

Chapter 67.

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Subchapter 1.
General Provisions.
[Reserved]

Subchapter 2.
Regulation of Insurance Rates.

23-67-201. Purpose.

- (a) This chapter shall be liberally construed to achieve the purposes stated in subsection (b) of this section, which shall constitute an aid and guide to interpretation but not an independent source of power.
- (b) The purposes of this chapter are to:
 - (1) Promote the public welfare by regulating insurance rates to the end that they shall not be excessive, inadequate, or unfairly discriminatory;
 - (2) Prohibit price-fixing agreements and other anticompetitive behavior by insurers;
 - (3) Promote price competition among insurers so as to provide rates that are responsive to competitive market conditions;
 - (4) Provide regulatory controls in the absence of competition;
 - (5) Improve availability, fairness, and reliability of insurance;
 - (6) Authorize essential cooperative action among insurers in the ratemaking process and to regulate that activity to prevent practices that tend to lessen substantially competition or to create a monopoly;
 - (7) Encourage the most efficient and economic marketing practices; and
 - (8) Require the providing of price and other information to enable consumers to purchase insurance suitable for their needs and to foster competitive insurance markets.

23-67-202. Definitions.

As used in this chapter, unless the context otherwise requires:

(1)(A)(i) "Advisory organization" or "rate service organization" means any entity which either has two (2) or more member insurers or is controlled either directly or indirectly by two (2) or more insurers, licensed under § 23-67-214, and which assists insurers in ratemaking-related activities such as those enumerated in § 23-67-216.

(ii) Two (2) or more insurers having a common ownership or operating in this state under common management or control constitute a single insurer for the purpose of this definition.

(B) The term "advisory organization" shall not include a joint underwriting association prescribed by law, any actuarial or legal consultant, or any employee of an insurer;

(2) "Competitive market" means a market in which a reasonable degree of competition exists and which has not been found to be noncompetitive pursuant to § 23-67-207;

(3) "Commercial risk" means any kind of risk which is not a personal risk, as defined in subdivision (7) of this section;

(4) "Loss development" means the adjustment of losses as of some particular date to an ultimate settlement basis based on past maturity patterns;

(5) "Loss trending" means any procedure for projecting developed losses for the cost-level adjustment to the average date of loss for the period during which the policies are to be effective;

(6) "Noncompetitive market" means a market in which a reasonable degree of competition does not exist pursuant to the provisions of this chapter;

(7) "Personal risks" means homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs;

(8) "Pool" means a voluntary arrangement, established on an ongoing basis, pursuant to which two (2) or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate, or other pooling agreement;

(9) "Pure premium" means that part of the premium which is sufficient to pay losses and loss adjustment expenses only;

(10) "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded to applicants who are unable to obtain insurance through ordinary methods;

(11) "Rates" or "supplementary rate information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, and any other similar information needed to determine the applicable rate in effect or to be in effect; and

(12) "Supporting information" means:

(A) The experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer;

(B) The interpretation of any statistical data relied upon by the filer;

(C) Descriptions of methods used in making the rates; and

(D) Other information required by the Insurance Commissioner to be filed.

23-67-203. Scope.

This chapter applies to all kinds of insurance written on risks in this state by any insurers authorized to do business in this state, except:

- (1) Life insurance;
- (2) Annuities;
- (3) Disability, including accident and health, insurance;
- (4) Ocean marine insurance;
- (5) Reinsurance;
- (6) Aircraft insurance;
- (7) Title insurance;
- (8) Workers' compensation and employers' liability insurance, except that the following provisions shall apply to these lines: §§ 23-66-206; 23-67-202(1), (4)-(6), and (9)-(12); 23-67-204; 23-67-205; 23-67-208; 23-67-214; 23-67-215(a) and (c); 23-67-216; 23-67-218; 23-67-219; and the Publisher's Note to Title 23, Chapter 67;
- (9) Motor vehicle service contracts, for so long as the motor vehicle service contract providers' exposures to their customers are fully insured by an insurer that is authorized to transact property and casualty insurance business in this state; or
- (10) Surplus lines insurance.

23-67-204. Payment of dividends.

Nothing in this chapter shall be construed to prohibit the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

23-67-205. Penalties.

- (a) Whenever the Insurance Commissioner shall have reason to believe that any person has violated any provision of this chapter, he or she shall issue and serve upon the person a statement of the alleged violations and a notice of hearing as provided by § 23-67-221 [repealed].
- (b) If, after a hearing, the commissioner determines that the person has violated a provision of this chapter, the commissioner shall issue a written order which, in his or her discretion, may do one (1) or more of the following:
 - (1) Revoke the certificate of authority of the insurer or the license of the advisory organization;
 - (2) Suspend the certificate of authority of the insurer or the license of the advisory organization; or
 - (3) Require the payment of a monetary penalty of not more than one thousand dollars (\$1,000) for each violation or a penalty of not more than ten thousand dollars (\$10,000) for each violation if the commissioner has found willful violations.

23-67-206. Exemptions.

- (a) In a competitive market, property and casualty insurance for commercial risks, excluding workers' compensation, employers' liability, and professional liability

insurance, including, but not limited to, medical malpractice insurance, are exempted from the rate filing and review provisions set forth in this chapter.

(b) Risks or portions thereof which are not rated according to manuals, rating plans, or schedules including "a" rates, risks rated under the "referral to company" or "individual risk situations" rules, are exempted from the rate filing and review provisions set forth in this chapter. Insurers must maintain complete files on how they determined the rate for such risks and make these files available to the Insurance Commissioner upon request.

(c) The commissioner, upon his or her own initiative or upon request of any person, by order, may exempt any market, segment, or line from any or all of the provisions of this chapter if and to the extent that he or she finds the exemption necessary to achieve the purposes of this chapter.

23-67-207. Noncompetitive market.

(a) If the Insurance Commissioner has cause to believe that a reasonable degree of competition does not exist in a market, the commissioner shall hold a hearing. In determining whether a reasonable degree of competition exists, insurers operating within that market shall have the burden of establishing that a reasonable degree of competition exists within that market.

