DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

INSURANCE BUREAU

ESSENTIAL INSURANCE

(By authority conferred on the commissioner of insurance by section 210 of Act No. 218 of the Public Acts of 1956, as amended, being S500.210 of the Michigan Compiled Laws)

R 500.1501 Definitions.

Rule 1. As used in these rules:

(a) "Automobile insurance" means insurance as defined in section 2102(2) of the code.

(b) "Classification" means a grouping of individuals or risks on the basis of 1 or more characteristics for purposes of measuring and rating differences in anticipated losses or expenses, or both. For purposes of these rules, a classification shall not include a grouping of individuals or risks solely for statistical data gathering purposes.

(c) "Code" means Act No. 218 of the Public Acts of 1956, as amended, being S500.100 et seq. of the Michigan Compiled Laws.

(d) "Commissioner" means the Michigan commissioner of insurance and the designees of the commissioner.

(e) "Complaint" means a statement by a person to an insurer, an agent, or the commissioner that an insurer or agent has improperly denied him or her automobile insurance or home insurance or has charged an inappropriate premium for that insurance.

(f) "Denial" means both declination as defined in section 2102(4) of the code and termination as defined in section 2104(5) of the code.

(g) "Home insurance" means insurance as defined in section 2103(3) of the code.

(h) "Loss portion" means that portion of a rate which is attributable to provisions for incurred losses and allocated loss adjustment expenses.

(i) "Loss ratio," for purposes of R 500.1505(b)(v), means any of the following ratios for a specified time period, as appropriate for the context of evaluation:

(i) The ratio of actual incurred losses to total earned premiums at collected rate levels.

(ii) The ratio of actual incurred losses to total earned premiums at current rate levels.

(iii) The ratio of reasonably anticipated incurred losses to total estimated earned premiums at proposed rate levels.

(j) "Meeting" means a meeting of the commissioner and 1 or both of the following to resolve a complaint:

(i) A person who has made a complaint or the person's designated representative.

(ii) The insurer about which the complaint was made.

(k) "Private informal managerial-level conference" means a personal meeting or a telephone conference involving the person making the complaint or the person's designated representative and a representative of the insurer with authority to decide the contested issues on behalf of the insurer. The conference, if it involves a personal meeting, shall be held within a reasonably accessible distance from the Michigan residence of the person or persons

named on the policy as insured or the location of the risk and shall be at a time reasonably convenient to the person making the complaint or the person's designated representative.

(l) "Rate differential" means either the ratio of rates for any 2 rating cells or the absolute difference in rates for any 2 rating cells, whichever is applicable for a particular rating system.

(m) "Rating cell" means a group of individuals or risks for which a single rate is determined when 2 or more rating classifications are combined to define a population of individuals or risks for rating purposes.

(n) "Relativity" means either the ratio of rates for any 2 rating classifications or the absolute difference in rates for any 2 rating classifications, whichever is applicable for a particular rating system.

(o) "Uncertainty of loss" means a measure of the nature and the extent of the variability of actual losses for a group of individuals or risks from the mean anticipated loss for the group and includes other similar measures of risk.

(p) "Underwriting" means the offer or refusal to insure, the offer or refusal to continue to insure, or the limitation of the amount of coverage available to, an individual, risk, or class of individuals or risks.

History: 1981 AACS.

R 500.1502 Other insurance coverages to be considered to be automobile insurance.

Rule 2. In addition to the insurance coverages described in section 2102(2)(a), (b), and (c) of the code, all of the following insurance coverages shall be considered to be automobile insurance under section 2102(2)(d) of the code:

(a) Insurance coverage commonly known as "uninsured motorist insurance," for both bodily injury and property damage claims.

(b) Insurance coverage for the liability existing under section 3135(2)(d) of the code.

(c) Insurance coverage commonly known as "underinsured motorist insurance."

History: 1981 AACS.

R 500.1503 Excessive rates.

Rule 3. For the purposes of section 2109(1)(a) of the code, both of the following provisions shall apply:

(a) A rate is unreasonably high for the insurance coverage provided if it is unreasonably high in relation to anticipated losses or expenses, or both, or to the uncertainty of loss for the insurance coverage provided.

