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STATE OF MICHIGAN
87TH LEGISLATURE
REGULAR SESSION OF 1993

Introduced by Senators Wartner, Welborn and McManus

ENROLLED SENATE BILL No. 346

AN ACT to amend sections 1207, 2236, 2301, 2303, 2312, 2402, 2403, 2406, 2409, 2409a, 2418, 2420, 7911, and 7921 of Act No. 218 of the Public Acts of 1956, entitled as amended "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state, to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates, and to provide for certain powers and duties, upon certain persons, as they affect the continued availability and affordability of that insurance; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain persons; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide an appropriation; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; to repeal certain parts of this act on specific dates; and to provide penalties for the violation of this act," section 1207 as amended by Act

No. 170 of the Public Acts of 1990, section 2236 as amended by Act No. 305 of the Public Acts of 1990, sections 2301, 2303, 2409, and 2409a as added by Act No. 8 of the Public Acts of 1982, sections 2312 and 7921 as amended by Act No. 137 of the Public Acts of 1990, section 2402 as added and section 2406 as amended by Act No. 7 of the Public Acts of 1982, section 2403 as amended by Act No. 173 of the Public Acts of 1986, and section 7911 as amended by Act No. 143 of the Public Acts of 1993, being sections 500.1207, 500.2236, 500.2301, 500.2303, 500.2312, 500.2402, 500.2403, 500.2406, 500.2409, 500.2409a, 500.2418, 500.2420, 500.7911, and 500.7921 of the Michigan Compiled Laws; to add chapter 51; and to repeal certain parts of the act.

The People of the State of Michigan enact:

Section 1. Sections 1207, 2236, 2301, 2303, 2312, 2402, 2403, 2406, 2409, 2409a, 2418, 2420, 7911, and 7921 of Act No. 218 of the Public Acts of 1956, section 1207 as amended by Act No. 170 of the Public Acts of 1990, section 2236 as amended by Act No. 305 of the Public Acts of 1990, sections 2301, 2303, 2409, and 2409a as added by Act No. 8 of the Public Acts of 1982, sections 2312 and 7921 as amended by Act No. 137 of the Public Acts of 1990, section 2402 as added and section 2406 as amended by Act No. 7 of the Public Acts of 1982, section 2403 as amended by Act No. 173 of the Public Acts of 1986, and section 7911 as amended by Act No. 143 of the Public Acts of 1993, being sections 500.1207, 500.2236, 500.2301, 500.2303, 500.2312, 500.2402, 500.2403, 500.2406, 500.2409, 500.2409a, 500.2418, 500.2420, 500.7911, and 500.7921 of the Michigan Compiled Laws, are amended and chapter 51 is added to read as follows:

Sec. 1207. (1) An agent shall be a fiduciary for all money received or held by the agent in his or her capacity as an agent. Failure by an agent in a timely manner to turn over the money which he or she holds in a fiduciary capacity to the persons to whom they are owed is prima facie evidence of violation of the agent's fiduciary responsibility. An agent shall not accept payment of a premium for a medicare supplemental policy or certificate in the form of a check or money order made payable to the agent instead of the insurer. Upon receiving payment of a premium for a medicare supplemental policy or certificate, an agent shall immediately provide a written receipt to the insured.

(2) An agent shall use reasonable accounting methods to record funds received in his or her fiduciary capacity including the receipt and distribution of all premiums due each of his or her insurers. An agent shall record return premiums received by or credited to him or her which are due an insured on policies reduced or canceled or which are due a prospective purchaser of insurance as a result of a rejected or declined application. Records required by this section shall be open to examination by the commissioner.

(3) Except as provided in section 1212 and subsection (4), an agent shall not reward or remunerate any person for procuring or inducing business in this state, furnishing leads or prospects, or acting in any other manner as an agent.

(4) If an agent is unable to immediately provide, through his or her insurers that are authorized to underwrite the coverage, all or a part of the coverage requested on a risk, the agent may obtain the part of the coverage refused by his or her insurers through another licensed agent or through a risk sharing plan permitted by state law. An agent who attempts to place the refused part of the coverage through another licensed agent shall advise the buyer in writing that the refused part of the coverage is not in effect until the buyer receives written evidence of insurance.

(5) A person may not sell or attempt to sell insurance by means of intimidation or threats, whether express or implied. Except as provided in section 2077(4) a person may not induce the purchase of insurance through a particular agent or from a particular insurer by means of a promise to sell goods, to lend money, to provide services, or by a threat to refuse to sell goods, to refuse to lend money, or to refuse to provide services.

(6) After January 1, 1973, an insurer or an agent may not be a party to a contract under which the agent assumes any responsibility or obligation for payment, from his or her commission or any allocation of premium to him or her by the insurer, of any losses on insurance policies sold by the agent unless the claim adjusting is done by insurance company adjusters or licensed independent adjusters.