(b)(1) The commissioner shall consider relevant tests of competition pertaining to market structure, market performance, and market conduct, and the practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers.

(2) These tests may include, but are not limited to, the following:

(A) Size and number of insurers actively engaged in the market;

(B) Market shares and changes in market shares of insurers;

(C) Ease of entry into and exit from a given market;

(D) Underwriting restrictions; and

(E) Whether long-term profitability for insurers generally in the market is unreasonably high.

(c) After the hearing, the commissioner shall issue an order as to his or her findings. This order shall expire no later than one (1) year after it is effective as provided in the order.

23-67-208. Rate standards.

(a) Rates shall not be excessive, inadequate, or unfairly discriminatory.

(b) A rate in a competitive market is assumed not to be excessive. A rate is excessive in a competitive or noncompetitive market if it is likely to produce a profit from Arkansas business that is unreasonably high in relation to past and prospective loss experience for that class of business which the filing affects or if expenses are unreasonably high in relation to services rendered.

(c) A rate is clearly inadequate if, together with the investment income attributable to it, it fails to satisfy projected losses and expenses in the class of business to which it applies.

(d)(1) A rate is not unfairly discriminatory in relation to another in the same class of business if it reflects equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like

loss exposures but different expense factors, or with like expense factors but different loss exposures, if the rates reflect the differences with reasonable accuracy.

(2) A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among the risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

23-67-209. Rating criteria.

(a) Due consideration must be given to past and prospective loss and expense experience within and outside this state, to catastrophe hazards and contingencies, to events or trends within and outside this state, to loadings for leveling rates over a period of time, to dividends or savings to be allowed or returned by insurers to their policyholders, members, or subscribers, and to all other relevant factors. All submissions for rate changes or supplementary rate changes must include this information with Arkansas experience shown as well as companywide experience for the past five (5) years for the class of business which this filing affects. The determination of the weighting of credibility assigned to Arkansas must be fully explained. If, within a particular class, the data is not sufficiently credible for Arkansas or companywide, and common classes are grouped together for rate-making purposes, all class codes utilized in developing credibility shall be shown as an exhibit in the filing, with Arkansas experience for each class affected shown separately. If significant trends within the state are utilized, a narrative describing the basis of the trend must be included.

(b) Risks may be classified in any reasonable way for the establishment of rates, except that no risks may be grouped by classifications based in whole or in part on race, color, creed, or national origin of the risk.

(c) The expense provisions included in the rates to be used by any insurer shall reflect the operating methods of the insurer and its actual and anticipated expense experience.

(d) The rates may contain provisions for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration must be given to all investment income attributable to premiums and to the reserves associated with those premiums and to loss reserve funds.

23-67-210. Rating plans.

(a) Rates may be modified to produce premiums for individual risks in accordance with filed rating plans which establish standards for measuring variations in hazards or expense provisions. Those standards may measure differences among risks that can be demonstrated to have a probable effect upon losses or expenses. The modification shall apply to all risks under the same or substantially the same circumstances or conditions.

(b) This provision does not apply to filed modification plans which may be offered to an insured including, but not limited to, retrospective rating plans and composite rating plans.

23-67-211. Filing of rates and other rating information.

(a)(1) Filings as to Competitive Markets. In a competitive market, every insurer shall file with the Insurance Commissioner all rates, supplementary rate information, and supporting information for risks which are to be written in this state. The rates and information shall be filed twenty (20) days prior to the effective date. A filing shall be deemed to meet the requirements of this chapter and to become effective upon the expiration of the waiting period.

(2) In a competitive market, if the commissioner determines after a hearing or by agreement that an insurer's rates require closer supervision because of the insurer's financial condition or its rating practices, the insurer shall file with the commissioner at least sixty (60) days prior to the effective date all rates and supplementary rate information and supporting information prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date. A filing shall be deemed to meet the requirements of this chapter and to become effective upon the expiration of the waiting period.

(b) Filings as to Noncompetitive Markets. In a noncompetitive market, every insurer shall file with the commissioner all rates for that market. These rates, supplementary rate information, and supporting information required by the commissioner shall be filed at least sixty (60) days prior to the effective date. Upon application by the filer, the commissioner may authorize an earlier effective date. A filing shall be deemed to meet the requirements of this chapter and to become effective upon the expiration of the waiting period unless disapproved by the commissioner.

(c) Adherence to Filings. Insurers must adhere to filings made pursuant to this section until the filings are amended or withdrawn.

23-67-212. Procedural requirements.

(a)(1) Rates filed pursuant to this section shall be filed in such form and manner as prescribed by the Insurance Commissioner.

(2) An insurer may satisfy its obligation to file supplementary rate information or supporting information by filing a reference to a filing made by an advisory organization, with or without deviation.

(b) Each filing and supporting nonproprietary information filed under this chapter shall, as soon as filed, be open to public inspection. Notwithstanding the provisions of the Freedom of Information Act of 1967, § 25-19-101 et seq., information which is a trade secret or of a proprietary nature, or both, shall not be open to public inspection.

23-67-213. Disapproval of rates.

(a) Basis of Disapproval.

(1) The Insurance Commissioner may disapprove a rate without a hearing if the insurer fails to file the information required pursuant to this chapter.

(2) The commissioner may disapprove a rate without a hearing if he or she finds that the rate is excessive, inadequate, or unfairly discriminatory under § 23-67-208(b), (c), or (d).

(b) Disapproval Procedures.

(1) If the commissioner disapproves a rate without a hearing, he or she shall send a notice to the insurer or rating organization stating wherein the filing is deficient in terms

of the criteria in § 23-67-209. An insurer or rating organization aggrieved by any order or decision of the commissioner made without a hearing, within thirty (30) days after notice to the insurer or organization, may make written request to the commissioner for a hearing thereon. The commissioner shall hear the party or parties within twenty (20) days after receipt of the request and shall give not less than ten (10) days' written notice of the time and place of the hearing. The hearing shall be concluded within fifteen (15) days from its commencement, except that the commissioner, for good cause shown and with notice to the interested parties, may grant additional time, not to exceed thirty (30) days. Within fifteen (15) days after the hearing, the commissioner shall affirm, reverse, or modify his or her previous action, specifying his or her reasons therefor. Pending the hearing and decision thereon, the commissioner may suspend or postpone the effective date of his or her previous action.