(b) A determination regarding the existence of a reasonable degree of competition shall give due consideration to, at a minimum, all of the following:

(i) The relevant market for the coverage or the type of insurance to which the rate applies.

(ii) The number of insurers and the number of self-insurers actively engaged in writing or providing the coverage or type of insurance in the relevant market.

(iii) The distribution of rates and market shares for such insurers in the relevant market. Market shares may be measured either by premiums or exposures.

(iv) Past and prospective trends in the availability of coverage and coverage options for insurance of that type in the relevant market.

(v) Profits attributable to insurance of that type in relation to the profitability of other types of insurance, to the uncertainty of loss for that and other types of insurance, and to the amount of capital and surplus funds available to support premium writings for that and other types of insurance.

(vi) The ability and potential for firms to enter and exit the relevant market and for financial capital and surplus funds to be allocated to, and to be removed from, the relevant market.

History: 1981 AACS.

R 500.1504 Inadequate rates.

Rule 4. For purposes of section 2109(1)(b) of the code, all of the following provisions shall apply:

(a) A rate is unreasonably low for the insurance coverage provided if it is unreasonably low in relation to anticipated losses or expenses, or both, or to the uncertainty of loss for the insurance coverage provided.

(b) A rate is inadequate if the use of the rate has or will have the effect of destroying competition among insurers or creating a monopoly.

(c) An applicant who is in good faith entitled to procure insurance through ordinary methods is an eligible person with respect to that insurance, as defined in section 2103(1) of the code.

History: 1981 AACS.

R 500.1505 Unfairly discriminatory rates.

Rule 5. (1) For purposes of section 2109(1)(c) of the code, a rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage if the differential between the rates is not reasonably justified by differences in mean anticipated losses or expenses, or both, or by differences in the uncertainty of loss for the individuals or risks to which the rates apply. A reasonable justification shall be supported by a reasonable classification system, by sound actuarial principles, and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience.

(2) A rate is not unfairly discriminatory because it reflects differences in anticipated expenses for classifications of risks with similar anticipated losses or because it reflects differences in anticipated losses for classifications of risks with similar anticipated expenses.

(3) A reasonable classification system is a system designed to group individuals or risks with similar characteristics into rating classifications which are likely to identify significant differences in mean anticipated losses or expenses, or both, between the groups, as determined by sound actuarial principles and by actual and credible loss and expense statistics or, in the case of new coverages or classifications, by reasonably anticipated loss and expense experience.

(4) Sound actuarial principles shall include, but not be limited to, all of the following principles:

(a) That data used in developing classifications and rates are derived from the experience of a population or sample of risks that is sufficiently similar to the anticipated insured population so that the statistics thereby obtained can reasonably be expected to produce representative and reliable estimates of the anticipated loss and expense experience for the insured population and so that such statistics are calculated in a manner that is suitable to their intended use.

(b) That a reasonable predictive relationship can be demonstrated to exist between a characteristic used in defining a rating classification and anticipated losses, anticipated expenses, or the uncertainty of loss for the risks to which the classification applies.

(c) That if rates for individual rating cells are calculated by means of arithmetic combinations of relativities for the classifications defining those cells, the relativities are combined in a manner that equitably reflects the anticipated loss and expense experience for those rating cells.

(d) That sampling techniques used in developing classifications and in estimating loss and expense experience are suitable to their intended application.

(e) That with regard to private passenger automobile insurance and private residential property insurance, rates for an insurance coverage provided are established in a manner that can reasonably be anticipated to produce loss ratios which are substantially uniform among the classifications, kinds, or types of individuals or risks to which the rates apply. Evaluation of loss ratios shall make appropriate adjustments for differences in deductibles and limits of liability among insureds, for expense provisions which are not allocated to premiums on a percentage-of-premium basis, and for differences in contingency factors among classifications and shall give due consideration to the credibility of experience for groupings of individuals or risks, to trends in past and prospective loss experience, and to historical patterns between projected and realized loss ratios. For purposes of this subdivision, "substantially uniform" means the absence of significant variations among loss ratios.This subdivision shall not be construed to prohibit the use of appropriate pure premium relativities to estimate or evaluate rate relativities.