Sec. 2236. (1) A basic insurance policy form or annuity contract form shall not be issued or delivered to any person in this state, and an insurance or annuity application form if a written application is required and is to be made a part of the policy or contract, a printed rider or indorsement form or form of renewal certificate, and a group certificate in connection with the policy or contract, shall not be issued or delivered to a person in this state, until a copy of the form is filed with the insurance bureau and approved by the commissioner as conforming with the requirements of this act and not inconsistent with the law. Failure of the commissioner to act within 30 days after submittal shall constitute approval. All such forms, except policies of disability insurance as defined in section 3400, shall be plainly printed with type size not less than 8-point unless the commissioner determines that portions of such a form printed with type less than 8-point is not deceptive or misleading.

(2) An insurer may satisfy its obligations to make form filings by becoming a member of, or a subscriber to, a rating organization, licensed under section 2436 or 2630, which makes such filings and by filing with the commissioner a copy of its authorization of the rating organization to make the filings on its behalf. Every member of or subscriber to a rating organization shall adhere to the form filings made on its behalf by the organization except that an insurer may file with

the commissioner a substitute form, and thereafter if a subsequent form filing by the rating organization affects the use of the substitute form, the insurer shall review its use and notify the commissioner to withdraw its substitute form.

(3) Beginning January 1, 1992, the commissioner shall not approve a form filed pursuant to this section providing for or relating to an insurance policy or an annuity contract for personal, family, or household purposes if the form fails to obtain the readability score or meet the other requirements of this subsection, as applicable:

(a) The readability score for a form for which approval is required by this section shall not be less than 45, as determined by the method provided in subdivisions (b) and (c).

(b) The readability score for a form shall be determined as follows:

(*i*) For a form containing not more than 10,000 words, the entire form shall be analyzed. For a form containing more than 10,000 words, not less than two 200-word samples per page shall be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(*ii*) Count the number of words and sentences in the form or samples and divide the total number of words by the total number of sentences. Multiply this quotient by a factor of 1.015.

(*iii*) Count the total number of syllables in the form or samples and divide the total number of syllables by the total number of words. Multiply this quotient by a factor of 84.6. As used in this subparagraph, "syllable" means a unit of spoken language consisting of 1 or more letters of a word as indicated by an accepted dictionary. If the dictionary shows 2 or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(*iv*) Add the figures obtained in subparagraphs (*ii*) and (*iii*) and subtract this sum from 206.835. The figure obtained equals the readability score for the form.

(c) For the purposes of subdivision (b)(*ii*) and (*iii*), the following procedures shall be used:

(*i*) A contraction, hyphenated word, or numbers and letters when separated by spaces shall be counted as 1 word.

(*ii*) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as 1 sentence.

(d) In determining the readability score, the method provided in subdivisions (b) and (c):

(*i*) Shall be applied to an insurance policy form or an annuity contract, together with a rider or indorsement form usually associated with such an insurance policy form or annuity contract.

(*ii*) Shall not be applied to words or phrases that are defined in an insurance policy form, an annuity contract, or riders, indorsements, or group certificates pursuant to an insurance policy form or annuity contract.

(*iii*) Shall not be applied to language specifically agreed upon through collective bargaining or required by a collective bargaining agreement.

(*iv*) Shall not be applied to language that is prescribed by state or federal statute or by rules or regulations promulgated pursuant to a state or federal statute.

(e) Each form for which approval is required by this section shall contain both of the following:

(*i*) Topical captions.

(*ii*) An identification of exclusions.

(f) Each insurance policy and annuity contract that has more than 3,000 words printed on not more than 3 pages of text or that has more than 3 pages of text regardless of the number of words shall contain a table of contents. This subdivision does not apply to indorsements.

(g) Each rider or indorsement form that changes coverage shall do all of the following:

(*i*) Contain a properly descriptive title.

(*ii*) Reproduce either the entire paragraph or the provision as changed.

(*iii*) Be accompanied by an explanation of the change.

(h) If a computer system approved by the commissioner calculates the readability score of a form as being in compliance with this subsection, the form is considered in compliance with the readability score requirements of this subsection.

(4) After January 1, 1992, any change or addition to a policy or annuity contract form for personal, family, or household purposes, whether by indorsement, rider, or otherwise, or a change or addition to a rider or indorsement form to such policy or annuity contract form, which policy or annuity contract form has not been previously approved under subsection (3), shall be submitted for approval pursuant to subsection (3).

