 324, Section 12, provides as follows:

“This act takes effect July 1, 2002; provided, however, that Section 56‑10‑650 and Sections 5, 6, and 9 are effective one hundred eighty days after the latter of certification by the department to the President Pro Tempore of the Senate and the Speaker of the House of Representatives that the program has been implemented and is fully prepared to accept data transmitted by the insurers or publication of final regulations by the department.”

Effect of Amendment

2016 Act No. 275, Section 10, amended the section, providing that all or a portion of the fees or fines collected by the department of motor vehicles shall be credited to the state highway fund.

**SECTION 38‑73‑480.** Rate for group automobile insurance.

An automobile insurance contract sold on the basis of a group plan or contract pursuant to Section 38‑77‑130 shall have a rate not less than five percent less than the individual rate for which the insurer markets a substantially similar policy.

HISTORY: Former 1976 Code Section 38‑37‑350 [1962 Code Section 37‑591.15; 1974 (58) 2718] recodified as Section 38‑73‑480 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑490.** Workers’ compensation rates.

To secure fair, reasonable, adequate, and nondiscriminatory rates for workers’ compensation insurance the director or his designee shall approve the rate for each classification under which workers’ compensation insurance is written, which rate and classification must be the same for all insurers. The director or his designee shall, in approving the rates, make use of the experience data which may be available and any other helpful information that may be obtainable.

A proceeding under this section is considered a proceeding to fix or alter rates for consumer services in relation to the duties of the Division of Consumer Advocacy.

HISTORY: Former 1976 Code Section 42‑5‑90 [1936 (39) 1231; 1937 (40) 613; 1942 Code Section 7035‑76; 1952 Code Section 72‑409; 1962 Code Section 72‑409; 1960 (51) 1646; 1980 Act No. 517 Part II, Section 20] recodified as Section 38‑73‑490 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑495.** Authority to disapprove previously approved rate for classification of worker’s compensation insurance; reassignment of classifications; time for filing appeal.

The director or his designee may:

(1) disapprove a previously approved rate for any classification for workers’ compensation insurance upon a finding that the rate for that classification is excessive, inadequate, or unfairly discriminatory;

(2) require the division of a particular classification into separate classifications, or the joining of separate classifications into one classification, upon a finding that such action is in the public interest;

(3) direct that a particular risk be classified in a particular classification upon a finding that a risk is classified incorrectly;

(4) disapprove an experience modification rate for workers’ compensation insurance upon a finding that the rate is excessive, inadequate, or unfairly discriminatory. This includes an experience modification rate that fails to account for third party reimbursements, including the Second Injury Fund. Appeals regarding experience modification rates must first be exhausted through the National Council on Compensation Insurance’s dispute resolution process prior to appealing with the Department of Insurance.

Appeals to the department must be filed within one year of policy expiration date or cancellation date, whichever comes first.

HISTORY: 1990 Act No. 321, Section 1; 1990 Act No. 600, Section 1; 1993 Act No. 181, Section 783; 2000 Act No. 312, Section 17; 2007 Act No. 111, Pt II, Section 1, eff July 1, 2007, applicable to injuries that occur on or after that date.

**SECTION 38‑73‑500.** Merit rating for workers’ compensation insurance; credit; testing.

(A) For the purpose of uniformity and equality the director or his designee shall approve a system of merit rating for use in the writing of workers’ compensation insurance. No system of merit rating except the one so approved may be used.

(B) This system of merit rating shall include a credit of at least five percent for an insured who participates in a program designed to prevent the use of drugs or alcoholic beverages on the job by employees of the insured. The credit must be actuarially sound and filed with the director or his designee. However, if the director determines that a credit of at least five percent is not actuarially sound, the director shall allow and order a credit of less than five percent which is actuarially sound. The director or his designee shall provide for certification of an employer drug prevention program and shall promulgate regulations for the implementation of this subsection including, but not limited to, the establishment of guidelines or a plan defining a qualified employer drug prevention program eligible for the credit which shall be used by the insurer unless the insurer has established its own guidelines or plan. In the establishment of guidelines or a plan by the director or insurer concerning a qualified drug prevention program eligible for the credit, the guidelines or plan shall include the policy statement and employee notification requirement pursuant to Section 41‑1‑15.

(C) The testing procedure established by the insurer, employer, or his designee, or, approved by the director, must include a provision for random sampling of all persons who receive wages and compensation in any form from the employer. If a second test is administered, the testing procedure may allow for a single sample to be split for use in the first and second tests. Positive test results must be provided in writing to the employee within twenty‑four hours of the time the employer receives the test results. Each employer must keep records of each test for up to one year.

HISTORY: Former 1976 Code Section 42‑5‑100 [1936 (39) 1231; 1937 (40) 613; 1942 Code Section 7035‑76; 1952 Code Section 72‑410; 1960 (51) 1646; 1962 Code Section 72‑410] recodified as Section 38‑73‑500 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 1997 Act No. 92, Section 1; 2014 Act No. 197 (S.826), Section 1, eff June 2, 2014.

Effect of Amendment

2014 Act No. 197, Section 1, in subsection (C), substituted “If a second test is administered, the testing procedure may allow for a single sample to be split for use in the first and second tests” for “and must provide for a second test to be administered within thirty minutes of the administration of the first test”.

**SECTION 38‑73‑505.** Reductions in premiums.

For each policy of workers’ compensation insurance issued or renewed in the State on or after October 1, 1997, there shall be granted by the insurer a reduction in premium of not less than five percent pursuant to Section 38‑73‑500 as contained and amended in Section 1 of 1997 Act No. 92.

HISTORY: 1997 Act No. 92, Section 3.

**SECTION 38‑73‑510.** Nonpartisan rating bureau for workers’ compensation.

Every workers’ compensation insurer, including the parties to any mutual insurance association, must be a member of a nonpartisan rating bureau. The stock and nonstock insurers which are members of the bureau must be represented in the bureau management and on all committees of the bureau. One‑half of the members of each committee must be chosen by the stock companies and one‑half by the nonstock companies. In a case of a tie vote on any committee the director or his designee shall cast the deciding vote.

HISTORY: Former 1976 Code Section 42‑5‑110 [1936 (39) 1231; 1937 (40) 613; 1942 Code Section 7035‑76; 1952 Code Section 72‑411; 1960 (51) 1646; 1962 Code Section 72‑411] recodified as Section 38‑73‑510 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑515.** Deductibles.

(A) Each insurer issuing a policy of workers’ compensation insurance shall offer, as a part of the policy or as an optional endorsement to the policy, deductibles optional to the policyholder for benefits payable under Title 42. Deductible amounts offered must be disclosed fully to the prospective policyholder in writing in the amount of one hundred dollars, two hundred dollars, three hundred dollars, four hundred dollars, five hundred dollars, or increments of five hundred dollars up to a maximum of two thousand five hundred dollars for each compensable claim. The policyholder exercising the deductible option shall choose only one deductible amount.

(B) If the policyholder exercises the option and chooses a deductible, the insured employer is liable for the amount of the deductible for benefits paid for each compensable claim of work injury suffered by an employee. The insurer shall pay all or part of the deductible amount, whichever is applicable to a compensable claim, to the person or provider entitled to the benefits conferred by this chapter and then seek reimbursement from the insured employer for the applicable deductible amount. The payment or nonpayment of deductible amounts by the insured employer to the insurer must be treated under the policy insuring the liability for workers’ compensation in the same manner as payment or nonpayment of premiums.

(C) Optional deductibles must be offered in each policy insuring liability for workers’ compensation which is issued, delivered, issued for delivery, or renewed after June 30, 1996, unless an insured employer and insurer agree to renegotiate a workers’ compensation insurance policy in effect on July 1, 1996, so as to include a provision allowing for a deductible.

(D) Premium reduction for deductibles must be determined before the application of any experience modification, premium surcharge, or premium discounts. To the extent that an employer’s experience rating or safety record is based on benefits paid, money paid by the insured employer under a deductible as provided in this section must not be included as benefits paid so as to harm the experience rating of the employer.

(E) This section does not apply to employers who are approved to self‑insure against liability for workers’ compensation or group self‑insurance funds for workers’ compensation established pursuant to the laws of this State.

HISTORY: 1996 Act No. 424, Section 9.

**SECTION 38‑73‑520.** Rate filings required.

Every insurer must file with the department, except as to exempt commercial policies, every manual of classifications, rules, and rates, every rating plan, and every modification of any of these which it proposes to use. The filing exemption shall not apply to loss cost filings by advisory or rating organizations or to the multiplier for expenses, assessments, profit, and contingencies and any modifications to loss costs used by a workers’ compensation insurer to be applied to approved loss costs to develop the insurer’s rates as provided in Section 38‑73‑525. Every filing must state the proposed effective date and indicate the character and extent of the coverage contemplated.

HISTORY: Former 1976 Code Section 38‑43‑440 [1947 (45) 322; 1952 Code Section 37‑684; 1962 Code Section 37‑684] recodified as Section 38‑73‑520 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 2000 Act No. 235, Section 7; 2002 Act No. 300, Section 3, eff January 1, 2003; 2007 Act No. 111, Pt III, Section 1, eff July 1, 2007, applicable to injuries that occur on or after that date.