(5) Data of an insurer or rating organization used in calculating actual and credible loss statistics shall be of sufficient volume, or shall be combined in an appropriate manner with suitable data of sufficient volume, so that the statistics thereby calculated are reasonably credible and can reasonably be anticipated to produce reliable estimates of anticipated loss and expense experience.

(6) Data for reasonably anticipated experience used in calculating rates for new coverages and in establishing new classifications shall, to the extent possible, be based on actual experience for similar coverages and for groups of risks similar to the proposed classification and shall be of sufficient volume so that statistics thereby produced can reasonably be anticipated to produce reliable estimates of loss and expense experience.

(7) Relevant external information, including general economic data and other indicators, may be given due consideration in evaluating or projecting loss and expense experience.

History: 1981 AACS.

R 500.1506 Expense provisions.

Rule 6. (1) The expense portion of a rate shall, with regard to each category of expense, be examined and evaluated independent of the loss portion of the rate. Expenses shall not be presumed to change by the same percentage as losses are anticipated to change.

(2) Predictions of future expense costs shall give due consideration to trends and changes in historical expense levels, in actual or reasonably allocated expenses incurred, and in external expense indices and indicators.

History: 1981 AACS.

R 500.1507 Expense allocation.

Rule 7. (1) Expense provisions for each category of expenses shall be reasonably allocated among classifications in a manner that equitably reflects variations, if any, in the manner in which such expenses are anticipated to be incurred with respect to the groups of individuals or risks defined by those classifications. Expenses, other than allocated loss adjustment expenses, shall not be presumed to be incurred proportionally to classification relativities based on anticipated loss.

(2) Expense provisions for premium taxes, if any, shall reflect the applicable premium tax rate.

(3) Expense provisions for each other category of expenses shall be reasonably allocated among classifications based on losses, coverages, exposures, or other basis that equitably measures the variations, if any, in the manner in which such expenses are anticipated to be incurred with respect to the classifications. Expense allocation methods may include percentage-of-premium, uniform-per-coverage, uniform-per-exposure, or other basis, as appropriate and justified.

History: 1981 AACS.

R 500.1508 Denial; notice of right to appeal.

Rule 8. (1) At the time of a denial of insurance as defined in R 500.1501, the insurer or agent making the denial shall notify a person of his or her right to appeal the decision if he or she has reason to believe that such denial is improper.

(2) The notice of a person's right to appeal shall be in language understandable to a person of ordinary intelligence and shall contain, but need not be limited to, an explanation of all of the following:

(a) The procedure to be followed in the complaint resolution process, including the option to request a private informal managerial level conference.

(b) The person's right to request and receive, subject to a reasonable copying charge, copies of information relating to the denial. A reasonable copying charge shall not exceed the rate charged for copying by the Michigan Insurance Bureau in accordance with Act No. 442 of the Public Acts of 1976, as amended, being S15.231 et seq. of the Michigan Compiled Laws. The commissioner shall inform insurers of the maximum allowable copying charge on an annual basis.

(c) The person's right to participate in an informal process for complaint resolution. This process shall be concluded within 30 days of the complaint to the insurer and may include discussions by telephone, by mail, and by a private, informal, managerial-level

conference. If the conference is by means of a telephone conference, the insurer shall identify all persons by name and title who are listening to the phone conference. In addition, the insurer shall either provide toll-free telephone service or pay all telephone charges associated with such telephone conferences. If the private managerial-level conference is to be conducted by telephone, the notice shall indicate the telephone number which the insured must call and inform the insured that he or she may call collect if a toll-free number is not provided.

(d) The person's right to bring the matter before the commissioner for resolution if the insurer's internal complaint resolution process fails to resolve the dispute.

(e) The person's right to appoint another person to act on his or her behalf throughout the appeals process set forth in these rules.

History: 1981 AACS.

R 500.1509 Complaint; insurer's responsibility upon conclusion of internal complaint resolution process.

Rule 9. (1) Upon conclusion of the internal complaint resolution process, the insurer shall provide the following information to the complainant:

(a) The action taken by the insurer.

(b) The facts, with supporting documentation, upon which the action is based.