(2) For rates in effect pursuant to §§ 23-67-211 and 23-67-212, if the commissioner finds after a hearing that a rate is not in compliance with §§ 23-67-208 - 23-67-210, the commissioner shall issue an order specifying in what respects it so fails and stating when, within a reasonable period thereafter, the rates shall be deemed no longer effective.

(c) Consent to Excessive Rate. Upon written consent of the insured stating his or her reasons therefor, a rate in excess of that provided by an otherwise applicable filing may be used on a specific risk. The "consent-to-rate" shall be on a form signed by the insured that includes a statement that the insured consents to a rate in excess of the filed rate. This form shall remain on file with the producing agent or broker.

23-67-214. Licensing of advisory organizations.

(a) No advisory organization shall provide any service relating to the rates of any insurance subject to this chapter, and no insurer shall utilize the services of the organization for those purposes unless the organization has obtained a license from the Insurance Commissioner.

(b) No advisory organization shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

(c)(1) An advisory organization applying for a license shall include with its application:

(A) A copy of its constitution, charter, or articles of organization, agreement, association, or incorporation and a copy of its bylaws, plan of operation, and any other rules or regulations governing the conduct of its business;

(B) A list of its members and subscribers;

(C) The name and address of one (1) or more residents of this state upon whom notices, process affecting it, or orders of the commissioner may be served;

(D) A statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(E) License fees as provided by § 23-61-401; and

(F) Any other relevant information and documents that the commissioner may require.

(2) Every organization which has applied for a license shall notify the commissioner of every material change in facts or in the documents on which its application was based.

Any amendment to a document filed under this section shall be filed at least thirty (30) days before it becomes effective.

(3) If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed and that all requirements of the law are met, the commissioner shall issue a license specifying the authorized activity of the applicant. The commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to lessen substantially the competition in any market.

(4) Licenses issued pursuant to this section shall remain in effect until the licensee withdraws from the state or until the license is suspended or revoked, subject, however, to continuance of the license by the advisory organization each calendar year by:

(A) Payment on or before January 1 of a continuation fee as provided in § 23-61-401;

(B) Due filing of a letter requesting continuation of its license for the following calendar year; and

(C) Submission of information which may be required by the commissioner.

23-67-215. Insurers and advisory organizations - Prohibited activities.

(a) Monopolies. No insurer or advisory organization shall attempt to monopolize or to combine or conspire with any other person to monopolize an insurance market or make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of unreasonably restraining trade or of substantially lessening competition in the business of insurance.

(b) Advisory Organizations: Prohibited Activity. In addition to the other prohibitions contained in this chapter, no advisory organization shall, except as specifically permitted under §§ 23-67-204, 23-67-211, 23-67-212, and 23-67-216:

(1) Compile or distribute recommendations relating to rates that include expenses, other than loss adjustment expenses, or profit except in lines designated by the Insurance Commissioner; or

(2) File any manual or plan of rates, policy fees, or supporting information on behalf of an insurer.

(c) An advisory organization may not have or adopt any rule, or exact any agreement, or formulate or engage in any program which would require any member, subscriber, or other insurer to:

(1) Interfere with the right of any insurer to develop its rates independent of that advisory organization;

(2) Utilize some or all of its services;

(3) Adhere to its rates, rating plan, rating systems, underwriting rules, or policy forms; or

(4) Prevent any insurer from acting independently.

23-67-216. Advisory organizations - Permitted activities.

Any advisory organization, in addition to other activities permitted, is authorized to:

(1) Develop statistical plans, including territorial and class definitions;

(2) Collect statistical data from members, subscribers, or any other source;

(3) Prepare and distribute pure premium data, adjusted for loss development and loss trending, in accordance with its statistical plans;

- (4) Prepare, distribute, and file rates and supplementary rate information except as prohibited by § 23-67-215(b). Those filings made by advisory organizations shall be for advisory purposes only and shall not be made on behalf of any insurer;
- (5) Distribute information that is filed with the Insurance Commissioner and open to public inspection;
- (6) Conduct research and on-site inspections in order to prepare classifications of public fire defenses;
- (7) Consult with public officials regarding public fire protection as it would affect members, subscribers, and others;
- (8) Conduct research and collect statistics in order to discover, identify, and classify information relating to cause or prevention of losses;
- (9) Prepare and file policy forms and endorsements and consult with members, subscribers, and others relative to their use and application;
- (10) Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;
- (11) Collect, compile, and distribute past and current prices of individual insurers if that information is made available to the general public;
- (12) File rates, supplementary rate information, and supporting information for residual market mechanisms; and
- (13) Furnish any other services not prohibited by this chapter.

23-67-217. Advisory organizations - Filings.

Every advisory organization shall file with the Insurance Commissioner every advisory document pursuant to § 23-67-216 thirty (30) days prior to the effective date. The commissioner may extend the review period an additional thirty (30) days by written notice to the filer before the thirty-day period expires.

23-67-218. Records and reports.

- (a) The Insurance Commissioner may adopt reasonable rules for use by companies to record and report to the commissioner rates and other information determined by the commissioner to be necessary or appropriate for the administration of this chapter and for the effectuation of its purposes.
- (b) The commissioner may designate one (1) or more advisory organizations to assist him or her in gathering, compiling, and reporting the information. No insurer shall be required to record or report its experience on a classification basis inconsistent with its own rating system.

23-67-219. Workers' compensation and employers' liability insurance.

With regard to workers' compensation and employers' liability insurance incidental thereto and written in connection therewith, the following provisions shall apply:

- (1)(A) Every insurer shall file with the Insurance Commissioner every manual of classifications, rules and rates, every rating plan, and every modification of any of the

foregoing which it proposes to use for workers' compensation and employers' liability insurance;

(B) Every insurer shall file with the commissioner every manual, minimum, class rate, rating schedule or rating plan, every other rating rule, and every modification of any of the foregoing which it proposes to use for workers' compensation and employers' liability insurance;

(C)(i) Every filing must be submitted for approval to the commissioner at least thirty (30) days prior to the proposed effective date.