**SECTION 38‑73‑525.** Filing of multiplier for expenses by insurers writing workers’ compensation.

(A) Each insurer writing workers’ compensation insurance shall adopt the most recent loss costs within sixty days after approval of these loss costs. This loss costs adoption must become effective no later than one hundred twenty days after the effective date of the approved loss costs. An insurer must notify the department of its adoption of the most recently approved loss costs by filing a notification on a form and in a manner prescribed by the director or his designee. The notification filing required by this subsection does not constitute a rate filing and is not subject to prior approval.

(B)(1) At least sixty days before using a new multiplier for expenses, assessments, profits, and contingencies, each insurer writing workers’ compensation shall file its multiplier for expenses, assessments, profit, and contingencies and any information relied upon by the insurer to support the multiplier and any modifications to loss costs. A copy of the filing must be provided simultaneously to the consumer advocate.

(2) Filings submitted pursuant to item (1) must be filed on a form and in the manner prescribed by the director or his designee and must contain, at a minimum, the following information: commission expense; other acquisition expense; general expense; expenses associated with recoveries from the Second Injury Fund; guaranty fund assessments; other assessments; premium taxes; miscellaneous taxes, licenses, or fees; a provision for profit and contingencies, and the date of approval of the loss costs to which the multiplier is applied, which must be the most recently approved loss costs.

(3) Filings submitted pursuant to item (1) are subject to approval of the director or his designee and must be reviewed by an actuary employed or retained by the department who is a member of the American Academy of Actuaries or an associate or fellow of the Casualty Actuarial Society.

(4)(a) Within the sixty‑day period, if the director or his designee believes the information filed is not complete, the director or his designee shall notify the insurer of additional information to be provided. Within fifteen days of receipt of the notification, the insurer shall provide the requested information or file for a hearing challenging the reasonableness of the director’s or his designee’s request. The burden is on the insurer to justify the denial of the additional information.

(b) Unless a hearing is requested, upon expiration of the sixty‑day period or the fifteen‑day period, whichever is later, the insurer may use the multiplier for expenses, assessments, profit, and contingencies.

HISTORY: 2007 Act No. 111, Pt III, Section 2, eff July 1, 2007, applicable to injuries that occur on or after that date; 2016 Act No. 213 (S.1064), Section 1, eff June 3, 2016.

Effect of Amendment

2016 Act No. 213, Section 1, rewrote the section, requiring an insurer writing workers’ compensation insurance to adopt loss costs within a certain time frame, and requiring an insurer to file its multiplier for expenses, assessments, profit and contingencies sixty days before using a new multiplier.

**SECTION 38‑73‑526.** Report as to availability and affordability of workers’ compensation coverage.

The director or his or her designee must issue a report to the General Assembly by the first of January each year that evaluates the state of the workers’ compensation insurance market in this State. The report must contain an analysis of the availability and affordability of workers’ compensation coverage and document that the department has complied with the provisions of Sections 38‑73‑430 and 38‑73‑525 with regard to both workers’ compensation loss cost filings submitted by an advisory or rating organization and multiplier filings submitted by every insurer writing workers’ compensation insurance.

HISTORY: 2007 Act No. 111, Pt III, Section 7, eff July 1, 2007, applicable to injuries that occur on or after that date.

**SECTION 38‑73‑530.** Competitive rate on specific risk.

The director or his designee may, upon the filing with him of an affidavit setting forth information required by him, grant permission to a licensed insurer to make a rate competing with any nonlicensed insurer in any specific risk.

HISTORY: Former 1976 Code Section 38‑43‑450 [1947 (45) 322; 1952 Code Section 37‑685; 1962 Code Section 37‑685] recodified as Section 38‑73‑530 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑540.** Assigned risk.

(A)(1) Assigned risk agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure, insurance through ordinary methods, and the insurers may agree among themselves on the use of reasonable rate modifications for this insurance. Such residual market agreement and any mechanism designed to implement such agreement, and any amendments thereto, must be submitted in writing to the director or his designee for approval prior to use, together with such additional information as the director or his designee may reasonably require. Insurers that participate in the voluntary market shall participate in these mechanisms and shall pay their assessments, if any.

(2) If, after a hearing, the director or his designee finds that any activity or practice of insurers participating in the residual market mechanism is unfair, unreasonable, or otherwise inconsistent with the provisions of this title, the director or his designee must issue a written order specifying in what respects such activity or practice is unfair, unreasonable, or otherwise inconsistent with the provisions of this title and require the discontinuance of such activity or practice. The director or his designee may establish, by written order, an assigned risk plan or mechanism if he finds that insurers have failed to agree pursuant to item (1), or to implement assigned risk agreements if the director or his designee finds that the existing residual market mechanism is unfair, unreasonable, or inconsistent with the provisions of this chapter.

(3) The servicing carriers for the workers’ compensation assigned risk pool may be competitively bid as provided for in this subsection. If the workers’ compensation assigned risk pool is competitively bid, then the director or his designee must appoint a committee or committees of individuals as he considers qualified to establish standards and procedures for the consideration and evaluation of bids. Insurers, or other vendors in conjunction with a licensed workers’ compensation insurer, may submit bids. The committee or committees must evaluate and award contracts pursuant to the bidding process established by the committee or committees, subject to the final approval of the director or his designee. The director may require a bid fee to cover the expenses of implementing this section.

(4) Notwithstanding any other provision of this section or of this article, assigned risk pools must accept a policy of workers’ compensation insurance on the basis that it provides coverage to a vendor who provides logging services to a named insured or on the basis that the policy provides coverage to an association of these vendors.

(B) Notwithstanding the provisions of subsection (A), no insurer may act as a servicing carrier for any assigned risk pool for workers’ compensation insurance authorized pursuant to subsection (A) unless such insurer participates in the voluntary market for workers’ compensation insurance in this State.

(C) It is essential for maintaining the viability of the assigned risk plan to establish and maintain rates at a level which permits the plan to operate as a self‑funded mechanism. The plan administrator shall maintain necessary rate making data in order to permit the actuarial determination of rates and rating plans appropriate for the business insured through the plan. All assigned carriers shall report their experience on business written under the plan to the plan administrator in a format prescribed by the plan administrator. The plan administrator shall monitor rate adequacy and plan results and shall notify the director of the Department of Insurance in the event that excessive losses are indicated so as to enable the director to take corrective action.

HISTORY: Former 1976 Code Section 38‑43‑460 [1947 (45) 322; 1952 Code Section 37‑686; 1962 Code Section 37‑686] recodified as Section 38‑73‑540 by 1987 Act No. 155, Section 1; 1991 Act No. 104, Section 1; 1992 Act No. 436, Section 1; 1993 Act No. 181, Section 783; 1996 Act No. 451, Section 1; 1998 Act No. 291, Section 1.

**SECTION 38‑73‑545.** Applicability to self‑insurers.

Nothing in Section 38‑73‑540 applies to self‑insurers.

HISTORY: 1998 Act No. 291, Section 3.

ARTICLE 7

State Rating and Statistical Division

**SECTION 38‑73‑710.** State Rating and Statistical Division established; executive director.

There is established within the department a State Rating and Statistical Division which is under the administrative direction of the Director of the Department of Insurance. Nothing precludes the appointment by the director of a deputy director of any person who is now or may hereafter be an employee of the department, in addition to or substitution for his other duties or responsibilities.

HISTORY: Former 1976 Code Section 38‑37‑510 [1962 Code Section 37‑591.21; 1974 (58) 2718] recodified as Section 38‑73‑710 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑736.** Rate reductions for nonyouthful operator completing approved driver training course.

(A) As used in this section:

(1) “Approved driver training course” means a driver’s training course that:

(a) is approved by the Department of Motor Vehicles or exempt pursuant to Chapter 23, Title 56;

(b) is administered by a driver’s training school that is licensed or approved by the Department of Motor Vehicles or exempt pursuant to Chapter 23, Title 56;

(c) is conducted by a person holding a valid driver’s instructor permit pursuant to Chapter 23, Title 56; and

(d) includes a minimum of four hours of classroom instruction.

(2) “Satisfactory evidence of course completion” means a certificate signed by an official of the licensed driver’s training school or the Department of Motor Vehicles, which certifies that:

(a) the person has successfully completed the course; and

(b) the course is an approved driver training course and meets the requirements of Chapter 23, Title 56.

(3) “Youthful operator” means a person under the age of twenty‑five for which premium rates charged for liability coverages and collision coverage under a private passenger automobile insurance policy are determined by a youthful driver classification.

(B) Premium rates charged for liability coverages and collision coverage under a private passenger automobile insurance policy are subject to an appropriate driver training course credit once satisfactory evidence of course completion is presented by an applicant for the credit that is the named insured or principal operator of the vehicle and is not a youthful operator. The amount of the credit may be determined by each individual insurer based upon factually or statistically supported data and is subject to prior approval or review by the director. The credit must be afforded for a minimum of thirty‑six months from the date the approved driver training course was completed. The insurer may require, as a condition of providing and maintaining the credit, that the applicant not be involved in an accident for which the applicant is at fault for a three‑year period after course completion. The credit must be afforded by each insurer in a nondiscriminatory manner to all applicants, other than those considered youthful operators.