(5) Upon written notice to the insurer, the commissioner may disapprove, withdraw approval or prohibit the issuance, advertising or delivery of any form to any person in this state if it violates any provisions of this act, or contains inconsistent, ambiguous or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy. The notice shall specify the objectionable provisions or conditions and state the reasons for the commissioner's decision. If the form is legally in use

by the insurer in this state, the notice shall give the effective date of the commissioner's disapproval, which shall not be less than 30 days subsequent to the mailing or delivery of the notice to the insurer. If the form is not legally in use, then disapproval shall be effective immediately.

(6) If a form is disapproved or approval is withdrawn under the provisions of this act, the insurer shall be entitled upon demand to a hearing before the commissioner or a deputy commissioner within 30 days after the notice of disapproval or of withdrawal of approval; and after the hearing, the commissioner shall make findings of fact and law, and either affirm, modify or withdraw his or her original order or decision.

(7) Any issuance, use or delivery by an insurer of any form without the prior approval of the commissioner as required by subsection (1) or after withdrawal of approval as provided by subsection (5) constitutes a separate violation for which the commissioner may order the imposition of a civil penalty of $25.00 for each offense, but not to exceed the maximum penalty of $500.00 for any 1 series of offenses relating to any 1 basic policy form, which penalty may be recovered by the attorney general as provided in section 230.

(8) The filing requirements of this section shall not apply to:

(a) Insurance against loss of or damage to:

(*i*) Imports, exports, or domestic shipments.

(*ii*) Bridges, tunnels, or other instrumentalities of transportation and communication.

(*iii*) Aircraft and attached equipment.

(*iv*) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(b) Insurance against loss resulting from liability, other than worker's compensation or employers' liability arising out of the ownership, maintenance, or use of:

(*i*) Imports, exports, or domestic shipments.

(*ii*) Aircraft and attached equipment.

(*iii*) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(c) Surety bonds other than fidelity bonds.

(d) Policies, riders, indorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder or certificate holder. Beginning September 1, 1968, the commissioner by order may exempt from the filing requirements of this section and sections 2242, 3606, and 4430 for so long as he or she considers proper any insurance document or form, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a, as specified in the order to which this section practicably may not be applied, or the filing and approval of which are considered unnecessary for the protection of the public. Insurance documents or forms providing medical payments or income replacement benefits, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a, exempt by order of the commissioner from the filing requirements of this section and sections 2242 and 3606 are considered approved by the commissioner for purposes of section 3430.

(9) Every order made by the commissioner under the provisions of this section shall be subject to court review as provided in section 244.

Sec. 2301. Each insurer authorized to write worker's compensation insurance in this state shall participate in the Michigan worker's compensation placement facility for the purpose of doing all of the following:

(a) Providing worker's compensation insurance to any person who is unable to procure the insurance through ordinary methods.

(b) Preserving to the public the benefits of price competition by encouraging maximum use of the normal private insurance system.

Sec. 2303. As used in this chapter:

(a) "Facility" means the Michigan worker's compensation placement facility created under this chapter.

(b) "Participating member" means an insurer who is a member of the facility and who in any given calendar year has a participation ratio greater than zero in the facility for that year.

(c) "Participation ratio" means the ratio of the participating member's voluntary Michigan worker's compensation premiums to the comparable statewide totals of all participating members.

(d) "Worker's compensation insurance" means insurance which provides any of the following:

(*i*) Security required pursuant to the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws.

(*ii*) Security required pursuant to the United States longshoreman's and harbor worker's compensation act.

(*iii*) Coverage customarily known as employer's liability insurance, when contained in or endorsed to a policy providing the security in subparagraph (*i*) or (*ii*).

Sec. 2312. (1) A plan of operation of the facility shall be prepared by the board of governors and shall be subject to the approval of the commissioner. The commissioner shall review the plan of operation on an ongoing basis, and the plan shall be subject to revision at the request of the commissioner at any time.

(2) The plan of operation shall provide for all of the following:

(a) Appointment by the board of governors of 1 or more servicing carriers, subject to the approval of the commissioner. Appointments may be rescinded for cause by either the board subject to the approval of the commissioner, or by the commissioner.

(b) Creation of servicing carrier performance standards including all of the following:

(*i*) Sufficient personnel to provide support for safety management services offered by the plan.

(*ii*) Providing for sufficient personnel for claims adjustment.

(c) Agreements among all insurers authorized to write worker's compensation insurance in this state with respect to the equitable apportionment among them of worker's compensation insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure such insurance through ordinary methods.

(d) Payment of commissions to producing agents not to exceed 5% of a total premium.

(e) Creation of 3 rating plans as follows:

(*i*) Rating plan "A" which shall provide coverage for insureds who have a demonstrated accident frequency problem, who have a measurably adverse loss ratio over a period of years, or who have demonstrated an attitude of noncompliance with safety requirements. The commissioner shall approve rates for rating plan A which shall be adequate to cover losses and which shall not be excessive, inadequate, or unfairly discriminatory. This plan shall contain a system of surcharges established by the board of governors and approved by the commissioner.