(c) The specific section or sections of the law upon which the action is based.

(d) A statement explaining the person's right to appeal the matter to the commissioner within 120 days after the insurer makes or delivers the written statement.

(e) A statement describing the status of the insurance coverage or coverages involved.

(2) The insurer shall offer to provide the information in writing. If the insured accepts the offer, the insurer shall mail the written statement via first-class mail within 3 business days after acceptance.Such a written statement shall be phrased in terms understandable to a person of ordinary intelligence.

History: 1981 AACS.

R 500.1510 Complaint; appeals to the commissioner.

Rule 10. (1) If a person believes an insurer has improperly denied him or her automobile or home insurance or has charged an incorrect premium for that insurance and if the insurer's internal complaint resolution process fails to resolve the dispute, the person has a right to bring the matter before the commissioner for resolution.

(2) The complainant shall appeal the denial to the commissioner within 120 days of the date the insurer mails or delivers a proposed resolution or within 120 days after the end of the 30-day period which the insurer has to provide such a resolution, if no proposed resolution is provided.

(3) The complainant is entitled to a review of the matter by the commissioner either by a review of written materials or, upon request, through a meeting with the parties involved in the dispute.

History: 1981 AACS.

R 500.1511 Review of dispute; commissioner's actions.

Rule 11. (1) When conducting a review of a dispute through written materials, the commissioner shall, by first-class mail, notify the insurer of the matter under consideration and inform the insurer of the time period within which any reply shall be made. Such notification shall be given within 10 working days after the commissioner receives the complaint.

(2) When conducting a review of a dispute through a meeting with the parties involved, the commissioner shall do all of the following within 10 working days after he or she receives the complaint:

(a) Set a time for the meeting and notify the complainant, by first-class mail, of the time and place of the meeting.

(b) Send, by first-class mail, a copy of the notice of the meeting to the insurer.

(c) Inform the insurer of the time period within which any reply shall be made.

(3) The commissioner shall conduct meetings in a manner which allows the disputing parties to present relevant facts, records, dates, times, and names to substantiate their positions.

History: 1981 AACS.

R 500.1512 Basis for decisions.

Rule 12. The commissioner shall base his or her decision upon written materials submitted by the parties and the statements of the parties at the meeting, if any. Failure of either party to supply any information in a timely manner shall result in a decision based upon information available to the commissioner at the time of the decision.

History: 1981 AACS.

R 500.1513 Decision.

Rule 13. (1) The commissioner shall prepare a written decision within 10 working days after the insurer submits a reply to a complaint or, if a reply is not submitted, within 10 working days after the time for submitting a reply has expired.

(2) If a meeting is held, the commissioner shall prepare a written decision within 10 working days after the meeting is concluded.

(3) The commissioner shall indicate in the written decision that if either the insurer or the complainant disagrees with the determination, the commissioner, if requested to do so by either party, shall proceed to hear the matter as a contested case under Act No. 306 of the Public Acts of 1969, as amended, being S24.201 et seq. of the Michigan Compiled Laws.

(4) The commissioner shall send copies of the written decision to the parties by first-class mail.

History: 1981 AACS.

R 500.1514 Improper termination; status of coverage.

Rule 14. If the commissioner's decision indicates that the complainant's insurance was improperly terminated, the complainant may select any of the following remedies:

(a) The termination may be deemed invalid and coverage shall be reinstated effective as of the date of the termination upon payment of the applicable premium.

(b) Coverage may be reinstated with the terminating insurer as of the date of the commissioner's decision upon payment of the applicable premium, subject to the following conditions:

(i) If the complainant has secured coverage from another insurer, upon notice from the complainant, such coverage shall be canceled and the insurer providing the coverage shall provide the complainant with a refund of premium pursuant to the insurer's filed rating rules.

(ii) If the complainant has secured coverage from another insurer, the improperly terminating insurer shall pay the insured any additional premium expenditures incurred by the insured as a result of seeking additional coverage which are in excess of the pro rata premium the complainant would have paid for the coverage from the improperly terminating insurer for the same period of time.

(c) If the complainant has secured coverage from another insurer, the complainant may continue that coverage and the termination shall be deemed invalid but coverage shall not be reinstated.