(C) Only the vehicle driven by an applicant that has completed successfully an approved driver training course qualifies for the insurance credit required by this section. Other vehicles under the private passenger automobile insurance policy do not qualify for the insurance credit required by this section unless the named insured or principal operator of the additional vehicle has successfully completed an approved driver training course.

(D) The insurer must provide the driver training course credit upon receipt of satisfactory evidence of course completion. Nothing in this section may be construed so as to require the insurer to provide the credit for any period of time before the date of receipt of satisfactory evidence of course completion.

(E) An applicant qualifying for the insurance credit required by this section only may claim the credit for successful completion of one approved driver training course during any private passenger automobile insurance policy period.

(F) Only an approved driver training course taken on a voluntary basis qualifies for the insurance credit. A driver training course taken as a requirement of a driving offense including, but not limited to, ADSAP or driver training courses taken to reduce the number of traffic violation points against a driver’s license, do not qualify for the insurance credit provided in this section.

(G) A schedule of rates, rate classification, or rating plan for private passenger automobile insurance must provide for an appropriate reduction in premium charges for an insured person who is not a youthful operator and who qualifies as provided in this section.

HISTORY: 1997 Act No. 154, Section 5; 2011 Act No. 7, Section 1, eff December 31, 2011; 2015 Act No. 26 (S.361), Section 1, eff June 1, 2015.

Effect of Amendment

2015 Act No. 26, Section 1, in (A)(1)(d), substituted “four hours” for “six hours”; deleted former (2), definition of “Approved driver training refresher course”; redesignated the paragraphs accordingly; and deleted references to “approved driver training refresher course” throughout.

**SECTION 38‑73‑737.** Rate reductions for youthful operator completing approved driver training course.

(A) As used in this section:

(1) “Approved driver’s education course” means a driver’s training course that:

(a) is approved by the Department of Motor Vehicles pursuant to Chapter 23, Title 56 or is approved by the Department of Education pursuant to Section 59‑39‑320;

(b) is administered by a driver’s training school that is licensed by the Department of Motor Vehicles or a state institution or duly accredited and approved college, private, parochial, or public high school pursuant to Chapter 23, Title 56; and

(c) is conducted by a person holding a valid driver’s instructor permit pursuant to Chapter 23, Title 56.

(2) “Satisfactory evidence of course completion” means a certificate signed by an official of the school, the Department of Motor Vehicles, the Department of Education, or other responsible educational entity which certifies that:

(a) the person has successfully completed the course; and

(b) the course is an approved driver’s education course and meets the requirements of Chapter 23, Title 56 or Section 59‑39‑320.

(3) “Youthful operator” means a person under the age of twenty‑five for which premium rates charged for liability coverages and collision coverage under a private passenger automobile insurance policy are determined by a youthful driver classification.

(B) Premium rates charged for liability coverages and collision coverage under a private passenger automobile insurance policy are subject to an appropriate driver’s education course credit once satisfactory evidence of course completion is presented by an applicant for the credit that is the named insured or principal operator of the vehicle and is a youthful operator. The amount of the credit may be determined by each individual insurer based upon factually or statistically supported data and is subject to prior approval or review by the director. The credit must be afforded from the date the approved driver’s education course was completed for as long as the premium rates continue to be determined by a youthful driver classification. The insurer may require, as a condition of providing and maintaining the credit, that the applicant not be involved in an accident for which the applicant is at fault or be convicted of, plead guilty to, or plead nolo contendere to a violation of the motor vehicle laws for any moving violation. The credit required by this section must be afforded by each insurer in a nondiscriminatory manner to all applicants.

(C) Only the vehicle driven by an applicant that has completed successfully an approved driver’s education course qualifies for the insurance credit required by this section. Other vehicles under the private passenger automobile insurance policy do not qualify for the insurance credit required by this section unless the named insured or principal operator of the additional vehicle has successfully completed an approved driver’s education course.

(D) The insurer must provide the driver’s education course credit upon receipt of satisfactory evidence of course completion. Nothing in this section may be construed so as to require the insurer to provide the credit for any period of time before the date of receipt of satisfactory evidence of course completion.

(E) An applicant qualifying for the insurance credit required by this section only may claim the credit for successful completion of one approved driver’s education course during any private passenger automobile insurance policy period.

(F) An approved driver’s education course taken on a voluntary basis or taken as a requirement of driver licensing qualifies for the insurance credit. Driver training courses taken as a requirement of a driving offense including, but not limited to, ADSAP or driver training courses taken to reduce the number of traffic violation points against a driver’s license, do not qualify for the insurance credit provided in this section.

(G) A schedule of rates, rate classification, or rating plan for private passenger automobile insurance must provide for an appropriate reduction in premium charges for an insured person who is a youthful operator and who qualifies as provided in this section.

HISTORY: 1994 Act No. 496, Section 1; 2011 Act No. 7, Section 2, eff December 31, 2011.

**SECTION 38‑73‑740.** Certain information must be retained; inspection by applicant.

All information, including investigative and credit reports used in determining the classification or premium rates of any person applying for automobile insurance, must be kept on file by the insurer for at least three years from the date the application was made. Upon request of the applicant, the contents of the file must be made available for inspection by the applicant and copies of the documents must be furnished the applicant if he pays the cost of reproducing the copies.

HISTORY: Former 1976 Code Section 38‑37‑330 [1962 Code Section 37‑591.13; 1974 (58) 2718] recodified as Section 38‑37‑740 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

ARTICLE 9

Rates and Rate Making and Rate Filing Generally

**SECTION 38‑73‑910.** Notice of hearing as a prerequisite to granting of rate increase; exceptions; rate level increase or decrease limitations; flexible rating for automobile insurance policies; report.

(A) An increase in the premium rates may not be granted for workers’ compensation insurance, nor for any other line or type of insurance with respect to which the director or his designee has, by order, made a finding that (a) legal or other compulsion upon the part of the insured to purchase the insurance interferes with competition, or (b) under prevailing circumstances there does not exist substantial competition, unless notice is given in all newspapers of general, statewide circulation at least thirty days in advance of the insurer’s proposed effective date of the increase in premium rates. The notice must state the amount of increase, the type and line of coverage, and the proposed effective date and must allow any insured or affected party to request within fifteen days a public hearing upon the propriety of the rate increase request before the Administrative Law Court. A copy of the notice must be sent to the Consumer Advocate.

However, the requirements of public notices and public hearings in this section do not apply to applications for rate increases when the applicant insurer had earned premiums in this State in the previous calendar year of less than two million dollars for the line or type of insurance for which the rate increase is sought or, if the rate increase is sought by a modeling organization, the earned premiums in this State for all members and subscribers of the organization for whom an increase is sought were less than two million dollars for the previous calendar year for the line or type of insurance for which the rate increase is sought. The two million dollars must be increased by a factor equal to the increase in the consumer price index, all items, every three years.

(B) Except as provided in subsection (C), overall average rate level increases or decreases, for all coverages combined, of seven percent above or below the insurer’s rates then in effect may take effect without prior approval on a file and use basis with respect to rates for automobile insurance policies. The seven percent cap does not apply on an individual insured basis.

(C) Notwithstanding any other provisions of this chapter, for any policies governed by this section, filings that produce rate level changes within the limitation specified in subsection (B) become effective without prior approval; provided, that (1) no more than one rate increase within the limitation specified in subsection (B) may be implemented during any twelve‑month period, and (2) no rate increase within the limitation specified in subsection (B) may be implemented until the onset of the new policy period unless the insurer, at least thirty days in advance of the end of the policy period, mails or delivers to the named insured at the address shown in the policy a written notice of its intention to change the rate. The overall statewide rate change implemented under this section must be stated in the notice.

A rate increase or decrease falling within the limitation in subsection (B) may become effective not less than thirty days after the date of the filing with the director. The filing is deemed to meet the requirements of this chapter. The director may find that such a filing is not in compliance with this chapter. In the event of such a finding, the director shall issue a written order specifying in detail the provisions with which the insurer has not complied and state a reasonable period thereafter in which the filing shall be deemed no longer effective. Any order by the director pursuant to this section that is issued more than thirty days from the date on which the director received the rate filing shall be on a prospective basis only and shall not affect any contract issued or made prior to the effective date of the order.

Rate filings falling outside the limitation specified in subsection (B) are subject to the prior approval of the director. The director shall approve or disapprove these filings in accordance with the provisions of Sections 38‑73‑960 and 38‑73‑990.

(D) Individual automobile insurance companies and member companies of an affiliated group of automobile insurers may utilize different filed rates for automobile insurance coverages in accordance with rating plans filed with and approved by the director. These rating plans may provide for different rates, rating tiers, and rating plans among affiliated companies. For the purpose of this subsection, an affiliated group of automobile insurers includes a group of automobile insurers under common ownership, management, or control.

(E) The Director of the Department of Insurance or his designee shall promulgate regulations to implement the provisions of this section.

(F) On or before March 31, 2004, the Director of the Department of Insurance or his designee shall report to the General Assembly on the effectiveness of flexible rating for automobile insurance policies. The report may not include data regarding a specific insurer or insurer group, except data that is in the public record, and must analyze the impact of flexible rating on:

(1) the extent and nature of competition;

(2) size and significance of coverage;

(3) level and range of rates and rate changes among insurers;

(4) extent of consumer complaints to the Department of Insurance;

(5) volume of cancellations and nonrenewals;

(6) changes in the number of policies by territory and by class, including age and sex, in each territory; and

(7) the number of new insured, nonrenewed insured, and business written by each insurer.