(*ii*) Rating plan "B" which shall provide coverage to those employers who apply for worker's compensation insurance in the facility and are either self-insured or a member of a self-insurance group. This plan shall be established by the board of governors of the facility and approved by the commissioner. The commissioner shall convene and consult with an advisory organization including representatives of self-insureds and group self-insureds prior to approving rating plan "B". The recommendations of the advisory organization shall be given reasonable consideration by the commissioner. The commissioner shall approve rates for rating plan B which shall be adequate to cover losses and which shall not be excessive, inadequate, or unfairly discriminatory.

(*iii*) Rating plan "C" which shall provide coverage to all other insureds of the facility. Rating plan "C" shall not contain any surcharge system. The commissioner shall approve rates for rating plan C that are set through the lower of either of the following methods:

(A) By using 20% of the loss experience of insurers from employers while participants in rating plan C and 80% of the statewide loss experience of all insurers writing worker's compensation insurance in this state.

(B) Through the use of rates adequate to cover losses and which shall not be excessive, inadequate, or unfairly discriminatory.

(f) Prompt and fair hearings for purposes of section 2350.

(3) The application of the plans created under subsection (2)(e) to insureds shall be as determined by the commissioner. The plans shall be applied to insureds regardless of the number of employees or amount of payroll of the insured.

(4) Retrospective evaluation of premiums and loss and expense experience of insureds within each rating plan under subsection (2)(e) shall be performed by the board of governors, in a manner approved by the commissioner. If this evaluation indicates that a return of a portion of premiums is in order, then such a return shall be accomplished, subject to the approval of the commissioner.

Sec. 2402. (1) As used in this act with respect to worker's compensation insurance:

(a) "Data collection agency" means an agency established for the purpose of effectuating the worker's compensation data requirements of this chapter.

(b) "Designated advisory organization" means the advisory organization designated by the data collection agency pursuant to section 2407(2).

(c) "Rate" means the cost of insurance per payroll before adjustment for an individual insured's size, exposure, or loss experience.

(d) "Rating system" means every classification, rating plan, merit rating plan, rating values, and manual, containing the rules used by an insurer in the determination of premiums.

(2) There is created a data collection agency for the purpose of effectuating the worker's compensation data requirements of this chapter. The governing board of the data collection agency shall include all of the following:

(a) Three persons who represent private insurers in this state.

(b) One person who represents the general public.

(c) One person who represents employers in this state.

(d) One person who represents the executive branch of state government.

(e) One person who is an insurance agent.

(f) The commissioner of insurance.

(3) A member of the governing board of the data collection agency shall serve for a term of 1 year.

(4) The members specified in subsection (2)(b), (c), and (e) shall be appointed by the commissioner. The member specified in subsection (2)(d) shall be appointed by the governor with the advice and consent of the senate. The members specified in subsection (2)(a) shall be appointed by the commissioner from recommendations made by the insurance industry in this state and shall be generally representative of small, medium, and large insurers.

(5) Business of the governing board of the data collection agency shall be conducted at a public meeting pursuant to the open meetings act, Act No. 267 of the Public Acts of 1976, as amended, being sections 15.261 to 15.275 of the Michigan Compiled Laws. Notice of the date, time, and place of a public meeting of the governing body shall be as prescribed in Act No. 267 of the Public Acts of 1976, as amended.

Sec. 2403. (1) All rates shall be made in accordance with this section and all of the following:

(a) Due consideration shall be given to past and prospective loss experience within and outside this state; to 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; to underwriting practice, judgment, and to all other relevant factors within and outside this state. For worker's compensation insurance, in determining the reasonableness of the margin for underwriting profit and contingencies, consideration shall be given to all after-tax investment profit or loss from unearned premium and loss reserves attributable to worker's compensation insurance, as well as the factors used to determine the amount of reserves. For all other kinds of insurance to which this chapter applies, all factors to which due consideration is given under this subdivision shall be treated in a manner consistent with the laws of this state that existed on December 28, 1981.

(b) 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.

(c) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that measure variations in hazards, expense provisions, or both. The rating plans may measure any differences among risks that may have a probable effect upon losses or expenses as provided for in subdivision (a).