History: 1981 AACS.

R 500.1515 Collection and reporting of data by insurers.

Rule 15. For purposes of section 2127 of the code, all of the following shall apply:

(a) Every insurer subject to chapter 21 of the code writing automobile insurance or home insurance, or both, in Michigan shall report data concerning such insurance in accordance with statistical plans and reporting forms approved by the commissioner. The reporting plans and forms shall provide for the collection of only such information as the commissioner finds necessary to monitor and evaluate the automobile and home insurance markets in this state, as provided in section 2127 of the code.

(b) Statistical plans approved by order of the commissioner for licensed statistical gathering agencies will be accepted as providing adequate historical premium, exposure, loss, and expense information for automobile and home insurance.

(c) Supporting data for automobile and home insurance rate filings submitted in accordance with the forms with instructions as issued by the commissioner will be assumed to comply substantially with information needs for evaluating overall rate level needs, 1 of the elements in monitoring and evaluating markets per section 2127 of the code.

(d) The commissioner shall accept annual statement data on 1 element in the process of monitoring competition.

History: 1981 AACS.

R 500.1516 Exchange of claim information.

Rule 16. Every insurer subject to chapter 21 of the code shall exchange claim information for automobile insurance and home insurance as provided in these rules to the extent such

information is available from the responding company's data base. Such information shall not be requested for selected policyholders on the basis of age, sex, or other factor so as to be discriminatory in nature.

History: 1981 AACS.

R 500.1517 Exchange of automobile insurance claim information.

Rule 17. (1) Every insurer subject to chapter 21 of the code writing automobile insurance shall respond, on a form similar to figure 1, within 30 calendar days, to a request by another insurer for information concerning the claim history of a specified person.

(2) The reporting insurer shall report automobile insurance claim information as follows:

(a) The name and address of the insured.

(b) The policy number of such insured.

(c) The name of the driver of the insured vehicle, if known.

(d) The period of time insured, if available, but in all cases, the expiration date.

(e) Whether the claim is open or closed at the time of the report.

(f) Date or dates of loss.

(g) Amount of loss paid under each coverage.

(3) The requesting insurer shall specify in its request for claim information the name, address, and responding company's policy number of the insured who is the subject of the request. The requesting insurer shall also provide with the request a stamped, addressed envelope for the return of the completed claim information form.

History: 1981 AACS.

R 500.1518 Exchange of home insurance claim information.

Rule 18. (1) Every insurer subject to chapter 21 of the code writing home insurance shall respond, on a form similar to figure 1, within 30 calendar days, to a request by another insurer for information concerning the claim history of a specified person. The claim information which may be requested and reported shall be information as described in section 2111(12)(f) of the code.

(2) The reporting insurer shall report home insurance information as follows:

(a) Name and address of the insured.

(b) Policy number of such insured.

(c) Location of insured premises.

(d) Date of loss or losses.

(e) Amount paid.

(f) Coverage involved.

(g) Whether or not a fire loss was investigated by civil authorities.

(3) The requesting insurer shall specify in its request the name, address, and responding company's policy number of the insured who is the subject of the request. The requesting insurer shall also provide with the request a stamped, addressed envelope for the return of the completed claim information form.

History: 1981 AACS.

R 500.1519 Exchange of claim information; reporting period.

Rule 19. An insurer shall be responsible for reporting, upon request, automobile insurance and home insurance claim information only for current policies or those which expired 90 days immediately preceding the date of receipt of a request for claim information. The claim information reported shall cover the 3 years last preceding the expiration date, including claim information originally reported by another carrier.

History: 1981 AACS.

R 500.1520 Fee for providing claim data prohibited.

Rule 20. A fee shall not be charged by an insurer for providing the claim information required by these rules for the first 12 calendar months immediately following the effective date of this rule.

History: 1981 AACS.

R 500.1521 Figure 1.

Rule 21. Figure 1 reads as follows:

We recently received an application for auto property (circle one) insurance from the above individual. As provided for in Section 2130 of P.A. 145, please supply the claim experience for the past three years as available. If additional space is needed, please complete on the back of this form.

History: 1981 AACS.