(G) This section does not apply to insurers who write only exempt commercial policies. Exempt commercial policies are not subject to prior approval of the department.

HISTORY: Former 1976 Code Section 38‑43‑90 [1960 (51) 1646; 1962 Code Section 37‑658.1; 1969 (56) 239; 1972 (57) 2750] recodified as Section 38‑73‑910 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 1996 Act No. 300, Section 1; 1996 Act No. 360, Section 4; 1996 Act No. 378 Section 4; 1997 Act No. 154, Section 4; 1999 Act No. 4, Section 1; 2000 Act No. 235, Section 8; 2004 Act No. 290, Section 4, eff July 29, 2004.

**SECTION 38‑73‑915.** Authority granted director or designee; effect of legislation and court decisions.

(A) The director or his designee in reviewing rate filings may take into consideration recently passed legislation or recently rendered court decisions which will have an effect on insurance rates. The director or his designee may use such information to reduce or increase the rate level of the insurer or the rating organization.

(B) The director or his designee may order an insurer or rating organization to reduce or increase its current rate levels as a result of recently passed legislation or recently rendered court decisions. The director or his designee shall give the insurer or rating organization and the Consumer Advocate thirty days notice of his intention to order a reduction or increase in an insurer’s or rating organization’s rate level. The insurer or rating organization or the Consumer Advocate may request a hearing before the director or his designee under the Administrative Procedures Act to contest the proposed order. The Consumer Advocate may participate as a party in any such hearings.

HISTORY: 1989 Act No. 148, Section 30; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑920.** No insurance may be issued except on rates filed.

An insurer may not make or issue a contract or policy except in accordance with the filings which are in effect for the insurer as provided in this chapter or in accordance with Section 38‑73‑1060. Notwithstanding Section 38‑73‑10, Section 38‑73‑330(2), and Section 38‑73‑430(4), filings for property and casualty rate increases may not be approved for any insurer or rating organization for any line, subline, or otherwise identifiable property and casualty insurance coverage for which a rate increase has previously been granted within the immediately preceding twelve months. However, if satisfactory evidence is presented to the director or his designee by an insurer or rating organization that the continued use of the previously approved rates for the line, subline, or otherwise identifiable property and casualty insurance coverage may result in the insolvency of an insurer, more frequent rate increases may be approved. Rate changes proposed where the sole factor for the change is the impact of a revised assessment does not constitute a rate increase for purposes of this section. No rate increase based upon an assessment may become effective unless the assessment has been paid. This section does not apply to contracts or policies for inland marine risks as to which filings are not required.

However, a private insurer licensed to underwrite essential property insurance as defined by Section 38‑75‑310(1), notwithstanding any limitations included within this title, may file and use, pursuant to the provisions of Section 38‑73‑1095, any rates which result in insurance premium rates of ninety percent, or less, of the insurance premium rates then approved for the South Carolina Wind and Hail Underwriting Association which result in an insurance premium increase for any policyholder situated within a coastal area of South Carolina as defined by Section 38‑75‑310(5) not more than once in any six‑month period.

HISTORY: Former 1976 Code Section 38‑43‑610 [1947 (45) 322; 1952 Code Section 37‑691; 1962 Code Section 37‑691; 1977 Act No. 107] recodified as Section 38‑73‑920 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 1996 Act No. 378, Section 5; 2004 Act No. 315, Section 2, eff October 12, 2004.

**SECTION 38‑73‑930.** Guidelines and formats for filing.

The department shall, when it is considered appropriate, issue by regulation specific mandatory guidelines and formats for filing with the department so as to promote uniformity and consistency and facilitate meaningful comparisons. Any guidelines and formats issued shall include requirements for detailed breakdowns on the total expense component of any filing.

HISTORY: Former 1976 Code Section 38‑43‑615 [1962 Code Section 37‑691.1; 1977 Act No. 151 Section 1] recodified as Section 38‑73‑930 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑935.** Rate filings; information based upon; exceptions.

No rate filing for private passenger automobile insurance may include or be based upon actual or projected loss or expense data which includes payments made on policies, wherein the amount of the settlement, judgment, or other payment by the insurer was in excess of the policy limits, exclusive of interest and costs. No rate filing for private passenger automobile insurance may include or be based upon actual or projected loss or expense data which includes payments made as a result of the insurer’s tortious breach of it’s duty of good faith and fair dealing.

HISTORY: 1989 Act No. 148, Section 31; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑940.** Information in support of filing.

A filing and any supporting information are open to public inspection after the filing becomes effective.

The information furnished in support of a filing under Section 38‑73‑340 or 38‑73‑520 may include:

(1) the experience or judgment of the insurer or rating organization making the filing;

(2) its interpretation of any statistical data it relies upon;

(3) the experience of other insurers or rating organizations; and

(4) any other relevant factors.

A filing and any supporting information are open to public inspection after the filing becomes effective.

HISTORY: Former 1976 Code Section 38‑43‑620 [1947 (45) 322; 1952 Code Section 37‑692; 1962 Code Section 37‑692] recodified as Section 38‑73‑940 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑950.** Additional information may be required.

When a filing is not accompanied by the information upon which the insurer supports the filing and the director or his designee does not have sufficient information to determine whether the filing meets the requirements of this chapter, he shall require the insurer to furnish the information upon which it supports the filing, and in this event the waiting period commences as of the date the information is furnished.

HISTORY: Former 1976 Code Section 38‑43‑630 [1947 (45) 322; 1952 Code Section 37‑693; 1962 Code Section 37‑693] recodified as Section 38‑73‑950 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑960.** Effective date of filing.

The director or his or her designee must review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter. Subject to the exceptions specified in Sections 38‑73‑965, 38‑73‑970, and 38‑73‑980, each filing must be on file for a waiting period of sixty days before it becomes effective. This period may be extended by the director or his or her designee for an additional period not to exceed sixty days if he or she gives written notice within the waiting period to the insurer or rating organization which made the filing that he or she needs additional time for the consideration of the filing. Upon written application by the insurer or rating organization, the director or his or her designee may authorize a filing which he or she has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing meets the requirements of this chapter unless disapproved by the director or his or her designee within the waiting period or any extension thereof.

HISTORY: Former 1976 Code Section 38‑43‑640 [1947 (45) 322; 1952 Code Section 37‑694; 1962 Code Section 37‑694; 1978 Act No. 627] recodified as Section 38‑73‑960 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 2007 Act No. 111, Pt III, Section 3, eff July 1, 2007, applicable to injuries that occur on or after that date.

**SECTION 38‑73‑965.** Filing; effective date.

A filing made pursuant to Section 38‑73‑525 is governed by the effective dates specified in that section.

HISTORY: 2007 Act No. 111, Pt III, Section 4, eff July 1, 2007, applicable to injuries that occur on or after that date.

**SECTION 38‑73‑970.** Effective date for specially rated inland marine rates.

Specific inland marine rates on risks specially rated by a rating organization become effective when filed and are considered to meet the requirements of this chapter until the time the director or his designee reviews the filing and so long thereafter as the filing remains in effect.

HISTORY: Former 1976 Code Section 38‑43‑650 [1947 (45) 322; 1952 Code Section 37‑695; 1962 Code Section 37‑695] recodified as Section 38‑73‑970 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑980.** Effective date for certain surety or guaranty bonds.

Any special filing with respect to a surety or guaranty bond required by law, or by court or executive order, or by order or regulation of a public body, not covered by a previous filing, becomes effective when filed and is considered to meet the requirements of this chapter until the time the director or his designee reviews the filing and so long thereafter as the filing remains in effect.

HISTORY: Former 1976 Code Section 38‑43‑660 [1947 (45) 322; 1952 Code Section 37‑696; 1962 Code Section 37‑696] recodified as Section 38‑73‑980 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑990.** Disapproval of filings generally.

Except as provided in Section 38‑73‑995, if within the waiting period or any extension thereof as provided in Section 38‑73‑960 the director or his or her designee finds that a filing or a part of a filing does not meet the requirements of this chapter, he or she must send to the insurer or rating organization which made the filing written notice of disapproval of the filing or part of a filing specifying therein in what respects he or she finds the filing or part thereof fails to meet the requirements of this chapter and stating that the filing or the part may not become effective.

HISTORY: Former 1976 Code Section 38‑43‑670 [1947 (45) 322; 1952 Code Section 37‑697; 1962 Code Section 37‑697; 1978 Act No. 486] recodified as Section 38‑73‑990 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 2007 Act No. 111, Pt III, Section 5, eff July 1, 2007, applicable to injuries that occur on or after that date.

**SECTION 38‑73‑995.** Disapproval of insurer’s workers’ compensation rates using most recent multiplier for expenses.

An insurer’s workers’ compensation rates developed using its most recent multiplier for expenses, assessments, profit, and contingencies and any modifications to loss costs may be disapproved at any time after they become effective if the director or his or her designee determines that they do not meet the requirements of this chapter.

HISTORY: 2007 Act No. 111, Pt III, Section 6, eff July 1, 2007, applicable to injuries that occur on or after that date.