(d) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate shall not be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist with respect to the classification, kind, or type of risks to which the rate is applicable. Except as otherwise provided in this subdivision, a rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and the continued use of the rate endangers the solvency of the insurer; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods. For commercial liability insurance a rate shall not be held to be inadequate unless the rate, after consideration of investment income and marketing programs and underwriting programs, is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or will have the effect of destroying competition among insurers, creating a monopoly, or causing a kind of insurance to be unavailable to a significant number of applicants who are in good faith entitled to procure the insurance through ordinary methods. As used in this subdivision, "commercial liability insurance" means insurance that provides indemnification for commercial, industrial, professional, or business liabilities. For worker's compensation insurance provided by an insurer that is controlled by a nonprofit health care corporation

formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, a rate shall not be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided. 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 losses, 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 when applicable; 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. A rate is not unfairly discriminatory because the rate reflects differences in expenses for individuals or risks with similar anticipated losses, or because the rate reflects differences in losses for individuals or risks with similar expenses. Rates are not unfairly discriminatory if they are averaged broadly among persons insured on a group, franchise, blanket policy, or similar basis.

(2) Except to the extent necessary to meet the provisions of subsection (1)(d), uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

Sec. 2406. (1) Except for worker's compensation insurance, every insurer shall file with the commissioner every manual of classification, every manual of rules and rates, every rating plan, and every modification of any of the foregoing that it proposes to use. Every such filing shall state the proposed effective date thereof and shall indicate the character and extent of the coverage contemplated. If a filing is not accompanied by the information upon which the insurer supports the filing, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, the commissioner shall within 10 days of the filing give written notice to the insurer to furnish the information upon which it supports the filing. The information furnished in support of a filing may include the experience or judgment of the insurer or rating organization making the filing, its interpretation of any statistical data it relies upon, the experience of other insurers or rating organizations, or any other relevant factors. A filing and any supporting information shall be open to public inspection after the filing becomes effective.

(2) Except for worker's compensation insurance, an insurer may satisfy its obligation to make such filings by becoming a member of, or a subscriber to, a licensed rating organization that makes such filings, and by filing with the commissioner a copy of its authorization of the rating organization to make such filings on its behalf. Nothing contained in this chapter shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization.

(3) For worker's compensation insurance in this state the insurer shall file with the commissioner all rates and rating systems. Every insurer that insures worker's compensation in this state on the effective date of this subsection shall file the rates not later than the effective date of this subsection.

(4) Except as provided in subsection (3) and as otherwise provided in this subsection, the rates and rating systems for worker's compensation insurance shall be filed not later than the date the rates and rating systems are to be effective. However, if the insurer providing worker's compensation insurance is controlled by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, the rates and rating systems that it proposes to use shall be filed with the commissioner not less than 45 days before the effective date of the filing. These filings shall be considered to meet the requirements of this chapter unless and until the commissioner disapproves a filing pursuant to section 2418 or 2420.

(5) Each filing under subsections (3) and (4) shall be accompanied by a certification by the insurer that, to the best of its information and belief, the filing conforms to the requirements of this chapter.

Sec. 2409. (1) The commissioner shall hold a public hearing and shall issue a tentative report detailing the state of competition in the worker's compensation insurance market on a statewide basis and delineating specific classifications, kinds or types of insurance, if any, where competition does not exist not later than January 15, 1984 and each year thereafter. The report shall be based on relevant economic tests, including but not limited to those in subsection (3). The findings in the report shall not be based on any single measure of competition, but appropriate weight shall be given to all measures of competition. The report shall include a certification of whether or not competition exists. Any person who disagrees with the report and findings of the commissioner may request a contested hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws, not later than 60 days after issuance of the tentative report.

(2) Not later than August 1, 1984 and each year thereafter, the commissioner shall issue a final report which shall include a final certification of whether or not competition exists in the worker's compensation insurance market. The final report and certification shall be supported by substantial evidence.

(3) All of the following shall be considered by the commissioner for purposes of subsections (1) and (2):

(a) The extent to which any insurer controls all or a portion of the worker's compensation insurance market. With respect to competition on a statewide basis, an insurer shall not be considered to control the worker's compensation insurance market unless it has more than a 15% market share. In making a determination under this subdivision, the

commissioner shall use all insurers in this state, including self-insurers, group self-insurers as defined in chapter 65, and insurers writing risks under the placement facility created in chapter 23 as a base for calculating market share.

(b) Whether the total number of companies writing worker's compensation insurance in this state is sufficient to provide multiple options to employers.

(c) The disparity among worker's compensation insurance rates and classifications to the extent that such classifications result in rate differentials.

(d) The availability of worker's compensation insurance to employers in all geographic areas and all types of business.

(e) The residual market share.

(f) The overall rate level which is not excessive, inadequate, or unfairly discriminatory.

(g) Any other factors the commissioner considers relevant.

(4) The reports and certifications required under subsections (1) and (2) shall be forwarded to the governor, the clerk of the house, the secretary of the senate, all the members of the house of representatives committees on insurance and labor, and all the members of the senate committees on commerce and labor.

(5) Not later than 90 days after receipt of the final report and final certification, the legislature, by concurrent resolution, shall approve or disapprove the certification by a majority roll-call vote in each house. If the certification is approved, the commissioner shall proceed under section 2409a.