(ii) Upon written request of the filer, the commissioner may authorize an earlier effective date.

(iii) If the commissioner does not have sufficient information to determine whether the filing meets the requirements of this section, the commissioner shall require the filer to furnish the information upon which it supports the filing. In this event, the proposed effective date shall not be less than thirty (30) days after the date the information is furnished.

(iv) As soon as submitted, each filing shall be open to public inspection, except information which is a trade secret or of a proprietary nature, or both. Notwithstanding the provisions of the Freedom of Information Act of 1967, § 25-19-101 et seq., information which is a trade secret or of a proprietary nature, or both, shall not be open to public inspection.

(v) The commissioner may require that the rate filing be submitted to an independent consulting actuary of his or her choice for review. The full expense of the consulting actuarial review shall be borne by the filing insurer or rate service organization;

(D) An insurer may satisfy its obligation to file by filing by reference to the rates and supplementary information, with or without deviation, filed by a licensed rate service organization with which the insurer is a member or subscriber. However, nothing contained in this section shall be construed as requiring any insurer to become a member of or subscriber to any rate service organization. Filings made by licensed rate service organizations shall be for advisory purposes only and shall not be made on behalf of any insurer. Reference filings made in this manner can only be changed by subsequent filings by the insurer;

(E) Upon the written application of the insured, stating his or her reasons therefor, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk;

(F)(i) Any person or organization aggrieved with respect to any filing which is in effect may make written application to the commissioner for a hearing thereon, provided that the insurer or rate service organization that made the filing shall not be authorized to proceed under this subdivision (1)(F).

(ii) The application shall specify the grounds to be relied upon by the applicant.

(iii) If the commissioner finds that the application is made in good faith, that the applicant will suffer a legally cognizable injury if the grounds are established, and that the grounds otherwise justify holding a hearing, the commissioner shall, within thirty (30) days after receipt of the application, hold a hearing upon not less than ten (10) days' written notice to the applicant and to every insurer and rate service organization which made the filing;

(G) If, after the hearing, the commissioner finds that the filing does not meet the requirements of this section, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. Copies of the order shall be sent to all parties to the hearing. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order;

(H) A manual, minimum, class rate, rating schedule, rating plan, rating rule, rating system, plan of operation, or any modification of any of the foregoing shall be disapproved if the rates thereby produced are excessive, inadequate, or unfairly discriminatory;

(2)(A)(i) Every member of or subscriber to a rate service organization shall adhere to the filings by the organization to which it has filed by reference, except that the insurer may make written application to the commissioner to file a deviation from the class rates, schedules, rating plans, or rules thereof.

(ii) This application shall specify the basis for the modification, and a copy shall also be sent simultaneously to the rate service organization.

(iii) In considering the application to file a deviation, the commissioner shall give consideration to the available statistics and the principles for ratemaking as provided in § 23-67-207 and subdivision (1)(H) of this section.

(iv) The commissioner shall approve the deviation for the insurer if he or she finds it to be justified, and it shall thereupon become effective.

(v) The commissioner shall disapprove the application if he finds that the deviation applied for does not meet the requirements of this chapter.

(B)(i) In order to preserve a uniform data base, the commissioner may designate one (1) or more rate service organizations to assist him or her in gathering, compiling, and reporting information.

(ii) Insurers shall record their workers' compensation and employers' liability experience on a classification basis consistent with that of a rate service organization designated by the commissioner and shall report the experience to the designated rate service organization;

(3)(A) Every rate service organization and every insurer which makes its own rates for workers' compensation and employers' insurance, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, shall furnish to any insured affected by a rate made by it, or to the authorized representative of the insured, all pertinent information as to the rate.

(B)(i) Every rate service organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by his or her authorized representative, on his written request to review the manner in which the rating system has been applied in connection with the insurance afforded him or her.

(ii) If the rate service organization or insurer fails to grant or rejects the request within thirty (30) days after it is made, the applicant may proceed in the same manner as if his or her application had been rejected.

(iii) Any party affected by the action of the rate service organization or the insurer on the request may, within thirty (30) days after written notice of the action, appeal to the commissioner.

(iv) The commissioner shall be furnished a written transcript of the proceedings before the rate service organization or the insurer, including a written memorandum of decision. The commissioner shall, within thirty (30) days after submission of the transcript and memorandum of decision, render his or her decision on the appeal, which decision shall be based on the transcript and memorandum of decision submitted. The commissioner shall promptly notify the appellant and the rate service organization or insurer in writing of his decision on the appeal.

23-67-220. Examinations.

- (a) The Insurance Commissioner may examine any insurer, pool, advisory organization, or residual market mechanism as he or she deems necessary to ascertain compliance with this chapter.
- (b) Every insurer, pool, advisory organization, and residual market mechanism shall maintain reasonable records of the type and kind reasonably adapted to its method of operation containing its experience or the experience of its members including the data, statistics, or information collected or used in its activities. These records shall be available at all reasonable times to enable the commissioner to determine whether the activities of any advisory organization, insurer, or association comply with the provisions of this chapter. The records shall be maintained in an office within this state or shall be made available to the commissioner for examination or inspection at any time upon reasonable notice.
- (c) The reasonable cost of an examination made pursuant to this section shall be paid by the examined party upon presentation of a detailed account of the costs.
- (d) In lieu of any examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state pursuant to the laws of that state.

23-67-221. [Repealed.]

23-67-222. Administrative procedures.

- (a) Administrative procedures exercised by the Insurance Commissioner under this chapter shall be in accordance with §§ 23-61-303 - 23-61-306.
- (b) Appeals from orders of the commissioner made under this chapter shall be made in accordance with § 23-61-307.

Subchapter 3.

Arkansas Workers' Compensation Insurance Plan.

23-67-301. Title.

This subchapter shall be known and cited as the "Arkansas Workers' Compensation Insurance Plan".