**SECTION 38‑73‑1000.** Disapproval of specially rated specific inland marine rates.

If, within thirty days after a specific inland marine rate on a risk specially rated by a rating organization subject to Section 38‑73‑970 has become effective, the director or his designee finds that the filing does not meet the requirements of this chapter, he shall send to the rating organization which made the filing written notice of disapproval of the filing specifying therein in what respects he finds that the filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, the filing is no longer effective. This disapproval does not affect any contract made or issued prior to the expiration of the period set forth in the notice.

HISTORY: Former 1976 Code Section 38‑43‑680 [1947 (45) 322; 1952 Code Section 37‑698; 1962 Code Section 37‑698] recodified as Section 38‑73‑1000 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1010.** Disapproval of special surety or guaranty filings.

If, within thirty days after a special surety or guaranty filing subject to Section 38‑73‑980 has become effective, the director or his designee finds that the filing does not meet the requirements of this chapter, he shall send to the insurer or rating organization which made the filing written notice of disapproval of the filing specifying therein in what respects he finds that the filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, the filing is considered no longer effective. This disapproval does not affect any contract made or issued prior to the expiration of the period set forth in the notice.

HISTORY: Former 1976 Code Section 38‑43‑690 [1947 (45) 322; 1952 Code Section 37‑699; 1962 Code Section 37‑699] recodified as Section 38‑73‑1010 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1020.** Disapproval after applicable review period.

If at any time after the applicable review period provided for in Sections 38‑73‑990 to 38‑73‑1010 the director or his designee finds that a filing does not meet the requirements of this chapter, he shall, after a hearing held upon not less than thirty days’ written notice to every insurer and rating organization which made the filing, specifying the matters to be considered at the hearing, issue an order specifying in what respects he finds that the filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, the filing is considered no longer effective. Copies of the order must be sent to every insurer and rating organization which made the filing. The order does not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

HISTORY: Former 1976 Code Section 38‑43‑700 [1947 (45) 322; 1952 Code Section 37‑700; 1962 Code Section 37‑700] recodified as Section 38‑73‑1020 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1030.** Review of filings on application of person aggrieved.

Any person or organization aggrieved with respect to any filing which is in effect may make written application to the director or his designee for a hearing thereon, except that the insurer or rating organization that made the filing may not proceed under this section. The application shall specify the grounds to be relied upon by the applicant. If, within thirty days after receipt of the application, the director or his designee finds that the application is made in good faith, that the applicant would be so aggrieved if his grounds are established, and that the grounds otherwise justify holding a hearing, he shall hold a hearing upon not less than thirty days’ written notice to the applicant and to every insurer and rating organization which made the filing. If, after the hearing, the director or his designee finds that the filing does not meet the requirements of this chapter, he shall issue an order specifying in what respects he finds that the filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, the filing is considered no longer effective. Copies of the order must be sent to the applicant and to every insurer and rating organization which made the filing. The order does not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

HISTORY: Former 1976 Code Section 38‑43‑710 [1947 (45) 322; 1952 Code Section 37‑701; 1962 Code Section 37‑701] recodified as Section 38‑73‑1030 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1040.** No disapproval of certain fire, allied lines, or inland marine filings.

No manual, minimum, or class rate, rating schedule, rating plan, or rating rule of or with respect to fire and allied lines or inland marine insurance, or any modification of the foregoing, which has been filed pursuant to the requirements of Section 38‑73‑340 may be disapproved if the rates thereby produced meet the requirements of this chapter.

HISTORY: Former 1976 Code Section 38‑43‑720 [1947 (45) 322; 1952 Code Section 37‑702; 1962 Code Section 37‑702] recodified as Section 38‑73‑1040 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1050.** No disapproval of certain casualty or automobile filings.

No manual of classifications, rules, rating plans, or any modification of any of the foregoing for casualty insurance or automobile insurance which establishes standards for measuring variations in hazards or expense provisions, or both, and which has been filed pursuant to the requirements of Section 38‑73‑520 may be disapproved if the rates thereby produced meet the requirements of this chapter.

HISTORY: Former 1976 Code Section 38‑43‑730 [1947 (45) 322; 1952 Code Section 37‑703; 1962 Code Section 37‑703] recodified as Section 38‑73‑1050 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1060.** Use of rates and policy forms different from those filed; exceptions.

(A) Upon the written application of the insured, stating his reasons therefor, filed with the department and approved by the director or his designee, a rate different from that provided by a filing otherwise applicable may be used on any specific risk.

(B) Upon the written application of an insured which has aggregate insurance premiums, other than life, accident, and health, in excess of one hundred thousand dollars, stating the reasons therefor, filed with the department, and approved by the director or his designee, a policy form different from that provided by a filing otherwise applicable may be used on any specific risk. Any policy form filed with the department pursuant to this subsection must be considered approved if not approved or disapproved within thirty days of receipt by the department. However, the consent‑to‑form does not apply to policy forms providing private passenger automobile insurance coverage subject to the mandate‑to‑write, workers’ compensation insurance coverage, or employer’s liability insurance coverage and policy forms underwritten by joint underwriting transactions or joint insurance transactions.

HISTORY: Former 1976 Code Section 38‑43‑740 [1947 (45) 322; 1952 Code Section 37‑704; 1962 Code Section 37‑704] recodified as Section 38‑73‑1060 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 1997 Act No. 68, Section 8.

**SECTION 38‑73‑1070.** Suspension or modification of filing requirement.

Under regulations the department promulgates, the director or his designee may, by written order, suspend or modify the requirements of filing as to any kind of insurance, subdivision, or combination thereof or as to classes of risks, the rates for which cannot practicably be filed before they are used. These orders and regulations must be made known to insurers and rating organizations affected thereby. The director or his designee may make any examination he considers advisable to ascertain whether any rates affected by the order meet the standards set forth in Section 38‑73‑330(2) or Section 38‑73‑430(4), as the case may be.

HISTORY: Former 1976 Code Section 38‑43‑750 [1947 (45) 322; 1952 Code Section 37‑705; 1962 Code Section 37‑705] recodified as Section 38‑73‑1070 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1080.** Information to be furnished insureds; hearings and appeals of insureds.

Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it or to the authorized representative of the insured all pertinent information as to the rate. Every rating organization and every insurer which makes its own rates shall provide within this State reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his authorized representative, on his written request to review the manner in which the rating system has been applied in connection with the insurance afforded him. If the rating organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if his application had been rejected. Any party affected by the action of the rating organization or the insurer on the request may, within thirty days after written notice of the action, appeal to the director or his designee, who, after a hearing held upon not less than thirty days’ written notice to the appellant and to the rating organization or insurer, may affirm or reverse the action.

HISTORY: Former 1976 Code Section 38‑43‑760 [1947 (45) 322; 1952 Code Section 37‑706; 1962 Code Section 37‑706] recodified as Section 38‑73‑1080 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1085.** Publication of representative sample of premiums.

The director or his designee shall no less than annually cause to have published and make available a representative sample of the private passenger premiums being charged by at least the twenty insurance companies having the largest market share in each territory to facilitate price comparisons by insureds and prospective insureds who are seeking new coverage.

HISTORY: 1989 Act No. 148, Section 29; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1090.** Determination of discrimination and removal.

The director or his designee, upon his own motion, or upon written complaint, has the power in the first instance to determine whether or not any rate fixed by any individual, bureau, or insurer is unfairly discriminatory. If he concludes, after careful and diligent inquiry and a full hearing and investigation, that there is unfair discrimination, he shall order the discrimination removed and require the individual rate maker, bureau, or insurer to promulgate a rate which is not unfairly discriminatory.

HISTORY: Former 1976 Code Section 38‑43‑770 [1947 (45) 322; 1952 Code Section 37‑707; 1962 Code Section 37‑707] recodified as Section 38‑73‑1090 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1095.** Essential property insurance; rating plan factors.

(A) Any private insurer licensed to underwrite “essential property insurance” as defined by Section 38‑75‑310(1), notwithstanding any limitations included within this title, may file and use any rates for the coverages detailed within Section 38‑75‑310(1) which result in insurance premium rates of ninety percent, or less, of the insurance premium rates then approved for the South Carolina Wind and Hail Underwriting Association for use within the coastal area of South Carolina as defined by Section 38‑75‑310(5). Filings for these insurance premium rates must be made upon forms prescribed by the director or his designee and must apply only to essential property insurance premium rates for the coastal area. Within thirty days after the filing of the rates, the director or his designee must notify the insurer or rating organization filing the rates of his approval or his disapproval of those rates. If the rates are disapproved, then the director or his designee must notify the insurer or the rating organization of the specific reason for disapproval. The director or his designee may extend for up to an additional thirty days the period within which he must approve or disapprove the rates. Any rates received, which are neither approved nor disapproved by the director, must be deemed approved at the expiration of the thirty‑day period or, if that period has been extended, at the expiration of the extended period. However, no insurer or rating organization may use rates considered approved under the provisions of this section unless and until the insurer or rating organization has filed a written notice of its intent to use the rates. The notice must be filed with the director or his designee at least ten days before the insurer’s or rating organization’s use of the deemed rates.

