S.B. 360

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 2027, 2121, 2264, 2925a, and 5208a (MCL 500.2027, 500.2121, 500.2264, 500.2925a, and 500.5208a), sections 2121 and 2925a as amended by 1980 PA 461 and section 5208a as added by 1981 PA 189.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

Sec. 2027. Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance include:

(a) Refusing to insure, or refusing to continue to insure, or limiting the amount of coverage available to an individual or risk because of any of the following:

(*i*) Race, color, creed, marital status, sex, or national origin, except that marital status may be used to classify individuals or risks for the purpose of insuring family units.

(*ii*) The residence, age, ~~handicap~~ DISABILITY, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, ~~handicap~~ DISABILITY, or lawful occupation of the individual or the location of the risk and the extent of the risk or the coverage issued or to be issued, but subject to subparagraph (*iii*). This section shall not prohibit an insurer from specializing in or limiting its transactions of insurance to certain occupational groups, types, or risks as approved by the commissioner of insurance. The commissioner shall approve the specialization for an insurer licensed to do business in this state and whose articles of incorporation contained a provision on July 1, 1976, requiring that specialization.

(*iii*) For property insurance, the location of the risk, unless there is a statistically significant relationship between the location of the risk and a risk of loss due to fire within the area in which the insured property is located. As used in this subparagraph, "area" means a single zip code number under the zoning improvement plan of the United States postal service.

(b) Refusing to insure or refusing to continue to insure an individual or risk solely because the insured or applicant was previously denied insurance coverage by an insurer.

(c) Charging a different rate for the same coverage based on sex, marital status, age, residence, location of risk, ~~handicap~~

DISABILITY, or lawful occupation of the risk unless the rate differential is based on sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience in the case of new coverages. This subdivision shall not apply if the rate has previously been approved by the commissioner.

Sec. 2121. (1) If an insurer uses an inspection of a dwelling to determine whether the insured or applicant is an eligible person for home insurance, criteria for selecting dwellings for inspection shall not be based upon any of the following:

(a) Location, whether by political subdivision, census tract, zip code, neighborhood, or area which may be described as a block, set of blocks, or by street coordinates.

(b) The age of the dwelling or the age of its plumbing, heating, electrical, or structural components, or of any other components which form a part of the dwelling.

(c) The market value of a dwelling, unless the value is used as a minimum value above which all dwellings will be inspected.

(d) The amount of insurance, unless the amount is used as a minimum above which all dwellings will be inspected.

(e) Race, color, creed, marital status, sex, national origin, residence, age, ~~handicap~~ DISABILITY, or lawful occupation.

(2) If an insurer establishes an inspection program which provides for inspection of a portion of its existing business on a periodic basis, the inspection program shall not be based upon any of the criteria in subsection (1).

(3) Criteria for selecting dwellings for inspection shall be filed with the commissioner for informational purposes only. The commissioner, after a hearing held pursuant to ~~Act No. 306 of the Public Acts of 1969, as amended~~ THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328, shall disapprove the further use of inspection criteria, if the commissioner finds that the criteria are inconsistent with the provisions of this chapter.

(4) There shall be no civil liability, other than contractual liability where applicable, on the part of, and a cause of action of any nature shall not arise against, the commissioner, an insurer, an inspection bureau, or an authorized representative, agent, employee, affiliate of the commissioner, an insurer, or an inspection bureau or any licensed insurance agent, for acts or omissions related solely to the physical condition of the property in an inspection conducted for insurance purposes pursuant to this chapter.

Sec. 2264. Any contract or insurance policy hereinafter delivered in this state providing for hospital care or reimbursement for such care of the policyholders and dependents which provides for termination of dependent coverage at a specified age shall not apply to an unmarried child of the policyholder who is incapable of self-support due to mental retardation or physical ~~handicap~~ DISABILITY, and who is dependent upon such policyholder for support and maintenance, if the policyholder submits satisfactory proof of such dependent's incapacity to the

insurance carrier not later than 31 days after the attainment of the age limit by such dependent child.

Sec. 2925a. (1) Any qualified applicant for home insurance may apply to the pool for home insurance. The form of the application shall be prescribed by the commissioner.

(2) If the pool finds upon inspection that the property is qualified property for home insurance and that the person is a qualified applicant for home insurance, then the pool in its own name or in the name of a servicing facility, upon receipt of the premium, shall issue a policy of home insurance under the pool's underwriting program. Policies issued in the name of a servicing facility may be reinsured by the pool.

(3) If the pool finds that the property is not qualified property for home insurance or that the applicant is not a qualified applicant for home insurance, the applicant shall be entitled to a written statement setting forth the features of the property or conditions which prevent it from constituting qualified property or the applicant from being a qualified applicant and the measures which must be taken in order to make the property qualified property for home insurance or to make the applicant a qualified applicant for home insurance.