23-67-302. Purpose.

The purpose of this subchapter is to amend title 23 of this Code to provide for the establishment of a mandatory workers' compensation insurance plan to assure coverage for employers who are in good faith entitled, but unable to procure, workers' compensation insurance in this state, and to provide that the operation and regulation of the Arkansas Workers' Compensation Insurance Plan shall be the responsibility of the Insurance Commissioner.

23-67-303. Establishment, operation, and regulation.

The Insurance Commissioner shall be responsible for the establishment, operation, and regulation of the Arkansas Workers' Compensation Insurance Plan pursuant to the provisions of this subchapter.

23-67-304. Plan for coverage.

(a) The Arkansas Workers' Compensation Insurance Plan shall give consideration to:

- (1) The need for adequate and readily accessible coverage;
- (2) Optional methods of improving the market affected;
- (3) The need for reasonable underwriting standards;
- (4) The need for adequate supervisory and servicing procedures to ensure proper operation of the plan;
- (5) The need to establish procedures that will have minimum interference with the voluntary market;
- (6) Distributing the obligations imposed by the plan and any profits or losses experienced by the plan equitably and efficiently among the participating insurers; and
- (7) Establishing procedures for applicants and participants to have their grievances reviewed and resolved.

(b)(1) The plan shall provide for the issuance of a policy covering the entire liability of the employer as to the business for which workers' compensation insurance has been rejected.

(2) Nothing in this subsection shall modify or repeal the provisions of § 23-92-409.

(c) The rates and supplementary rate information of the plan shall meet the standards specified in § 23-67-208.

(d) The plan may obtain reinsurance for any part or all of its risks.

(e)(1)(A) At his or her discretion, the Insurance Commissioner is authorized to delegate all or any part of the commissioner's responsibility to establish and operate the plan.

(B) However, any such plan, or plan of operation, and any amendments thereto must receive the prior approval of the commissioner.

(2) Any person or entity to whom the establishment, implementation, or operation of the plan is delegated pursuant to this subsection shall file with and obtain the approval of the commissioner as to all policy forms, rates, or supplementary rate information necessary to effectuate the plan.

(3)(A) In delegating all or part of the commissioner's responsibility, the commissioner shall not approve any plan or filing that abrogates or restricts his or her authority to select the plan administrator or servicing carriers.

(B) The commissioner shall competitively select the organization or organizations to whom the responsibility of plan administrator shall be delegated.

(C) If the administration of the plan is delegated, the plan administrator or administrators shall have an office in Arkansas adequately staffed, outfitted, and maintained to provide the plan services delegated.

(D) The commissioner shall specify duties and functions of plan administrators and may structure and delegate administrative functions separately such as, but not limited to, rates, forms, and statistics for the best operation of the plan.

(4) Under the provisions of this subsection, the commissioner shall vigorously promote competition for the designation of the plan administrator and servicing carrier for the most effective operation of the plan.

(5)(A) The office in Arkansas is established to improve services provided by the plan, to promote and secure courteous and timely service, and to assure that the minimum standards as provided under subdivision (f)(2) of this section are met.

(B) The office in Arkansas shall also assist employers or agents with questions, problems, or complaints pertaining to the servicing carriers and secure and expedite prompt and fair treatment to employers for servicing carrier errors and service failures.

(6)(A) The Arkansas office manager shall have the authority to intervene with servicing carriers to secure an adequate level of service and prevent servicing carriers from imposing unreasonable demands or actions.

(B) The office manager shall keep a record of all employer or agent problems and complaints by a servicing carrier, including a description of the problem. This record shall be provided to the commissioner within sixty (60) days of each calendar year or upon the request of the commissioner.

(C) The manager shall promptly notify the commissioner of any problems upon a request by an employer.

(f)(1)(A) In order to promote competition and improve servicing carrier performance, the commissioner shall competitively select those servicing carriers who shall serve the plan.

(B) Any insurer licensed to transact workers' compensation and employers' liability insurance in Arkansas may apply for selection as a servicing carrier, but if an adequate number of qualified insurers do not apply, the commissioner may appoint any such insurer, as needed, to serve as a servicing carrier.

(2) All servicing carriers shall be subject to the following minimum standards:

(A) Each insurer shall continually employ such number of qualified administrative personnel and dedicate such equipment and facilities to the administration of the plan as the commissioner, in his or her reasonable discretion, deems adequate to service the needs of the plan; and

(B) Each such insurer shall comply with the following specific service or performance standards and such further standards as the commissioner may by rule and regulation provide:

(i) Provide a level of service comparable to that provided to employer-insureds in its voluntary workers' compensation line of business and assure the same by putting into effect internal administrative procedures, which shall assure that such is the case;

- (ii) Maintain with the commissioner a list of responsible management personnel of the insurer qualified to make administrative decisions on the insurer's behalf concerning policies issued within the plan;
- (iii) Keep the commissioner continually advised of the address and telephone number of the insurer's office servicing the plan on its behalf;
- (iv) Maintain a toll-free telephone number or numbers adequate to service the plan and keep the commissioner, employers, and agents continually apprised of same;
- (v)(a) Maintain its billing and rating procedure in timely compliance with orders of the commissioner.

(b) In particular, no insurer shall ever purport to effect a retroactive rate adjustment based upon a succeeding rate filing unless the insurer has specifically included within its policies a specific notice of pending rate change.

(c) No insurer shall fail to physically implement any rate change later than sixty (60) days of the date the order effecting the change is entered;

(vi) Such other service or performance standards, including, but not limited to, matters relating to loss experience, safety and loss control success, and profitability as the commissioner shall by rule and regulation prescribe; and

(vii) Such further standards as the commissioner may by rule and regulation provide.

(g) The commissioner is vested with the power and the reasonable discretion, after notice and hearing, to impose upon any servicing carrier not meeting the standards herein prescribed or set forth by rule and regulation an administrative fine or penalty in the sum of not more than one thousand dollars (\$1,000) for each such violation of standards. The commissioner shall use this authority to discourage unreasonable or unfair actions by the servicing carriers.