(B) In considering any rate filing for insurance premium rates for essential property insurance in the coastal area or in the seacoast area, the director or his designee, in addition to other factors considered under this title, may consider past and prospective expenses and recoveries associated with catastrophe reinsurance and past and prospective loss experience including windstorm catastrophe models and simulations.

(C) Rating plans for essential property insurance in the coastal area or in the seacoast area, shall include discounts and credits or surcharges and debits calculated upon the following rating factors:

(1) use of storm shutters;

(2) use of roof tie downs;

(3) construction standards;

(4) building codes;

(5) distance from water;

(6) elevation;

(7) flood insurance;

(8) policy deductibles; and

(9) other applicable factors requested by the insurer or rating organization or selected by order of the director involving the risk or hazard. An order issued pursuant to this section must comply with the requirements of Section 1‑23‑140.

The department may by regulation define how the implementation of these factors qualify for credits or discounts. The regulation must specify what evidence or proof the policyholder or applicant shall present to obtain the credit or discount. This section applies to policies issued or renewed after December 31, 2007.

(D) This section does not preclude any insurer from using consent‑to‑rate pursuant to Section 38‑73‑1060 for any essential property insurance risk in the coastal area or the seacoast area of this State.

HISTORY: 1996 Act No. 360 Section 1 and 1996 Act No. 378, Section 1; 2007 Act No. 78, Section 9, eff June 11, 2007, applicable to taxable years beginning after December 31, 2006.

**SECTION 38‑73‑1097.** Applicability of certain provisions.

Notwithstanding any other provision of law, the provisions of Section 38‑73‑1095(C) and Section 38‑75‑755 do not apply to an insurer who issues a single or dual interest coverage property insurance policy provided through, placed by, or obtained by the creditor, lender, finance company, financial institution, bank, mortgage company, or entity having a security interest in or mortgage on the property.

HISTORY: 2008 Act No. 326, Section 15, eff June 16, 2008.

**SECTION 38‑73‑1100.** Determination of excessive or unreasonable rates; general reduction; refund.

If at any time it appears to the director or his designee that rates charged for property, casualty, surety, marine, title, or allied lines of insurance in this State are excessive or unreasonable, in that the results of the business of the insurer in this State during the five years immediately preceding the year in which the investigation is made, as indicated by the insurer’s annual statements and any supplements to them, show an aggregate operating profit in excess of a reasonable amount, then the director or his designee may order a general reduction in rates which will reduce the operating profit to a reasonable amount. Any reduction ordered by the director or his designee must be applied to the class or classes of risks as the insurer or rating bureau may elect, and they may not be compelled to reduce rates on classes which have not produced a reasonable operating profit for the five‑year period. In addition to ordering a general reduction in rates, the director or his designee may also order a pro rata refund of any excessive or unreasonable profits found to have been realized by the insurer, together with interest. The director or his designee shall determine the rate of interest which must be the insurer’s average rate of return for the five‑year period. Any refund which is ordered must be equitably apportioned among the policyholders entitled to it, and may be given either in the form of a cash refund or as a credit toward future premiums or a combination of these two methods. In determining the question of a reasonable operating profit under this section, the director or his designee as a protection to policyholders shall give proper and reasonable consideration to conflagration liabilities, both within and without this State.

HISTORY: Former 1976 Code Section 38‑43‑780 [1947 (45) 322; 1952 Code Section 37‑708; 1962 Code Section 37‑7] recodified as Section 38‑73‑1100 by 1987 Act No. 155, Section 1; 1988 Act No. 442, Section 1; 1988 Act No. 673, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1105.** Insurer’s use of definition of “underinsured motor vehicle”.

The definition of “underinsured motor vehicle” contained in Section 38‑77‑30(15) may not be used by an insurer unless the insurer reduces his rate for underinsured motorist coverage by an amount determined appropriate by the director or his designee and refunds any such premium that the director or his designee determines is necessary to correspond with the new definition. An insurer may not use the definition in its settlement negotiations unless the insurer has filed and the director or his designee has approved an endorsement to its contract. If an insurer uses the new definition in its negotiations with a person before having the contract endorsed it is an unfair claims practice and, in addition, is bad faith entitling the injured person to reasonable attorney fees, punitive damages, and all actual damages.

HISTORY: 1988 Act No. 503; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1110.** Regulation of calculation and refunding of excess profit.

In order to assure fair implementation of Section 38‑73‑1100, the department shall promulgate a regulation concerning the calculation and refunding of excess profits. The regulation shall include consideration of:

(1) the total operating profits of each insurer in this State for the lines of insurance enumerated in Section 38‑73‑1100;

(2) the margin by which any insurer’s operating results differ from the insurance industry’s total results;

(3) the amount of excessive profits earned after the effective date of the refund provision of Section 38‑73‑1100;

(4) the insurers that operate in this State as affiliates of a group; and

(5) the development period used to determine if unpaid losses are fairly estimated.

HISTORY: 1988 Act No. 673, Section 2; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1120.** Provisions to ensure expenses are allocated and treated properly; penalty.

(A) No automobile insurer or representative of any automobile insurer may wilfully include in a private passenger automobile insurance rate filing any expense or loss which was generated in whole or part by either another line of insurance or general expenses or overhead applicable to all lines, unless the insurer has allocated properly the expense or loss among all its lines of insurance. The insurer’s compliance with generally accepted accounting and actuarial principles constitutes a complete defense to an action brought under this section. No insurer may adopt a different method or usage of allocating or treating expenses or losses for purposes of rate filings in South Carolina from that which it uses in other states for similar lines of insurance, unless different treatment is required by statute or regulation.

(B) The director or his designee, at least once every four years, shall make or cause to be made, for each insurer which writes more than one percent of the private passenger market in South Carolina, an examination of each insurer’s books, records, and accounts to ensure that the expenses are being allocated or treated properly. In lieu of an independent examination, the director or his designee may request a sworn affidavit from the insurer’s controller, accountant, or actuary that the companies’ expenses are being allocated and treated properly and that private passenger automobile insureds are not being charged an inequitable or unfair share of the insurer’s expenses, acquisition costs, overhead, or other expenses. The director or his designee shall survey for the companies at appropriate intervals a comparison of the acquisition cost of private passenger business in South Carolina versus other similar states in which the companies do business.

(C) An insurer violating the provisions of this section is subject to a civil penalty of not less than twenty‑five thousand dollars. A person who violates the provisions of this section is guilty of a felony and, upon conviction, must be imprisoned for not more than ten years or fined not less than ten thousand dollars, or both.

HISTORY: 1989 Act No. 148, Section 32; 1993 Act No. 181, Section 783.

ARTICLE 11

Rating Organizations

**SECTION 38‑73‑1210.** Members of rating organization not required to file individually; rates for members in first year; collection, compilation and dissemination of premium data.

(A)(1) This item applies to property and casualty insurance but does not apply to workers’ compensation insurance. An insurer may satisfy its obligation to make required filings by becoming a member of, or a subscriber to, a licensed rating organization which makes filings and by authorizing the director or his designee to accept the filings on its behalf. However, notwithstanding another provision of this article, a member or subscriber, within twelve months after its membership or subscribership, may not file to adopt a rate approved for use for the rating organization if the rate is more than the rate in use by the member or subscriber before its membership or subscribership in the rating organization. Further, notwithstanding the provisions of Sections 38‑73‑1300 and 38‑73‑1310, a member or subscriber, within twelve months after its membership or subscribership, may not be granted an upward deviation from its rate in use when becoming a member or subscriber. However, if a rate increase for the rating organization is approved within twelve months after an insurer becomes a member or subscriber, the member or subscriber may increase its rates by the same percentage of increase granted the rating organization. Nothing contained in this chapter may be construed to require an insurer to become a member of or a subscriber to a rating organization.

(2) This item applies to workers’ compensation insurance. An insurer may satisfy its obligation to make required filings by becoming a member of, or a subscriber to, a licensed rating organization that makes filings and by authorizing the director or his designee to accept the filings on its behalf. However, a licensed rating organization may not satisfy the insurer’s obligation to make filings required pursuant to Section 38‑73‑525.

(B) In addition to other activities not prohibited by this chapter, a rating organization may collect, compile, and disseminate to insurers compilations of past and current premiums of insurers.

HISTORY: Former 1976 Code Section 38‑43‑910 [1947 (45) 322; 1952 Code Section 37‑721; 1962 Code Section 37‑721; 1977 Act No. 162] recodified as Section 38‑73‑1210 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 1998 Act No. 291, Section 2; 2016 Act No. 213 (S.1064), Section 2, eff June 3, 2016.

Effect of Amendment

2016 Act No. 213, Section 2, rewrote (A), establishing that an insurer writing workers’ compensation insurance may satisfy its filing obligation by becoming a member of or subscriber to a licensed rating organization.

**SECTION 38‑73‑1215.** Applicability to self‑insurers.

Nothing in Section 38‑73‑1210 applies to self‑insurers.

HISTORY: 1998 Act No. 291, Section 3.

