

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES ~~INSURANCE AND~~
FINANCIAL SERVICES

~~INSURANCE BUREAU~~

ESSENTIAL INSURANCE

Filed with the secretary of state on

These rules take effect immediately upon filing with the secretary of state unless adopted under section 33, 44, or 45a(6) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of state.

(By authority conferred on the ~~commissioner~~ **director** of insurance and financial services by section 210 of **the insurance code of 1956, 1956 PA 218, MCL Act No. 218** of the Public Acts of 1956, as amended, being ~~S500.210~~ of the Michigan Compiled Laws and Executive Reorganization No. 2013-1, MCL 550.991)

R 500.1501, R 500.1503, R 500.1505, R 500.1506, R 500.1507, R 500.1508, R 500.1509, R 500.1510, R 500.1511, R 500.1512, R 500.1513, R 500.1514, and R 500.1515 of the Michigan Administrative Code are amended, as follows:

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~~ **must** not include a grouping of individuals or risks solely for statistical data gathering purposes.
- (c) "Code" means **the insurance code of 1956, MCL Act No. 218** of the Public Acts of 1956, as amended, being ~~S500.100 to 500.8302 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 **written** statement by a person to an insurer, an agent, or the ~~commissioner~~ **director** that an insurer or agent has improperly denied him or her automobile insurance or home insurance or has charged an inappropriate premium for ~~that~~ **automobile insurance or home** 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.
- (f) "**Director**" means **the director of the department of insurance and financial services**.
- (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~~ **director** 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 **supervisory or higher level** 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~~ **must** 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~~ **must** 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.

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~~ **must** 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.

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~~ **must** 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~~ **must** 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~~ **must** 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~~ **must** 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~~ **must**, to the extent possible, be based on actual experience for similar coverages and for groups of risks similar to the proposed classification and ~~shall~~ **must** 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.

R 500.1506 Expense provisions.

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

(2) Predictions of future expense costs ~~shall~~ **must** 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.

R 500.1507 Expense allocation.

Rule 7. (1) Expense provisions for each category of expenses ~~shall~~ **must** 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~~ **must** not be presumed to be incurred proportionally to classification relativities based on anticipated loss.

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

(3) Expense provisions for each ~~other~~ category of expenses ~~shall~~ **must** 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.

R 500.1508 Denial; **incorrect premium charge**; 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~~ **producer** making the denial shall notify a person of his or her right to ~~appeal the decision~~ **a private informal managerial level conference** if ~~he or she has reason to the person~~ believes that such denial is improper.

(2) An insurer or producer who is informed by a person that the person believes he or she has been charged an incorrect premium must notify the person, in writing, of his or her right to a private informal managerial level conference.

(23) The **written notices required under subrule (1) and (2)** ~~shall~~ **must** be in language understandable to a person of ordinary intelligence and ~~shall~~ **must** contain, but need not be limited to, an explanation of all of the following:

(a) The procedure to be followed ~~in the~~ **by the person if he or she wishes to** ~~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 **or premium charge**. A reasonable copying charge ~~shall~~ **must** not exceed the rate charged for copying by the ~~Michigan Insurance Bureau~~ **department of insurance and financial services** in accordance with **the freedom of information act, 1976 PA 442, MCL Act No. 442** ~~of the Public Acts of 1976, as amended, being S15.231 to 15.246 et seq. of the Michigan Compiled Laws.~~ The ~~commissioner~~ **director** 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 **through the private informal managerial level conference**. This process ~~shall~~ **must** be concluded within 30 days of the **person's** complaint to the insurer and may ~~include discussions~~ **be held by telephone or in person, upon the person's request,** ~~by mail, and by a private, informal, managerial level conference.~~ If the conference is by means of a telephone conference, the insurer ~~shall~~ **must state at the beginning of the telephone conference that it is a private informal managerial level conference. The insurer must also** identify all persons by name and title who are listening to the ~~phone~~ **telephone** conference. In addition, the insurer ~~shall~~ **must** 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~~ **must** indicate the

telephone number which the ~~insured person~~ must call and inform the ~~insured person~~ 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~~ **director** for resolution if the insurer's ~~internal complaint resolution process~~ **private informal managerial level conference** 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.

