Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bill 973 (as passed by the Senate)
Senate Bill 974 (Substitute S-1 as passed by the Senate)
Senate Bill 1022 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Mike Rogers (Senate Bills 973 & 974)
Senator Michael J. Bouchard (Senate Bill 1022)
Committee: Financial Services

Date Completed: 6-5-96

RATIONALE

Under current law, almost all property-casualty rates and forms, and a number of life and disability (health) insurance rates and forms, must be filed with the Insurance Bureau before they are used. Many of these rates and forms may not be used by an insurer until they are approved or deemed approved by the Insurance Commissioner. According to the Bureau, each year it receives approximately 15,000 rate and form filings, which are reviewed by nine analysts. These filing and approval requirements apparently date back to a time when rate-making was controlled by cartels, which were formed by insurance companies to act as central rating bureaus (rate-makers). Evidently, rating bureaus filed virtually all rates on behalf of insurers based upon aggregate claims data the bureaus collected from their member companies. According to the Bureau, with relatively few rating bureaus making and filing rates on behalf of most companies, the marketplace did not operate to keep pricing competitive.

The Bureau considers this regulatory oversight outdated. Apparently, because many companies now employ actuaries who collect and analyze claims data and then develop rates for the individual insurers, rating bureaus no longer represent a threat to competitive rate-making. Further, the Bureau reports that the size of the workload in its Market Standards Division means that volume, rather than priorities, sets the division's agenda. The Bureau has suggested that its resources could be more effectively allocated, and the public would receive a higher degree of protection, if most of the statutory requirements for prior approval of forms and rates were eliminated.

CONTENT

Senate Bill 973 would amend the Insurance Code to permit the Insurance Commissioner to exempt insurers from the requirement of filing rates and rating systems for automobile and home insurance, if a reasonable degree of competition existed with respect to the specific classifications, kinds, or types of insurance exempted.

Senate Bills 974 (S-1) and 1022 (S-1) would amend the Code to delete provisions under which insurers may not issue or deliver forms until they have been filed with the Insurance Bureau and approved by the Commissioner; require prior Commissioner approval of forms developed by a rating organization; authorize the Commissioner to disapprove any form under certain circumstances; permit the Commissioner to require that insurers file for prior approval forms that had a tendency not to conform to the Code; and allow the Commissioner to request that insurers provide him or her with copies of specific forms in use. Under both bills, these amendments would apply to basic insurance contract forms, although Senate Bill 974 (S-1) would continue to require prior Commissioner approval of disability and life insurance forms.

In addition, the bills contain provisions concerning the use of rating packages by insurers. Senate Bill 974 (S-1) applies to casualty and property insurers, and Senate Bill 1022 (S-1) applies to disability insurers. The bills specify that insurers would not have to

file a rating package unless required to do so by order of the Commissioner; insurers would have to file rating packages that were prepared by a rating organization; the Commissioner could order a rating package to be filed only if a reasonable degree of competition did not exist with respect to a specific classification, kind, or type of insurance; and insurers would have to maintain complete records of their rating packages and make them available for inspection upon the Commissioner's request.

Senate Bill 973

The bill would permit the Insurance Commissioner to exempt insurers from the requirement to file rates, rating systems, manuals of classification, manuals of rules and rates, rating plans, or modifications of those items for automobile and home insurance. If the Commissioner ordered an exemption under this provision, specific sections of Chapter 24 of the Code would apply to automobile insurance, and specific sections of Chapter 26 would apply to home insurance. (These sections would be added or amended by Senate Bill 974 and pertain to rating packages.)

Before issuing an exemption, the Commissioner would have to determine that a reasonable degree of competition existed with respect to the specific classifications, kinds, or types of insurance to which the exemption applied. In making that determination, the Commissioner would have to consider all of the following:

-- The extent to which an insurer controlled the automobile or home insurance market or any portion of it.
-- Whether the total number of insurers writing automobile or home insurance in Michigan was sufficient to provide multiple options to purchasers of that insurance.
-- Whether the overall rate level was excessive, inadequate, or unfairly discriminatory.
-- The availability of automobile or home insurance to purchasers in all geographic areas of the State.
-- Any other factors the Commissioner considered relevant.