**SECTION 38‑73‑1220.** Application for license as rating organization.

A corporation, an unincorporated association, a partnership, or an individual, whether located within or outside this State, may make application to the director or his designee for a license as a rating organization for the kinds of insurance or subdivisions thereof or, in the case of insurance to which Article 3 of this chapter is applicable, classes of risk or parts or combinations thereof as are specified in its application and shall file therewith:

(1) a copy of its constitution, its articles of agreement or association or certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business;

(2) a list of its members and subscribers;

(3) the name and address of a resident of this State upon whom notices or orders of the director or his designee or process affecting the rating organization may be served;

(4) a statement of its qualification as a rating organization.

HISTORY: Former 1976 Code Section 38‑43‑920 [1947 (45) 322; 1952 Code Section 37‑722; 1962 Code Section 37‑722] recodified as Section 38‑73‑1220 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1230.** Issuance or denial of license; duration; fee.

If the director or his designee finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, he shall issue a license specifying the kinds of insurance or subdivision or class of risk or part or combination thereof for which the applicant is authorized to act as a rating organization. Every application must be granted or denied in whole or in part by the director or his designee within sixty days of the date of its filing with him. Licenses issued pursuant to this section remain in effect for an indefinite term unless sooner suspended or revoked by the director or his designee. The fee for the license is two hundred dollars owed and payable annually by March first.

HISTORY: Former 1976 Code Section 38‑43‑930 [1947 (45) 322; 1948 (45) 1734; 1952 Code Section 37‑723; 1962 Code Section 37‑723; 1980 Act No. 306, Section 2] recodified as Section 38‑73‑1230 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1240.** Suspension or revocation of license.

Licenses issued pursuant to Section 38‑73‑1230 may be suspended or revoked by the director or his designee, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this article.

HISTORY: Former 1976 Code Section 38‑43‑940 [1947 (45) 322; 1952 Code Section 37‑724; 1962 Code Section 37‑724] recodified as Section 38‑73‑1240 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1250.** Changes within rating organization.

Every rating organization shall notify the director or his designee promptly of every change in:

(1) its constitution, its articles of agreement or association or certificate of incorporation, or its bylaws, rules, and regulations governing the conduct of its business;

(2) its lists of members and subscribers;

(3) the name and address of the resident of this State designated by it upon whom notices or orders of the director or his designee or process affecting the rating organization may be served.

HISTORY: Former 1976 Code Section 38‑43‑950 [1947 (45) 322; 1952 Code Section 37‑725; 1962 Code Section 37‑725] recodified as Section 38‑73‑1250 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1260.** Subscribers to rating organizations.

Subject to rules and regulations which have been approved by the department as reasonable, each rating organization shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance, subdivision, or class of risk or part or combination thereof for which it is authorized to act as a rating organization. If the rating organization refuses to admit an insurer as a subscriber or fails to grant or reject an insurer’s application for subscribership within thirty days after it was made, the insurer may request a review by the director or his designee. Upon review the failure to act must be treated as a rejection of the application. If the director or his designee finds at a hearing, held upon at least thirty days’ written notice to the rating organization, that the insurer has been refused admittance to the rating organization as a subscriber without justification, he shall order the rating organization to admit the insurer as a subscriber. If he finds that the action of the rating organization was justified, the director or his designee shall make an order affirming its action.

Each rating organization shall furnish its rating services without discrimination to its members and subscribers.

HISTORY: Former 1976 Code Section 38‑43‑960 [1947 (45) 322; 1952 Code Section 37‑726; 1962 Code Section 37‑726] recodified as Section 38‑73‑1260 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1270.** Changes in rules and regulations; review of reasonableness.

Notice of proposed changes in the rules and regulations referred to in Section 38‑73‑1260 must be given to subscribers.

The reasonableness of any rule or regulation in its application to subscribers must, at the request of any subscriber or any insurer, be reviewed by the director or his designee at a hearing held upon at least thirty days’ written notice to the rating organization and to the subscriber or insurer. If the director or his designee finds that the rule or regulation is unreasonable in its application to subscribers, he shall order that the rule or regulation is not applicable to subscribers.

HISTORY: Former 1976 Code Section 38‑43‑970 [1947 (45) 322; 1952 Code Section 37‑727; 1962 Code Section 37‑727] recodified as Section 38‑73‑1270 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1280.** Rules may not regulate certain payments.

No rating organization may adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

HISTORY: Former 1976 Code Section 38‑43‑980 [1947 (45) 322; 1952 Code Section 37‑728; 1962 Code Section 37‑728] recodified as Section 38‑73‑1280 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1290.** Filings must be adhered to.

Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by the organization, except as provided in Sections 38‑73‑1300 and 38‑73‑1310.

HISTORY: Former 1976 Code Section 38‑43‑990 [1947 (45) 322; 1952 Code Section 37‑729; 1962 Code Section 37‑729] recodified as Section 38‑73‑1290 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1300.** Application for modification by fire or inland marine insurer.

A member of or subscriber to a rating organization to whom the provisions of Article 3 of this chapter are applicable may make written application to the director or his designee for permission to file a modification from the class loss costs, schedules, rating plans, or rules respecting any kind of insurance or class of risk within a kind of insurance or any combination of them. The application must specify the basis for the modification. A copy of the application must be sent simultaneously to the rating organization.

HISTORY: Former 1976 Code Section 38‑43‑1000 [1947 (45) 322; 1952 Code Section 37‑730; 1962 Code Section 37‑730] recodified as Section 38‑73‑1300 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 2001 Act No. 82, Section 28, eff July 20, 2001.

**SECTION 38‑73‑1310.** Application for modification by casualty or automobile insurer.

A member of or subscriber to a rating organization to whom the provisions of Article 5 of this chapter are applicable may make written application to the department for permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system filed for a kind of insurance or for a class of insurance which is found by the director or his designee to be a proper rating unit for the application of such uniform percentage decrease or increase or for a subdivision of a kind of insurance. The application must specify the basis for the modification and must be accompanied by the data upon which the applicant relies. A copy of the application and data must be sent simultaneously to the rating organization.

HISTORY: Former 1976 Code Section 38‑43‑1010 [1947 (45) 322; 1952 Code Section 37‑731; 1962 Code Section 37‑731] recodified as Section 38‑73‑1310 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783; 2001 Act No. 82, Section 29, eff July 20, 2001.

**SECTION 38‑73‑1330.** Examination of policies and other papers; correction of errors.

Any rating organization acting for insurers to whom the provisions of Article 3 of this chapter are applicable may provide with respect to such insurers for the examination of policies, daily reports, binders, renewal certificates, endorsements, or other evidences of insurance, or the cancellation thereof, and may make reasonable rules governing their submission. The rules shall contain a provision that, in the event an insurer does not within sixty days furnish satisfactory evidence to the rating organization of the correction of any error or omission previously called to its attention by the rating organization, the rating organization shall notify the director or his designee thereof. All information so submitted for examination is confidential.

HISTORY: Former 1976 Code Section 38‑43‑1030 [1947 (45) 322; 1952 Code Section 37‑733; 1962 Code Section 37‑733] recodified as Section 38‑73‑1330 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1340.** Appeal by minority.

Any member of or subscriber to a rating organization may appeal to the Administrative Law Court from the action or decision of the rating organization in approving or rejecting any proposed change in or addition to the filings of the rating organization. The Administrative Law Court shall, after a hearing held before it upon not less than thirty days’ written notice to the appellant and to the rating organization, issue an order approving the action or decision of the rating organization or directing it to give further consideration to the proposal, or, if the appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, Administrative Law Court may, in the event it finds that the action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings on behalf of its members and subscribers in a manner consistent with its findings, within a reasonable time after the issuance of the order.

If the appeal in the case of an insurer to whom the provisions of Article 5 of this chapter are applicable is based upon the failure of the rating organization to make a filing on behalf of the member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in item (2) of Section 38‑73‑430, from the system of expense provisions included in a filing made by the rating organization, the Administrative Law Court shall, if it grants the appeal, order the rating organization to make the requested filing for use by the appellant. In deciding the appeal the Administrative Law Court shall apply the standards set forth in Section 38‑73‑430.

The actual cost to the Administrative Law Court, and the Department of Insurance provided it participates in the hearing, in connection with the appeal may be charged by the Administrative Law Court to the parties making the appeal in any proportion he considers proper and must be immediately paid by the respective parties.

HISTORY: Former 1976 Code Section 38‑43‑1040 [1947 (45) 322; 1952 Code Section 37‑734; 1960 (51) 1646; 1962 Code Section 37‑734] recodified as Section 38‑73‑1340 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1350.** Cooperation.

Notwithstanding the provisions of Sections 38‑73‑1370, 38‑73‑1380, 38‑73‑1400, 38‑73‑1410, 38‑73‑1420, and 38‑73‑1430, after public hearing the director or his designee may prohibit cooperation among or within property/casualty rating or advisory organizations by insurers or among or within these rating or advisory organizations and insurers in rate making or in other matters within the scope of this chapter, except to the extent that these organizations may compile and disseminate only historic loss data with no mathematical trending or analytical methodologies, upon a finding by the director or his designee that the anti‑competitive effects of this cooperation outweigh practical constraints of prohibitions. All property/casualty filings are subject to prior approval by the director or his designee. The provisions of Title 1, Chapter 23 (Administrative Procedures Act) apply to all property/casualty rate filings.