(h) In considering performance of servicing carriers, the commissioner shall require the plan administrator to:

(1) File with the State Insurance Department quarterly results of the plan, including, but not limited to, premiums written and earned, losses paid, incurred losses, and administration and servicing carrier allowances; and

(2) File with the department annually the performance review and plan results of each plan servicing carrier.

(i)(1) Servicing carriers may join cooperatively with other licensed insurers or general business corporations for the purpose of satisfying their duties as servicing carriers, including, but not limited to, claim review and payment, and loss control and safety functions.

(2) The commissioner shall actively encourage additional financially sound licensed carriers or combinations of licensed carriers to join together as joint venturers with shared responsibilities for servicing functions and, also, to utilize the services of such claim, safety, and other service organizations as reasonably necessary to provide the best servicing carrier service economically possible.

(j) The commissioner shall establish within the plan an alternate preferred plan for employers who have carried workers' compensation insurance continually for at least four (4) policy years and who have had better than average loss experience and meet such additional reasonable standards as the commissioner shall by rule and regulation prescribe.

- (k)(1) The commissioner shall by rule and regulation establish a performance plan related to the aforementioned service or performance standards and others to be promulgated with incentives and penalties to improve servicing carrier performance.
- (2) The performance plan shall provide for up to thirty-three percent (33%) of the servicing carrier's remuneration to be based on performance.
- (3) The servicing carrier performance plan shall provide an annual basis for penalties on carriers performing below standard to the extent of their underperformance under the criteria as hereinafter established by rule and regulation up to thirty-three percent (33%) of their remuneration.
- (4) These penalties shall be distributed as incentives to carriers performing at or above standard up to thirty-three percent (33%) of their remuneration.
- (5)(A)(i) The commissioner shall conduct a comprehensive performance review of the plan administrator as often as the commissioner deems advisable, which shall not be less frequent than one (1) time every five (5) years to the extent necessary for the proper operation of the plan.
- (ii) The commissioner shall conduct a performance review of each servicing carrier as often as the commissioner deems advisable in order to assure adequate levels of service.
- (B) This comprehensive performance review shall be conducted independently of any other performance review conducted by an organization owned or controlled by the insurance carriers.
- (C) A report of this review and action taken to improve plan performance shall be made to the Legislative Council and the House Interim Committee on Insurance and Commerce and the Senate Interim Committee on Insurance and Commerce no later than September 1 after the calendar year reviewed.

23-67-305. Mandatory participation in the Arkansas Workers' Compensation Insurance Plan.

- (a) All insurers licensed to transact workers' compensation and employers' liability insurance in this state, as defined in § 23-62-105(a)(3) and who have qualified to transact workers' compensation insurance pursuant to § 11-9-302(a) shall participate in the equitable apportionment among them of risks eligible for the Arkansas Workers' Compensation Insurance Plan.
- (b) Participation in the plan expenses, profits, and losses shall be in the proportion that the net direct workers' compensation insurance premiums of each member written in this state during the preceding calendar year bears to the aggregate net direct workers' compensation insurance premiums of all members of the plan written in this state during the preceding calendar year.

23-67-306. Employers entitled to insurance.

- (a) Any employer required to secure the payment of compensation under the provisions of § 11-9-404(a)(1) or any similar federal law shall be entitled to insurance under the provisions of this subchapter, provided:
- (1) The employer pays his or her premium based upon the premium payment rules approved by the Insurance Commissioner;

(2) The employer has complied with all effective laws, orders, rules, or regulations made by public authorities relating to the welfare, health, and safety of employees;

(3) The employer is not in default of premium payments owed for workers' compensation insurance; provided, however, that no employer shall be deemed to be in default of a premium payment if all of the sum by which he or she is alleged to be in default is properly attributable to a good faith, bona fide dispute between the insurer and the employer over the accuracy or legality of an audit of payroll performed by or at the request of the insurer, and which dispute is in formal process of resolution as provided in § 23-67-219(3). All such disputes shall be resolved in the manner set forth in § 23-67-219(3)(B).

(b) In order to promote competition and improve servicing carrier performance, an employer applying for coverage or on renewal in the Arkansas Workers' Compensation Insurance Plan may strike six (6) servicing carriers, not to exceed a maximum of one-half (1/2) of the eligible servicing carriers, from the list of eligible servicing carriers to which the employer can be assigned.

23-67-307. Cancellation of policy.

If, after the issuance of a policy providing insurance pursuant to the provisions of this subchapter, the insurer which issued the policy finds that the employer to whom the policy was issued is not, or has ceased to be, entitled to the insurance, the insurer shall have the right to cancel the policy in accordance with § 11-9-408(b).

23-67-308. Failure of insurer to comply.

If any insurer refuses or neglects to comply with the provisions of this subchapter or with any order or ruling made by the Insurance Commissioner pursuant to this subchapter, the insurer shall be subject to the administrative penalties provided for in the Arkansas Insurance Code.

23-67-309. Appeal.

Any person aggrieved by an order or ruling made by the Insurance Commissioner under the provisions of this subchapter shall have the right to appeal the order or ruling pursuant to § 23-61-307.

23-67-310. Rules and regulations.

The Insurance Commissioner is authorized to promulgate such reasonable rules and regulations as are necessary to carry out the provisions of this subchapter.

23-67-311. Association policies.

Under such rules and regulations as shall be adopted by the Insurance Commissioner, and notwithstanding other provisions of this chapter, the commissioner is given the authority in the Arkansas Workers' Compensation Insurance Plan to allow the issuance of group or

association workers' compensation insurance policies to logging contractors or dealers as sponsors. The policies may, in turn, insure for workers' compensation and employers' liability purposes no fewer than five (5) independent contractors who provide logging services to the sponsoring contractor or dealer. Provided, however, that such association or group coverage be made available on a nondiscriminatory basis to all other industries if the commissioner rules that the coverage is reasonably applicable to that industry and economically sound with respect to the plan.

23-67-312. Alternate preferred plan.