Sec. 2409a. If the commissioner certifies and the legislature resolves pursuant to section 2409 that a reasonable degree of competition does not exist with respect to the worker's compensation insurance market on a statewide basis or any geographic areas, classifications, kinds or types of risk, or that insurance is unavailable to a segment of the market who are, in good faith, entitled to obtain insurance through ordinary means, the commissioner shall create competition or availability where it does not exist. A plan for competition or availability adopted pursuant to this section shall be included in a final certification of noncompetition under section 2409. The plan shall only relate to those geographic areas, classifications, or kinds or types of risks where competition has been certified not to exist. The plan may include such methods designed to create competition or availability as the commissioner considers necessary, and may provide for the commissioner to do 1 or more of the following:

(a) Authorize, by order, joint underwriting activities in a manner specified in the commissioner's order.

(b) Modify the rate approval process in a manner to increase competition or availability while at the same time providing for reasonably timely rate approvals, including prior approval or file and use processes.

(c) Order excess profits regulation. Excess profits regulation authorized by this subdivision shall be based upon rules promulgated pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. Excess profits shall include both underwriting profits and all after-tax investment or investment profit or loss from unearned premiums and loss reserves attributable to worker's compensation insurance. The commissioner, pursuant to excess profits regulation, may establish forms for the reporting of financial data of an insurer.

(d) Establish and require worker's compensation insurance rates, by order, which insurers must use as a condition of maintaining their certificate of authority. The order setting the rates shall take effect not less than 90 days nor more than 150 days after the order is issued.

Sec. 2418. If at any time after approval of any filing either by act or order of the commissioner or by operation of law, or before approval of a filing made by a worker's compensation insurer controlled by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall, after a hearing held upon not less than 10 days' written notice, specifying the matters to be considered at the hearing, to every insurer and rating organization that made the filing, issue an order specifying in what respects the commissioner finds that the filing fails to meet the requirements of this chapter, and stating for a filing that has gone into effect when, within a reasonable period thereafter, that filing shall be considered no longer effective. Copies of the order shall be sent to every such insurer and rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Sec. 2420. (1) Any person or organization aggrieved with respect to any filing that is in effect may apply in writing to the commissioner for a hearing on the filing. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if his or her grounds are established, and that the grounds otherwise justify holding a hearing, the commissioner shall, within 30 days after receipt of the application, hold a hearing upon not less than 10 days' written notice to the applicant and to every insurer and rating organization that made the filing.

(2) If, after a hearing under subsection (1), the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order specifying in what respects he or she finds that the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing shall be considered no longer effective. Copies of the order shall be sent to the applicant and to every insurer and rating organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(3) Upon receipt of a rate or rating system filing by an insurer providing worker's compensation insurance that is controlled by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, the commissioner shall immediately notify each person of the filing who has requested in writing notice of the filing within the 2 years immediately preceding the filing. Notice to the person shall identify the location, time, and place where a copy of the filing will be open to public inspection and copying. The filing shall become effective on the filing's proposed effective date unless stayed or disapproved by the commissioner. An aggrieved person, which shall include any insurer transacting worker's compensation insurance in this state and any person acting on behalf of 1 or more such insurers, who claims a rate in the filing is inadequate is entitled to a contested case hearing pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws. The request for this hearing shall be filed with the commissioner within 30 days of the date of the filing alleged to contain inadequate rates and shall state the grounds upon which a rate contained in the filing is alleged to be inadequate. The notice of hearing shall be served upon the insurer and shall state the time and place of the hearing and the grounds upon which the rate is alleged to be inadequate. Unless mutually agreed upon by the commissioner, the insurer, and the aggrieved person, the hearing shall occur not less than 15 days or more than 30 days after notice is served. Within 10 days of receipt of the request for hearing, the commissioner shall issue an order staying the use of any rate alleged to be inadequate and with respect to which, on the basis of affidavits and pleadings submitted by the aggrieved person and the insurer, it appears likely that the aggrieved person will prevail in the hearing. The nonprevailing party shall have the right to an interlocutory appeal to circuit court of the commissioner's decision granting or denying the stay, and the court shall review de novo the commissioner's decision.

(4) An insurer or rating organization shall not use this section to obtain a hearing with the commissioner on the insurer's or rating organization's own filing.

CHAPTER 51

ORGANIZATION OF AN ACQUIRING INSURER FOR TRANSACTION OF CERTAIN TYPES OF INSURANCE

Sec. 5100. As used in this chapter:

(a) "Acquiring insurer" means a domestic stock insurer, domestic mutual insurer, or reciprocal or inter-insurance exchange organized pursuant to this chapter.

(b) "Effective date of the transfer" means the date upon which a transfer occurs.