R 500.1509 Complaint; insurer's responsibility upon conclusion of ~~internal complaint resolution process~~ **the private informal managerial level conference.**

Rule 9. (1) Upon conclusion of the ~~internal complaint resolution process~~ **private informal managerial level conference**, the insurer ~~shall~~ **must** provide the following information **in writing** to the ~~complainant~~ **person making the complaint**:

(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~~ **a review and determination by the director of the matter insurer's decision to the commissioner** within 120 days after the insurer ~~makes or delivers the written statement~~ **the date of the private informal managerial level conference, including the director's toll-free number and address.**

(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~~ **must mail the information listed in subrule (1) in writing to the person making the complaint** via first-class mail within 3 business days after acceptance. Such a written statement ~~shall~~ **must** be phrased in terms understandable to a person of ordinary intelligence.

R 500.1510 Complaint; ~~appeals to the commissioner~~ **review and determination by the director.**

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~~ **private informal managerial level conference** fails to resolve the dispute, the person has a right to bring the matter before the ~~commissioner~~ **director** for resolution.

(2) The ~~complainant~~ **person making the complaint** ~~shall appeal~~ **must file a request for a review and determination of the denial to the commissioner director, on a form approved by the director**, 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~~ **person making the complaint** is entitled to a review of the matter by the ~~commissioner~~ **director** either ~~by~~ **through** a review of written materials or, upon ~~the person's written~~ request, through a meeting, **either in person or by telephone conference**, with the parties involved in the dispute. **A request for an in-person meeting must be made at the same time the person files the request for review and determination.**

R 500.1511 Review of dispute; ~~commissioner's~~ **director's** actions.

Rule 11. (1) When conducting a review of a dispute through written materials, the ~~commissioner~~ **director** 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 ~~must~~ **must** be made. Such notification shall ~~must~~ **be given issued to the person making the complaint and the insurer** within 10 ~~working~~ **business** days after the ~~commissioner~~ **director** receives the complaint.

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

(a) Set a time for the meeting and notify the ~~complainant~~ **person making the complaint,** ~~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~~ **director** shall conduct meetings in a manner which allows the disputing parties to present relevant facts, records, dates, times, and names to substantiate their positions.

R 500.1512 Basis for decisions.

Rule 12. The ~~commissioner~~ **director** 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~~ **director** at the time of the decision.

R 500.1513 Decision.

Rule 13. (1) The ~~commissioner~~ **director** 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~~ **business** days after the time for submitting a reply has expired.

(2) If a meeting is held, the ~~commissioner~~ **director** shall ~~prepare~~ **issue** a written decision within ~~10~~ **15** ~~working~~ **business** days after the meeting is concluded.

(3) The ~~commissioner~~ **director** shall indicate in the written decision that if either the insurer or the ~~complainant~~ **person making the complaint** disagrees with the determination, the ~~commissioner~~ **director**, if requested to do so by either party, shall proceed to hear the matter as a contested case under **the administrative procedures act, 1969 PA 306, MCL Act No. 306 of the Public Acts of 1969, as amended, being S24.201 to 24.328 et seq. of the Michigan Compiled Laws.**

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

R 500.1514 ~~Improper termination; status of coverage~~ **Remedies.**

Rule 14.

(1) If the director concludes that the insurer improperly terminated or denied the person automobile insurance or home insurance, the director shall order an appropriate remedy.

(2) If the ~~commissioner's~~ **director** ~~decision indicates~~ **concludes** that the ~~complainant's~~ insurance was improperly terminated, the ~~complainant~~ **person making the complaint** 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~~ **director's** decision upon payment of the applicable premium, subject to the following conditions:

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

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

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

(3) If the director concludes that the person was charged an incorrect premium, the director shall order an appropriate remedy. If the director orders a refund of an incorrectly charged premium, the insurer must provide a refund to the person within 10 business days of the director's order, and must provide documentation to the director showing how the refund amount was calculated.

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~~ **director**. The reporting plans and forms shall provide for the collection of only such information as the ~~commissioner~~ **director** 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~~ **director** 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~~ **director** 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~~ **director** shall accept annual statement data on 1 element in the process of monitoring competition.