(a) The Insurance Commissioner shall establish within the Arkansas Workers' Compensation Insurance Plan an alternate preferred plan for employers, including logging or pulpwood dealers or contractors, who have carried workers' compensation insurance coverage continuously for at least four (4) policy years and who have had better than average loss experience and meet such additional reasonable standards as the commissioner shall by rule and regulation prescribe.

(b) Such an alternate preferred plan shall address the issues of deductibles and deposit premiums and make such provisions and allowances with respect thereto which are economically sound and in the best interest of the plan and the industries affected.

23-67-313. Competitive selection.

(a) The Insurance Commissioner shall make a good faith effort to comply with the intent of the provisions requiring competitive selection of the administrator of the Arkansas Workers' Compensation Insurance Plan and servicing carriers. The administrator and servicing carriers shall be competitively selected no less often than every three (3) years. Consideration for the administrator and servicing carriers shall include cost, finances, operating and service capabilities, and the record of service and other factors deemed necessary for the effective and proper operation of the plan. The commissioner may suspend formal bidding for the administrator provided that:

(1) The commissioner has sought and compared other administrative services available;

(2) The commissioner deems there to have been in the interim a satisfactory improvement in administrator and servicing carrier performance;

(3) The commissioner judges continuation of the present administrator subject to the modifications herein set forth and to hereafter be promulgated by rule and regulation to be in the best interests of Arkansas;

(4) Coverage and service is adequately and properly provided to Arkansas employers entitled to insurance, and coverage is provided in other states for employees of Arkansas employers to the extent possible and the proper coverage is in the best interests of the employers and plan operations. Adequate coverage of employees while working on a temporary or occasional basis in other states is essential to Arkansas employers and employees; and

(5) The administrator has an office in Arkansas and the office has the staff and authority necessary to properly serve Arkansas employers and the commissioner in accordance with the provisions of this act.

(b) The commissioner shall review the plan operations to ensure compliance with this act. The commissioner shall review and report to the Legislative Council and the Senate and House Interim Committees on Insurance and Commerce by September 1 of each year, with the first report to be submitted no later than September 1, 1997, including, but not limited to, the following information:

- (1) Competitive selection of the administrator and servicing carriers;
- (2) Plan operating performance and service in accordance with the intent of this act, including performance reviews of the administrator, servicing carriers, and plan regulations;
- (3) Proper authority and independence of the Arkansas office to properly perform and secure prompt, fair, and reasonable service as required by this act; and
- (4) Coverage provided by the plan in other states, including evidence providing that carriers promptly provide coverage for employees of Arkansas employers working in other states as provided in this act.

(c) The commissioner is encouraged to hold public hearings as needed to assist in achieving the objectives of the act and to assist with the review and report provided to the Legislative Council and the Senate and House Interim Committees on Insurance and Commerce.

Subchapter 4.

Use of Credit Information in Personal Insurance.

23-67-401. Title. [Effective Jan. 1, 2004.]

This subchapter shall be known and may be cited as the "Use of Credit Information in Personal Insurance Act".

23-67-402. Purpose. [Effective Jan. 1, 2004.]

The purpose of this subchapter is to regulate the use of credit information for personal insurance so that consumers are afforded certain protections with respect to the use of the information.

23-67-403. Scope. [Effective Jan. 1, 2004.]

This subchapter applies to personal insurance and not to commercial insurance or any other type of insurance.

23-67-404. Definitions. [Effective Jan. 1, 2004.]

For the purposes of this subchapter:

- (1) "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of personal insurance;

- (2) "Affiliate" means any company that controls, is controlled by, or is under common control with another company;
- (3) "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer;
- (4) "Consumer" means an insured whose credit information is used or whose credit score is calculated in the underwriting or rating of a personal insurance policy or an applicant for the policy;
- (5) "Consumer reporting agency" means any person who for monetary fees, dues, or on a cooperative nonprofit basis regularly engages, in whole or in part, in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties;
- (6)(A) "Credit information" means any credit-related information derived from a credit report or found on a credit report itself.
- (B) Information that is not credit-related shall not be considered "credit information" regardless of whether it is contained in a credit report or in an application or is used to calculate a credit score;
- (7)(A) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity that is used or expected to be used or collected, in whole or in part, for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.
- (B) Loss history reports and driving history reports are not considered to be credit reports;
- (8) "Credit score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based solely on credit information for the purpose of predicting the future insurance loss exposure of an individual applicant or insured; and
- (9) "Personal insurance" means private passenger automobile, homeowners, motorcycle, mobile home owners, noncommercial dwelling fire insurance, noncommercial farm owners, boat, personal watercraft, snowmobile, and recreational vehicle policies.

23-67-405. Use of credit information. [Effective Jan. 1, 2004.]

An insurer authorized to do business in Arkansas that uses credit information to underwrite or rate risks shall not:

- (1) Use a credit score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor;
- (2) Deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by subdivision (1) of this section;
- (3) Base an insured's renewal rates for personal insurance solely upon credit information without consideration of any other applicable factor independent of credit information;
- (4) Take an adverse action against a consumer solely because he or she does not have a credit card account without consideration of any other applicable factor independent of credit information;