The Commissioner could rescind an exemption if he or she determined that the basis on which it was ordered no longer existed.

Senate Bill 974 (S-1)

Basic Insurance Contract Forms

Currently, a basic insurance policy form or annuity contract form may not be issued or delivered in this State until a copy of it is filed with the Insurance Bureau and approved by the Commissioner as conforming with the requirements of the Code and not inconsistent with the law. The bill would delete reference to filing and approval. Under the bill, a form could not be issued or delivered unless it conformed with the Code and was not inconsistent with law.

The Code provides that an insurer may satisfy its obligations to make form filings by becoming a member of, or a subscriber to, a rating organization that makes such filings and by filing with the Commissioner a copy of its authorization of the organization to make filings on the insurer's behalf. The bill provides, instead, that an insurer that was a member of, or a subscriber to, a rating organization would have to file a copy of its authorization with the Commissioner. No member of or subscriber to a rating organization could issue a form developed by a rating organization until a copy of the form was filed with the Insurance Bureau and approved by the Commissioner as conforming with the Code and not inconsistent with law. As currently provided, the Commissioner's failure to act within 30 days after submittal would constitute approval.

The bill would retain current provisions that every member of or subscriber to a rating organization must adhere to the form filings made on its behalf by the organization although an insurer may file a substitute form. The bill would require an insurer to file that portion of a document or form that affected or established a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to the Code.

Currently, the Commissioner may exempt from the filing requirements for as long as he or she considers proper any insurance document or form, except that portion establishing a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles, if the requirements may not practicably be applied to the document or form, or if the filing and approval are considered unnecessary for the protection of the public. The

bill would delete the exception for portions of forms or documents establishing a relationship between group disability insurance and personal protection insurance benefits.

Currently, upon written notice to an insurer, the Commissioner may disapprove, withdraw approval of, or prohibit the issuance, advertisement, or delivery of any form if it violates any provisions of the Code, 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 bill would delete these provisions. Under the bill, upon written notice to the insurer or rating organization, the Commissioner could disapprove any form used in this State if he or she found one or more of the following:

-- It was unfairly discriminatory, misleading, deceptive, or obscure, or encouraged misrepresentation, including cases in which the form: was misleading because its benefits were too restricted to achieve the purposes for which the policy was sold; contained provisions whose natural consequence was to lessen competition; was unnecessarily verbose or complex in language; or was misleading, deceptive, or obscure because of such physical aspects as format, typography, style, color, material, or organization.
-- It provided benefits or contained other provisions that endangered the insurer's solidity.
-- For a policy only, it failed to provide the exact name and the full address of the insurer. This provision would not apply to a rider or endorsement.
-- It did not conform with the Code or a rule promulgated by the Commissioner, or was otherwise inconsistent with law.

As currently provided, when written notice was given to an insurer, it would have to specify the objectionable provisions or conditions and state the reasons for the Commissioner's decision. If the form were legally in use by the insurer in this State, the notice would have to give the effective date of the Commissioner's disapproval, which could not be less than 30 days after the notice was mailed or delivered to the insurer. If the form were not legally in use, disapproval would be effective immediately.

If the Commissioner determined that certain forms could have a tendency not to conform with the Code's requirements, he or she could order that insurers file for prior approval forms for a specified classification, type, or kind of insurance. The order would have to state the reasons for the decision. If an order were in effect, the forms would have to be filed at least 30 days before the proposed effective date. The Commissioner's failure to act within 30 days after submittal would constitute approval.

In the reasonable exercise of discretion, the Commissioner could request that insurers provide him or her with copies of specific forms that were in use for new or old business. These submissions would not be considered forms filed for the Commissioner's approval.

The bill would delete a requirement that any change or addition to a policy or annuity contract form for personal, family, or household purposes be submitted for approval if the form has not been previously approved.