(c) "State accident fund" means the state accident fund created pursuant to the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being sections 418.101 to 418.941 of the Michigan Compiled Laws.

(d) "Transfer" means the acquisition by an acquiring insurer of all or substantially all of the assets, and assumption by the acquiring insurer of all or substantially all of the liabilities of, the state accident fund pursuant to Act No. 317 of the Public Acts of 1969, being sections 418.101 to 418.941 of the Michigan Compiled Laws.

Sec. 5102. No person other than an acquiring insurer shall acquire all or substantially all of the assets of the state accident fund. A proposed transfer shall constitute a proposed change of control of a domestic insurer within the meaning of this act and shall be subject to all the requirements of this act governing a change of control of a domestic insurer.

Sec. 5104. (1) Subject to the requirements of this act applicable to domestic stock insurers, domestic mutual insurers, reciprocals or inter-insurance exchanges, and the further requirements of this chapter, 13 or more persons may organize a stock insurer or 20 or more persons may organize a mutual insurer for the purpose of transacting any or all of the following kinds of insurance: property, marine, inland navigation and transportation, casualty, or fidelity and surety, all as defined in chapter 6. Once organized and authorized, the acquiring insurer shall be subject to all applicable provisions of this act.

(2) If the acquiring insurer is a domestic stock insurer owned by a nonprofit health care corporation formed pursuant to the nonprofit health care corporation reform act, Act No. 350 of the Public Acts of 1980, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, then the acquiring insurer under this chapter shall only transact worker's

compensation insurance and employer's liability insurance and act as an administrative services organization for an approved self-insured worker's compensation plan.

Sec. 5106. On and after the effective date of the transfer, any acquiring insurer shall be subject to the following:

(a) The acquiring insurer shall assume, indemnify, and hold the state of Michigan and any of its subdivisions harmless from and against all existing liabilities of the state accident fund under policies of workers' compensation and employers' liability insurance issued by the state accident fund before the effective date of the transfer.

(b) The acquiring insurer shall, in a manner similar to that of the state accident fund in the year before the effective date of the transfer, provide worker's compensation insurance to insureds with premiums less than $10,000.00 adjusted annually according to the increase or decrease in the United States department of labor consumer price index as computed for each calendar year. The acquiring insurer shall not adopt or undertake any underwriting practices or procedures in connection with workers' compensation insurance that discriminate against insureds solely on the basis of the size of the premium of the insured.

(c) The acquiring insurer shall maintain investment securities, cash, and reserve funds acquired in the transfer and those generated from doing business in Michigan, on deposit or in custody within the state of Michigan.

(d) For a period of 5 years after the effective date of the transfer, the acquiring insurer shall administer the workers' disability compensation fund of the state of Michigan at the acquiring insurer's direct cost plus reasonably allocated overhead. Any agreement evidencing such arrangement shall be terminable by the state of Michigan 1 year after the effective date of the transfer upon 6 months' written notice.

(e) For a period of at least 1 year after the effective date of the transfer, the acquiring insurer shall recognize the collective bargaining representatives of employees as constituted on the effective date of the transfer.

(f) For a period of 1 year after the effective date of the transfer, the acquiring insurer shall employ, on terms and conditions determined by the acquiring insurer, and subject to the right of the acquiring insurer to terminate employment for good cause, the employees, other than those employees also employed by the department of attorney general, on the payroll of the state accident fund as of the effective date of the transfer.

(g) Within 90 days after the effective date of the transfer, the acquiring insurer shall notify each holder of a policy of insurance, the obligations of which are assumed by the acquiring insurer that the acquiring insurer is now the insurer under the policy, that the acquiring insurer is not a state agency, and that the acquiring insurer is a member of the property and casualty guaranty association created under chapter 79.

(h) The acquiring insurer shall file the applications described in section 5108.

Sec. 5108. Within 90 days after the effective date of the transfer, the acquiring insurer shall apply to the court or administrative agency in this state in which an action or proceeding is pending in which the state accident fund was a party pursuant to section 731 of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.731 of the Michigan Compiled Laws, to be substituted as a party in place of the state accident fund.

Sec. 5110. Upon probable cause the commissioner may examine and investigate into the affairs of an acquiring insurer to determine whether the insurer has been or is engaged in any practice in violation of section 5106.

Sec. 5112. (1) Upon probable cause to believe that an acquiring insurer has been or is engaged in any practice in violation of section 5106, the commissioner shall give notice, pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, to the acquiring insurer, setting forth the general nature of the complaint against it. Before the issuance of a notice of hearing, the commissioner or his or her designee shall give the acquiring insurer an opportunity to confer and discuss the possible complaint and proceedings with the commissioner or his or her representative and the matter may be disposed of summarily by the parties.