- (5) Consider an absence of credit information or an inability to calculate a credit score in underwriting or rating personal insurance unless the insurer does one of the following:
- (A) Treats the consumer as otherwise approved by the Insurance Commissioner if the insurer presents information that such an absence or inability relates to the risk for the insurer;
 - (B) Treats the consumer as if the applicant or insured had neutral credit information as defined by the insurer; or
 - (C) Excludes the use of credit information as a factor and uses only other underwriting criteria;
- (6) Take an adverse action against a consumer based on credit information unless an insurer obtains and uses a credit report issued or a credit score calculated within ninety (90) days prior to the date the policy is first written or renewal is issued;
- (7) Use credit information unless not later than thirty-six (36) months following the last time that the insurer obtained current credit information for the insured the insurer recalculates the credit score or obtains an updated credit report. Regardless of the requirements of this subdivision (7):
- (A)(i) Upon the written request of a consumer, the insurer shall reunderwrite and re-rate the policy based upon a current credit report or credit score.
 - (ii) An insurer need not recalculate the credit score or obtain the updated credit report of a consumer or reunderwrite or re-rate a policy more frequently than one (1) time in a twelve-month period;
 - (B) The insurer shall have the discretion to obtain current credit information prior to any renewal before the end of the thirty-six (36) months;
 - (C) No insurer need obtain current credit information for an insured despite the requirements of subdivision (7)(A) of this section if one of the following applies:
 - (i) The insurer is treating the consumer as otherwise approved by the commissioner;
 - (ii)(a) The insured is in the most favorably priced rating tier of the insurer within a group of affiliated insurers.
 - (b) However, the insurer shall have the discretion to order an updated credit report;
 - (iii)(a) Credit was not used for underwriting or rating the insured when the policy was initially written.
 - (b) However, the insurer shall have the discretion to use credit information for underwriting or rating the insured upon renewal;
 - (iv) The insurer reevaluates the insured beginning no later than thirty-six (36) months after inception and thereafter based upon other underwriting or rating factors excluding credit information; or
 - (v) If credit scoring is not used at renewal; or
- (8) Use the following as a negative factor in any credit-scoring methodology for the purpose of underwriting or rating a policy of personal insurance:
- (A) Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information;
 - (B) Inquiries relating to insurance coverage if so identified on a consumer's credit report;
 - (C) Medical collection accounts;
 - (D) Multiple-lender inquiries if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty (30) days of one another unless only one (1) inquiry is considered; or

(E) Multiple-lender inquiries if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within thirty (30) days of one another unless only one (1) inquiry is considered.

23-67-406. Dispute resolution and error correction. [Effective Jan. 1, 2004.]

(a) If it is determined through the dispute resolution process set forth in § 1681i(a)(5) of the federal Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., that the credit information of a current insured was incorrect or incomplete and if the insurer receives written notice of the determination from either the consumer reporting agency or from the insured, the insurer shall reunderwrite and rerate the consumer within thirty (30) calendar days of receiving the notice.

(b) After reunderwriting or rerating the insured, the insurer shall make any necessary adjustments consistent with its underwriting and rating guidelines.

(c) If an insurer determines that the insured has overpaid a premium, the insurer shall refund to the insured the amount of overpayment.

23-67-407. Initial notification. [Effective Jan. 1, 2004.]

(a)(1) If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose either on the insurance application or at the time the insurance application is taken that it may obtain credit information in connection with the application.

(2) The disclosure shall be either written or provided to an applicant in the same medium as the application for insurance.

(3) The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy if the insured has previously been provided a disclosure statement.

(b) Use of the following example disclosure statement constitutes compliance with this section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based score based on the information contained in that credit report. We may use a third party in connection with the development of your credit score."

23-67-408. Adverse action notification. [Effective Jan. 1, 2004.]

If an insurer takes an adverse action based upon credit information, the insurer shall:

(1) Provide the consumer the name, address, and phone number of the person or division at the insurance company responsible for handling applicant or policyholder questions concerning credit-based underwriting decisions;

(2) Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of § 1681m(a) of the federal Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., including:

(A) The name, address, and toll-free telephone number of the credit bureau that provided the insurer with the credit-based information;

- (B) The fact that the consumer has the right to obtain a free copy of his or her credit report from the appropriate credit bureau; and
 - (C) The fact that the consumer has the right to challenge information contained in his or her credit report; and
- (3)(A) Provide notification to the consumer explaining the reasons for the adverse action.
- (B)(i) The reasons shall be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action.
 - (ii) The notification shall include a description of up to four (4) factors that were the primary influences of the adverse action.
- (C) The use of generalized terms such as "poor credit history", "poor credit rating", or "poor credit score" does not meet the explanation requirements of this section.

23-67-409. Filing. [Effective Jan. 1, 2004.]

- (a)(1) Insurers that use credit scores to underwrite or rate risks shall file their scoring models or other scoring processes with the State Insurance Department.
 - (2) A third party may file scoring models on behalf of insurers.
 - (3) A filing that includes credit scoring shall include loss experience justifying the use of credit information.
- (b) Any proprietary consumer report scoring system or model filed with the Insurance Commissioner under this subchapter shall remain confidential unless otherwise directed by a court order.

23-67-410. Indemnification. [Effective Jan. 1, 2004.]

- (a) An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of a producer who obtains or uses credit information or credit scores, or both, for an insurer, provided the producer follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation.
- (b) Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

23-67-411. Sale of policy term information by consumer reporting organization.
[Effective Jan. 1, 2004.]

- (a)(1) No consumer reporting agency shall provide or sell data or lists that include any information that, in whole or in part, was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or credit score.
- (2) The information includes, but is not limited to:
 - (A) The expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire; and
 - (B) The terms and conditions of the consumer's insurance coverage.
- (b) The restrictions provided in subsection (a) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance producer from whom

information was received, the insurer on whose behalf the producer acted, or the insurer's affiliates or holding companies.

(c) Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

23-67-412. Fair Credit Reporting Act. [Effective Jan. 1, 2004.]

The provisions of this subchapter shall be subject to the federal Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq.

23-67-413. Individual underwriting allowed. [Effective Jan. 1, 2004.]

Nothing in this subchapter is intended to prevent an insurer from considering each risk on an individual basis, looking at individual risk characteristics and other factors predictive of future loss.

23-67-414. Regulations. [Effective Jan. 1, 2004.]

The Insurance Commissioner may make reasonable rules and regulations necessary for or as an aid to the effectuation of any provision of this subchapter.

23-67-415. Annual report regarding personal insurance. [Effective Jan. 1, 2004.]

(a) No later than March 31 of each year, each insurance company writing any personal insurance that uses credit-scoring information shall report to the Insurance Commissioner for each personal insurance type listed in § 23-67-404(9) the number of:

- (1) Policies written during the preceding year;
- (2) Policies that received a premium increase due to credit scoring during the preceding year; and
- (3) Policies that received a premium decrease due to credit scoring during the preceding year.

(b) Information filed with the commissioner under this section by an insurance company shall be treated as proprietary information and is exempt from public disclosure.