(4) Policies issued by the pool or a servicing facility shall have a term of 1 year.

(5) Policies issued by the pool or a servicing facility may be renewed upon property otherwise meeting the conditions of this chapter for 2 consecutive successive terms without additional inspection, if the pool waives the inspection. However, the

selection of dwellings for inspection upon renewal of policies shall not be based upon any of the following:

(a) Location, whether by political subdivision, census tract, zip code, neighborhood, or area which may be described as a block, set of blocks, or by street coordinates.

(b) The age of the dwelling or the age of its plumbing, heating, electrical, or structural components, or of any other components which form a part of the dwelling.

(c) The market value of a dwelling, unless the value is used as a minimum value above which all dwellings will be inspected.

(d) The amount of insurance, unless the amount is used as a minimum above which all dwellings will be inspected.

(e) Race, color, creed, marital status, sex, national origin, residence, age, ~~handicap~~ DISABILITY, or lawful occupation.

(6) The pool, upon receipt of an appropriate premium, may cause the issuance of binders for the applied for insurance for a period not exceeding 60 days upon property which at the time of issuance of the binders has not complied with all the applicable conditions of this chapter.

Sec. 5208a. (1) As used in this section:

(a) "Noninsured benefit plan" means a benefit plan without insurance or the noninsured portion of a benefit plan which has specific or aggregate excess loss insurance.

(b) "Process a claim" means the services performed in connection with a claim for benefits including the disbursement of benefit amounts.

(2) An insurer providing services under section 5208 in connection with a noninsured benefit plan, with respect to such services, shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to promptly, fairly, and equitably process a claim for benefits.

(g) Knowingly compel covered individuals to institute litigation to recover amounts due under a benefit plan by offering substantially less than the amounts due.

(h) For the purpose of coercing a covered individual to accept a settlement or compromise in a claim, inform the covered individual of a policy of appealing administrative hearing decisions which are in favor of covered individuals.

(i) Delay the investigation or processing of a claim by requiring a covered individual, or the provider of services to the covered individual, to submit a preliminary claim and then

requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(j) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(k) Fail to promptly process a claim where liability has become reasonably clear under 1 portion of a benefit plan in order to influence a settlement under another portion of the benefit plan.

(*l*) Refuse to enter into a service contract nor refuse to provide services under a service contract because of race, color, creed, marital status, sex, national origin, residence, age, ~~handicap~~ DISABILITY, or lawful occupation.

(3) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall not, in order to induce a person to contract or to continue to contract with the insurer for the provision of services under a service contract offered by the insurer; to induce a person to lapse, forfeit, or surrender a policy or service contract issued by the insurer; or to induce a person to secure or terminate coverage with another insurer, health care corporation, health maintenance organization, or other person, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a service contract other than as plainly expressed in the service contract.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or adjustment of the rate payable on the service contract, or an advantage in the services thereunder, except as reflected in the rate and expressly provided in the service contract. Readjustment of the rate for services provided under the service contract may be made at the end of any contract year or contract period and may be made retroactive.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a service contract, the advantages provided thereunder, or the true nature thereof.

(e) Make a misrepresentation in a comparison, whether oral or written, between service contracts of the insurer or between service contracts of the insurer and another insurer, health care corporation, health maintenance organization, or other person.

(4) When the commissioner has probable cause to believe that an insurer is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that an insurer is violating ~~,~~ or has violated subsection (3), he or she shall give written notice to the insurer, pursuant to the administrative procedures act OF 1969, ~~Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws~~ 1969 PA 306, MCL 24.201 TO 24.328, setting forth the general nature of the complaint against the insurer and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance

responsible for the matters which would be at issue in the hearing shall give the insurer an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(5) A hearing held pursuant to subsection (4) shall be held pursuant to the administrative procedures act OF 1969, 1969 PA 306, MCL 24.201 TO 24.328. If, after the hearing, the commissioner determines that the insurer is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has violated or is violating subsection (3), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the insurer a copy of the findings and an order requiring the insurer to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(6) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall process claims for benefits on a timely basis. When not paid on a timely basis,

benefits payable to a covered individual shall bear simple interest from a date 60 days after a satisfactory claim form was received by the insurer, at a rate of 12% interest per annum. The interest shall be paid by the noninsured benefit plan in addition to, and at the time of payment of, the claim.

(7) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall specify in writing the materials which constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the insurer.

(8) An insurer providing the services under section 5208 in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual what services are being provided; the fact that individuals are not insured or are only partially insured, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(9) An insurer which violates this section shall be subject to the same penalties as provided in section 2038.

(10) The sections and subsections of this act are declared to be severable and if any court of competent jurisdiction finds that any section or subsection is invalid, the remaining sections or subsections shall remain in full force and effect.