Under the Code, any issuance, use, or delivery by an insurer of any form without prior approval of the Commissioner or after withdrawal of approval is a separate violation subject to civil penalties. The bill would apply the penalty, instead, to any issuance, use, or delivery of any form that did not conform with the Code or was inconsistent with law. The bill specifies that a nonconforming form in use by an insurer would have to be construed in a manner not less favorable to the policyholder than that allowable under the Code. Insurers using a form filed for approval, or not filed for approval under exemptions from the filing requirements, would not be subject to penalties for use of that form if it were later determined nonconforming.

Disability and Life Insurance

The bill provides that a disability or life insurance policy could not be delivered or issued unless a copy of the form, any printed rider or endorsement form, and, if it were required and were to be made a part of the policy or contract, any written application, was filed and approved by the Commissioner as conforming with the requirements of the Code and not inconsistent with law.

Rating Packages

The bill would add language to Chapter 24, which governs casualty insurance rates, and Chapter 26, which governs property insurance, to provide for insurers' use of rating packages. "Rating package" would mean rates, rating systems, manuals of classification, manuals of rules and rates, rating plans, or modifications of those items. Insurers would not be required to file a rating package with the Commissioner unless required to do so by written order of the Commissioner. Insurers that used a rating package prepared by a licensed rating organization, however, would have to file the package with the Commissioner. These filings could be made by the insurer directly or by the organization on the insurer's behalf.

Currently, an insurer may not make or issue a contract or policy except in accordance with filings that are in effect for the insurer as provided in the Code. The bill specifies, instead, that an insurer could not make or issue a contract or policy of insurance except in accordance with a rating package that met the requirements of Chapter 24 or 26.

The Commissioner could order the filing of a rating package, or a part of a rating package, only after certifying that a reasonable degree of competition did not exist with respect to a specific classification, kind, or type of insurance. Any written order issued under these provisions would have to state the particular classification, kind, or type of insurance for which the filing was required, state the reasons for the order, and apply to all insurers writing that particular classification, kind, or type of insurance. If the Commissioner ordered the filing of a rating package, and subsequently determined that a reasonable degree of competition existed with respect to the specific classification, kind, or type of insurance covered by the order, the Commissioner could rescind the order. Current requirements of Chapters 24 and 26 concerning rate filings, and the review and effective date of filings, would apply to the filing of any rating package filed under the bill.

Regardless of whether such information was required to be filed with the Commissioner, an insurer would have to maintain complete records evidencing its rating package and any supporting information, and would have to make these records available for inspection upon written request by the Commissioner. The insurer would have to make the information available to the Commissioner at the insurer's office within 10 days after receiving the request.

Any person could request that the Commissioner inspect records or supporting information maintained by an insurer under these provisions with respect to a specific classification, type, or kind of insurance, stating the reasons for the request. In the reasonable exercise of discretion, the Commissioner could grant or deny the request. If the Commissioner inspected records or supporting information maintained by an insurer, he or she would have to make the information available to the person who requested the inspection. If a person were still aggrieved with respect to the rating package maintained by an insurer, or aggrieved with a denial of a request for an inspection, he or she could proceed under the grievance process established in the Code.

Electronic Filing

The bill provides that, if the National Association of Insurance Commissioners adopted a nationwide system of electronic reporting or filing of forms or rating packages, the Commissioner could order that insurers who used the system to make filings in any other state, also use the system to report or file forms or rating packages with the Commissioner.

Senate Bill 1022 (S-1)

Basic Insurance Forms/Disability Policies

Currently, a basic insurance policy form, annuity contract form, or group disability policy may not be issued or delivered in this State until a copy of it is filed with the Insurance Bureau and approved by the Commissioner as conforming with the requirements of the Code and not inconsistent with the law. The bill would delete reference to filing and approval. Under the bill, a form could not be issued or delivered unless it conformed with the Code and was not inconsistent with law. The bill also provides that a form or document issued in this State by an insurer that conformed with the Code and was not inconsistent with law would be approved until the Commissioner took action to disapprove or withdraw approval of the form or document.