HISTORY: Former 1976 Code Section 38‑43‑1050 [1947 (45) 322; 1952 Code Section 37‑735; 1962 Code Section 37‑735] recodified as Section 38‑73‑1350 by 1987 Act No. 155, Section 1; 1989 Act No. 148, Section 41(A); 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1360.** Actuarial, technical, and other services.

Any rating organization serving insurers to which the provisions of Article 3 of this chapter apply may subscribe for or purchase actuarial, technical, or other services and these services must be available to all insurers who are members and subscribers of the organization without discrimination.

HISTORY: Former 1976 Code Section 38‑43‑1060 [1947 (45) 322; 1952 Code Section 37‑736; 1962 Code Section 37‑736] recodified as Section 38‑73‑1360 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1370.** Rating organizations not permitted to file certain rate increases; filing pure loss component of rate or premium; use of approved pure loss component by members or subscribers.

After June 30, 1989, no rating organization may file a rate increase with the department for any previously approved final rate or premium charge for any private passenger automobile insurance coverage. A rating organization may file the pure loss component of the rate or premium charge for any private passenger automobile insurance coverage, by class and territory, for the approval of the director or his designee. The director or his designee may approve the pure loss component of the rate or premium charge for use by the members or subscribers of the rating organization. No member or subscriber may use the approved pure loss component of the rate or premium charge unless and until the expense component of the rate or premium charge has also been filed with the department and approved by the director or his designee pursuant to Section 38‑73‑1380.

HISTORY: 1989 Act No. 148, Section 41(B); 1993 Act No. 181, Section 783; 2000 Act No. 312, Section 18.

**SECTION 38‑73‑1380.** Approval of final rate or premium charge required; computation of final rate or premium charge; approval of expense component filed by each member or subscriber independently.

After June 30, 1989, no member or subscriber of a rating organization may utilize a rate or premium charge for any private passenger automobile insurance coverage unless and until the final rate or premium charge has been filed with the division and approved by the director or his designee. After the effective date of this section, the final rate or premium charge is the pure loss component filed and approved by a rating organization on behalf of its members or subscribers added to the expense component of the rate or premium charge, filed with the department and approved by the director or his designee, by each member or subscriber of a rating organization independently.

Any expense component filed by a member or subscriber of a rating organization may be approved by the director or his designee subject to Section 38‑73‑1370 and all other requirements of this chapter.

HISTORY: 1989 Act No. 148, Section 41(B); 1991 Act No. 129, Section 1; 1993 Act No. 181, Section 783; 2000 Act No. 312, Section 19.

**SECTION 38‑73‑1400.** Definition of pure loss component, expense component, and final rate or premium charge.

(1) After June 30, 1989, the “pure loss component” of the final rate or premium charge for private passenger automobile insurance is that portion of the final rate or premium charge applicable to calendar/accident year incurred losses (the sum of paid losses plus loss reserves including incurred but not reported loss reserves) and loss adjustment expense (those expenses directly related to the payment of claims) in this State, trended to include both the past and prospective loss experience. If the insurer writes one percent or more of the written premium for automobile insurance during the previous calendar year, that insurer must file its own trending methodology as independently derived.

(2) The “expense component” of the final rate or premium charge for private passenger automobile insurance is that portion of the final rate or premium charge applicable to production costs (including commissions and other acquisition expenses), underwriting costs, administrative costs (including the actual costs of taxes, licenses and fees), and profit margin in this State.

(3) The “final rate or premium charge” is the approved pure loss component added to the approved expense component. In the determination of whether the pure loss component should be approved and in the determination of whether the expense component should be approved, neither may be inadequate, excessive, nor unfairly discriminatory and the director or his designee shall take into account investment income from unearned premium and loss reserves, surplus and realized capital gains.

HISTORY: 1989 Act No. 148, Section 41(B); 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1410.** Refiling of final rates or premium charges previously approved not required.

After June 30, 1989, upon the effective date of this section, nothing herein should be construed to require a rating organization or its members or subscribers to immediately refile final rates or premium charges previously approved by the director or his designee for private passenger automobile insurance coverages. Members or subscribers of a rating organization are authorized to continue to use automobile insurance rates or premium charges, approved before the effective date of this section, or decreases from those rates or premium charges filed by the rating organization and, subsequently, approved after the effective date of this section.

HISTORY: 1989 Act No. 148, Section 41(B); 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1420.** Board of Governors of Reinsurance Facility to file expense component; use of component after approval.

After June 30, 1989, the Board of Governors of the South Carolina Reinsurance Facility shall file an expense component for private passenger automobile insurance rate or premium charges after the rating organization with the largest number of members or subscribers has filed a pure loss component for private passenger automobile insurance with the director or his designee. Upon the approval of such component by the director or his designee, those automobile insurers designated pursuant to Section 38‑77‑590(A), for risks written by them through producers designated pursuant to that same section, shall utilize these final rate or premium charges. Automobile insurers designated pursuant to Section 38‑77‑590(A) are not required to use those same final rates or premium charges for risks written through their agents not appointed pursuant to Section 38‑77‑590.

HISTORY: 1989 Act No. 148, Section 41(B); 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1425.** Final rate or premium charge for private passenger automobile insurance risk ceded to reinsurance facility.

The final rate or premium charge for a private passenger automobile insurance risk ceded to the facility which does not qualify for the safe driver discount in Section 38‑73‑760(e) is the final rate or premium charge required by Section 38‑73‑1420 or the final rate or premium charge approved for use by the insurer, whichever is greater.

HISTORY: 1991 Act No. 113, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1430.** Authority to extend provisions of Sections 38‑73‑1370, 38‑73‑1380, 38‑73‑1400, 38‑73‑1410 to other lines of insurance.

After June 30, 1989, the director or his designee may extend the provisions of Sections 38‑73‑1370, 38‑73‑1380, 38‑73‑1400, and 38‑73‑1410 to other lines of property and casualty insurance, by order, after public hearing, when the determination is made that to do so is in the public interest.

HISTORY: 1989 Act No. 148, Section 41(B); 1993 Act No. 181, Section 783.

ARTICLE 13

Advisory Organizations

**SECTION 38‑73‑1510.** “Advisory organization” defined.

Every group, association, or other organization of insurers, whether located within or outside this State, which assists insurers which make their own filings or rating organizations in rate making by the collection and furnishing of loss or expense statistics or by the submission of recommendations, but which does not make filings under this chapter, is known as an “advisory organization”.

HISTORY: Former 1976 Code Section 38‑43‑1210 [1947 (45) 322; 1952 Code Section 37‑741; 1962 Code Section 37‑741] recodified as Section 38‑73‑1510 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1520.** Filing certain data and agreement authorizing examination.

Every advisory organization shall file with the department:

(1) a copy of its constitution, its articles of agreement or association or certificate of incorporation, and its bylaws, rules, and regulations governing its activities;

(2) a list of its members;

(3) the name and address of a resident of this State upon whom notices or orders of the director or his designee or process issued at his discretion may be served;

(4) an agreement that the director or his designee may examine the advisory organization in accordance with the provisions of Section 38‑73‑90.

HISTORY: Former 1976 Code Section 38‑43‑1220 [1947 (45) 322; 1952 Code Section 37‑742; 1962 Code Section 37‑742] recodified as Section 38‑73‑1520 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1530.** Requiring discontinuance of certain acts or practices.

If, after a hearing, the director or his designee finds that the furnishing of information or assistance involves any act or practice which is unfair, unreasonable, or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects the act or practice is unfair, unreasonable, or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of the act or practice.

HISTORY: Former 1976 Code Section 38‑43‑1230 [1947 (45) 322; 1952 Code Section 37‑743; 1962 Code Section 37‑743] recodified as Section 38‑73‑1530 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1540.** Rate filings may not be supported by data from unauthorized advisory organization.

No insurer which makes its own filings nor any rating organization may support its filings by statistics or adopt rate‑making recommendations furnished to it by an advisory organization which has not complied with this article or with an order of the director or his designee involving statistics or recommendations issued under Section 38‑73‑1530. If the director or his designee finds an insurer or rating organization to be in violation of this section, he may issue an order requiring the discontinuance of the violation.

HISTORY: Former 1976 Code Section 38‑43‑1240 [1947 (45) 322; 1952 Code Section 37‑744; 1962 Code Section 37‑744] recodified as Section 38‑73‑1540 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

ARTICLE 15

Joint Underwriting or Joint Reinsurance

**SECTION 38‑73‑1710.** Regulation of joint underwriting and joint reinsurance.

Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance is subject to regulation with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other provisions of this chapter, and, with respect to joint reinsurance, to Sections 38‑73‑90 to 38‑73‑130.

HISTORY: Former 1976 Code Section 38‑43‑1310 [1947 (45) 322; 1952 Code Section 37‑751; 1962 Code Section 37‑751] recodified as Section 38‑73‑1710 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.

**SECTION 38‑73‑1720.** Discontinuance of unfair activity or practice may be ordered.

If, after a hearing, the director or his designee finds that any activity or practice of any such group, association, or other organization is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, he may issue a written order specifying in what respects the activity or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of the activity or practice.

HISTORY: Former 1976 Code Section 38‑43‑1320 [1947 (45) 322; 1952 Code Section 37‑752; 1962 Code Section 37‑752] recodified as Section 38‑73‑1720 by 1987 Act No. 155, Section 1; 1993 Act No. 181, Section 783.