(2) If, after opportunity for a contested case hearing held pursuant to Act No. 306 of the Public Acts of 1969, the commissioner determines that the acquiring insurer has violated any provision of section 5106, the commissioner shall reduce his or her findings and conclusions to writing and shall issue and cause to be served upon the acquiring insurer a copy of the findings and conclusions and an order requiring the acquiring insurer to cease and desist from engaging in the violation. The commissioner may also order any of the following:

(a) Payment of a civil penalty of not more than $5,000.00 for each violation but not to exceed an aggregate penalty of $50,000.00, unless the acquiring insurer knew or reasonably should have known that it was in violation of section 5106, in which case the penalty shall not be more than $10,000.00 for each violation and shall not exceed an aggregate penalty of $100,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the acquiring insurer's certificate of authority if it knowingly and persistently violated section 5106.

Sec. 5114. (1) All agents licensed by the state of Michigan to sell property and casualty insurance shall be authorized to sell workers' compensation and employers' liability insurance issued by, and to place such business with, the acquiring insurer for a period of 3 years commencing on the effective date of the transfer. The acquiring insurer shall pay reasonable compensation for business placed with and services rendered in connection with that business.

(2) After the effective date of the transfer to an acquiring insurer, the acquiring insurer shall contract with any insurance agent association having at least 300 members, to serve as a general agent of the acquiring insurer. Any agent licensed by the state of Michigan to sell property and casualty insurance, under contract with the general agent, shall be authorized to sell worker's disability compensation and employer's liability insurance for the acquiring insurer. The general agent shall not require the agent to be a member of the association.

(3) Notwithstanding subsections (1) and (2), but subject to the remaining provisions of this section, the acquiring insurer may contract with any licensed agent to represent the acquiring insurer.

(4) The acquiring insurer shall not unfairly discriminate against any agent in providing assistance in marketing, payment, or settlement of claims, or any other matters related to marketing, placing business, or handling claims. A pilot or test program of a term not exceeding 6 months in duration shall not constitute unfair discrimination under this section.

(5) After the 3-year period provided by subsection (1), the acquiring insurer shall not withhold such appointment unreasonably and shall pay reasonable compensation for business placed with and services rendered in connection with that business. After the 3-year period provided by subsection (1), the acquiring insurer, subject to the provisions of this section and chapter 12, shall have the sole discretion to determine those agents who shall be appointed to represent the acquiring insurer.

(6) During the 3-year period, the agent's authority shall not be suspended, limited, or terminated by the acquiring insurer, except for 1 or more of the following reasons:

(a) Malfeasance.

(b) Breach of fiduciary duty or trust.

(c) A persistent tendency to violate the procedures outlined in the acquiring insurer's basic manuals for Michigan worker's compensation and employer's liability insurance.

Sec. 7911. (1) To implement this chapter, there shall be maintained within this state, by all insurers authorized to transact in this state insurance other than life or disability insurance, except the Michigan basic property insurance association created pursuant to section 2920, an association of those insurers to be known as the property and casualty guaranty association, hereafter referred to as the "association". Each insurer shall be a member of the association as a condition of its authority to continue to transact insurance in this state.

(2) An insurer from which insurance has been or may be procured in this state solely by virtue of sections 1901 to 1955 shall not be considered to be an insurer authorized to transact insurance in this state for the purposes of this chapter.

(3) The association shall be subject to the requirements of this chapter, chapter 81, and section 3172a, but shall not be subject to the other chapters of this act. The association shall be subject to other laws of this state to the extent that it would be subject to those laws if it were an insurer organized and operating under chapter 50, to the extent that those other laws are consistent with this chapter.

Sec. 7921. As used in this chapter:

(a) "Insolvent insurer" means an insurer for which a domiciliary receiver has been appointed by a final order in this state or in a reciprocal state, as defined in section 8103 for the liquidation of the insurer and which has been a member insurer. The date on which the order becomes final shall be the date on which the receiver is appointed for purposes of this chapter.

(b) "Member insurer" means an insurer required to be a member of the association pursuant to section 7911.

Section 2. Sections 476c and 2400a of Act No. 218 of the Public Acts of 1956, being sections 500.476c and 500.2400a of the Michigan Compiled Laws, are repealed on the date the state administrative board certifies in writing to the secretary of state that an agreement for the transfer of the state accident fund has been consummated as described in enacting section 3.

Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws.

Section 4. This amendatory act shall not take effect unless all of the following bills of the 87th Legislature are enacted into law:

(a) Senate Bill No. 48.

(b) Senate Bill No. 49.

(c) Senate Bill No. 50.

(d) Senate Bill No. 51.

(e) Senate Bill No. 52.

Secretary of the Senate.

Co-Clerk of the House of Representatives.

Approved ----------

Governor.