The Code provides that an insurer may satisfy its obligations to make form filings by becoming a member of, or a subscriber to, a rating organization that makes such filings and by filing

with the Commissioner a copy of its authorization of the organization to make filings on the insurer's behalf. The bill provides, instead, that an insurer that was a member of, or a subscriber to, a rating organization would have to file a copy of its authorization with the Commissioner. No member of or subscriber to a rating organization could issue a form developed by a rating organization until a copy of the form was filed with the Insurance Bureau and approved by the Commissioner as conforming with the Act and not inconsistent with law. As currently provided, the Commissioner's failure to act within 30 days after submittal would constitute approval.

The bill would retain current provisions that every member of or subscriber to a rating organization must adhere to the form filings made on its behalf by the organization although an insurer may file a substitute form. The bill would require an insurer to file that portion of a document or form that affected or established a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to the Code.

The bill would delete a requirement that any change or addition to a policy or annuity contract form for personal, family, or household purposes be submitted for approval if the form has not been previously approved.

Under the Code, any issuance, use, or delivery by an insurer of any form without prior approval of the Commissioner or after withdrawal of approval is a separate violation subject to civil penalties. The bill would apply the penalty, instead, to any issuance, use, or delivery of any form that did not conform with the Code or was inconsistent with law. The bill specifies that a nonconforming form in use by an insurer would have to be construed in a manner not less favorable to the policyholder than that allowable under the Code. Insurers using a form filed for approval, or not filed for approval under exemptions from the filing requirements, would not be subject to penalties for use of that form if it were later determined nonconforming.

Form Disapproval/Required Filing

The bill would make the following amendments to Chapters 22, 34, 36, 40, and 44, which govern basic insurance policy forms, disability insurance policies, group and blanket disability insurance, life insurance policies, and disability life insurance.

Currently, upon written notice to an insurer, the Commissioner may disapprove, withdraw approval of, or prohibit the issuance, advertisement, or delivery of any form if it violates any provisions of the Code, 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 bill would delete these provisions.

Under the bill, upon written notice to the insurer or rating organization, the Commissioner could disapprove or withdraw approval of any form used or to be used in this State if he or she found one or more of the following:

-- It was unfairly discriminatory, misleading, deceptive, or obscure, or encouraged misrepresentation, including cases in which the form: was misleading because its benefits were too restricted to achieve the purposes for which the policy was sold; contained provisions whose natural consequence was to lessen competition; was unnecessarily verbose or complex in language; or was misleading, deceptive, or obscure because of such physical aspects as format, typography, style, color, material, or organization.
-- It provided benefits or contained other provisions that endangered the insurer's solidity.
-- For a policy only, it failed to provide the exact name and the full address of the insurer. This provision would not apply to a rider or endorsement.
-- It did not conform with the Code or a rule promulgated by the Commissioner, or was otherwise inconsistent with law.
-- For a disability insurance policy form applicable to individual or family expense coverage, either the benefits provided were unreasonable in relation to the premium charged, or the policy did not comply with other provisions of law.

As currently provided, the notice would have to specify the objectionable provisions or conditions and state the reasons for the Commissioner's decision. If the form were legally in use by the insurer in this State, the notice would have to give the effective date of the Commissioner's disapproval or withdrawal of approval, which could not be less than 30 days after the notice was mailed or delivered to the insurer. If the form were

not legally in use, disapproval or withdrawal of approval would be effective immediately.

If the Commissioner determined that certain forms could have a tendency not to conform with the Code's requirements, he or she could order that insurers file for prior approval forms for a specified classification, type, or kind of insurance. The order would have to state the reasons for the decision. If an order were in effect, the forms would have to be filed at least 30 days before the proposed effective date. The Commissioner's failure to act within 30 days after submittal would constitute approval.

In the reasonable exercise of discretion, the Commissioner could request that insurers provide him or her with copies of specific forms that were in use for new or old business (and with classifications and premium rates for individual disability policies). These submissions would not be considered forms filed for the Commissioner's approval.

The bill states that every order made by the Commissioner under these provisions would be subject to court approval as provided in the Code.

Rating Packages

The bill would add language to Chapter 34, which governs disability insurance policies, to provide for insurers' use of rating packages. "Rating package" would mean rates, rating systems, manuals of classification, manuals of rules and rates, rating plans, or modifications of those items. Insurers would not be required to file a rating package with the Commissioner unless required to do so by written order of the Commissioner. Insurers that used a rating package prepared by a licensed rating organization, however, would have to file the package with the Commissioner. These filings could be made by the insurer directly or by the organization on the insurer's behalf.

The Commissioner could order the filing of a rating package, or a part of a rating package, only after certifying that a reasonable degree of competition did not exist with respect to a specific classification, kind, or type of insurance. Any written order issued under these provisions would have to state the particular classification, kind, or type of insurance for which the filing was required, state the reasons for the order, and apply to all insurers writing that particular classification, kind, or type of insurance. If the Commissioner ordered the filing of a rating package, and subsequently determined that a reasonable degree of competition existed with respect to the specific classification, kind, or type of insurance covered by the order, the Commissioner could rescind the order.

Regardless of whether such information was required to be filed with the Commissioner, an insurer would have to maintain complete records evidencing its rating package and any supporting information, and would have to make these records available for inspection upon written request by the Commissioner. The insurer would have to make the information available to the Commissioner at the insurer's office within 10 days after receiving his or her request.

MCL 500.2106 (S.B. 973)
500.2236 et al. (S.B. 974)
500.2236 et al. (S.B. 1022)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The current filing requirements are outdated and unnecessary, and inappropriately consume Insurance Bureau resources. Since most insurers now employ actuaries who develop rates for the individual companies, rating bureaus no longer represent a threat to competitive rate-making. In fact, according to the Bureau, recent experience has shown that the "old style" rate and form regulation has deprived Michigan residents of the benefits of an even more active and competitive marketplace. By allowing insurers to respond quickly to marketplace changes and competitive pressures, these proposals would remove unnecessary impediments to competition. Furthermore, the Insurance Bureau currently must receive, review, act upon, and file an enormous amount of paperwork, which makes it impossible for Bureau staff to scrutinize the vast majority of filings. Eliminating the prior filing and approval requirements would result in a more appropriate allocation of Bureau resources, allowing staff to serve in an auditing capacity and focus on complicated issues or problem areas. This redirection of efforts would produce a cost-effective, higher level of protection for the public.

Response: Senate Bills 974 (S-1) and 1022 (S-1) contain a fundamental discrepancy concerning disability and life insurance. While Senate Bill 974 (S-1) would retain the prior filing and approval requirements for these types of insurance, the requirements would be lifted under Senate Bill 1022 (S-1).

Supporting Argument

By reducing the regulatory burden on insurers, the bills would lower the cost of doing business in this State, thus encouraging insurers to enter the Michigan market or increase their writings here. This ultimately could reduce the cost of insurance to Michigan consumers.

Opposing Argument

Without the prior approval of forms and rates by State regulators, illegal or improper actions by insurers could take advantage of or hurt people who are not knowledgeable about insurance. In addition, the Bureau's response to consumer inquiries or complaints could be delayed if the Bureau did not have policies or rating packages on site.

Legislative Analyst: S. Margules

FISCAL IMPACT

Senate Bills 973 and 974 (S-1)

The bills would change the way rates and forms are regulated for property casualty insurance. The Commissioner could exempt insurers from filing their forms and rates with the Insurance Bureau if he or she believed that there was a reasonable amount of competition. The Commissioner would no longer require that insurers file their forms and rates with the Bureau but would require insurers to keep their rates and forms on site subject to examination by the Commissioner.

This change would reduce the administrative responsibilities for the Bureau, but it is unclear as to the extent to which this would lead to administrative savings as there would be no reduction in staff. The Bureau believes that with the increased efficiency there would be some long-term administrative savings.

Senate Bill 1022 (S-1)

This bill would require group disability and personal protection insurers to maintain their own files of rates and forms as opposed to filing them with the Insurance Bureau, as currently required. This new requirement would make the insurers subject to examination by the Bureau to ensure conformity with the Insurance Code. The Insurance Bureau anticipates a reduction in administrative costs as greater efficiency would be realized through this new process. It is difficult to determine the actual amount of these savings as they would be realized over time.

Fiscal Analyst: M. Barsch

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