House
Legislative
Analysis
Section

Olds Plaza Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

INSURANCE BUREAU FUNDING

House Bills 4867-4871 as enrolled
Second Analysis (7-20-94)

Sponsor: Rep. Bill Martin
House Committee: Insurance
Senate Committee: Commerce

THE APPARENT PROBLEM:

The 1993-94 fiscal year budget for the Insurance Bureau approved by the legislature depends in large part on assessments by the bureau on the insurance companies it regulates. The bureau now has the authority to assess companies for the costs and expenses of examinations and investigations. But this is considered an inadequate method of raising revenue, particularly the large amount needed to fund a major portion of the bureau's budget. It puts the burden only on those companies examined or investigated in a given year, rather than on all companies evenly, and often puts an excessive burden on companies in financial difficulties. A new method of insurance company assessment has been devised, which spreads the cost of supporting regulation across the industry based on a company's volume of business. A reliable source of funding is said to be particularly important at this juncture, as are improved budgets for the bureau, because the bureau is in the process of meeting accreditation standards established by the National Association of Insurance Commissioners (NAIC). Among other things, new financial regulations have been enacted based on NAIC model legislation to guard against insurance company insolvencies, and the bureau needs the resources and procedures in place to carry out its task under the solvency legislation. The insurance commissioner has testified, also, that the bureau needs to substantially improve in other areas, including its consumer affairs department and its regulation of health care. The NAIC accreditation of the state's insurance regulatory apparatus is important to Michigan-based insurers doing business in other states, say specialists in the field. Companies that are based in states that do not meet NAIC standards will face regulatory hurdles when operating elsewhere that companies from accredited states will not. For this reason, regulators, insurance industry officials, and legislators have been working on a new method of funding for the Insurance Bureau.

THE CONTENT OF THE BILLS:

House Bill 4871 would amend the Insurance Code to impose a new "regulatory fee" on insurers authorized to do business in the state. (The term "insurers" would include Blue Cross and Blue Shield of Michigan, dental corporations, health maintenance organizations and the State Accident Fund.) The new fee would replace the current requirement that insurance companies and other regulated entities must pay the costs and expenses associated with Insurance Bureau examinations and investigations. Any costs and expenses assessed since October 1, 1993, would be canceled and amounts actually paid would be credited against the new regulatory fee levied for the 1993-94 fiscal year and excess amounts refunded.

(However, the fees found in the legislation would not apply after January 1, 1996, unless the insurance commissioner made reports to legislative committees on the receivership activities of the commissioner and insurance bureau pertaining to the liquidation of insolvent insurers. This requirement is described in more detail below.)

Money from the new fee would go to a newly created Insurance Bureau Fund to be used only for regulatory purposes under the authority of the insurance commissioner. Money in the fund would not revert to the general fund at the close of a fiscal year but would remain in the fund and be credited toward the appropriation for the bureau in the next fiscal year. The bill specifies that at least 67 percent of the revenue derived from the new fee be used for the regulation of financial conduct of entities regulated under the commissioner's authority and for the regulation of entities engaged in the business of health care and health insurance in the state.

House Bills 4867 through 4870 would each amend a different act governing a kind of insurance entity

to make that entity subject to the regulatory fee. House Bill 4867 would amend Public Act 125 of 1963 (MCL 550.359 et al.), which regulates nonprofit dental care corporations (such as Delta Dental). House Bill 4868 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1603 et al.), which regulates Blue Cross and Blue Shield of Michigan. House Bill 4869 would amend a section of the Public Health Code (MCL 333.21025a) dealing with health maintenance organizations (HMOs). House Bill 4870 would amend the Workers Disability Compensation Act (MCL 418.713) to make the fee apply to the State Accident Fund.

The commissioner would impose the regulatory fee on all insurers authorized to do business in the state by June 30 of each year or within 30 days after enactment into law of any appropriation for the Insurance Bureau's operation. The rate of the assessment would be determined based on the amount appropriated for bureau operations and the amount available from other sources of revenue. The total of regulatory fees could not exceed 80 percent of the gross appropriations for the fiscal year. (For fiscal year 1993-94, the gross appropriation would be considered to be $15 million.) The amount to be raised in regulatory fees would be divided by the total amount of direct premiums written in the state by all insurers for the immediately preceding calendar year to arrive at a base assessment rate. The maximum base assessment rate would be 38 cents per thousand (.00038). (The calculation would not include as direct written premiums amounts that represented claims payments made on behalf of, or administrative fees paid in connection with, any administrative service contract, cost-plus arrangement, or any other noninsured or self-insured business.)

The regulatory fee would not apply to annuity considerations and the burden of the resulting fee shortfall would be distributed 75 percent to life insurers and 25 percent to all other insurers based on formulas found in the bill. Those formulas would determine the two actual assessment rates each year, one for life insurers and one for other insurers. The actual amount due from an insurer would be determined by multiplying the actual assessment rate by the assessment base of the insurer (presumably, direct premiums written in the state in the previous calendar year) as determined by the commissioner from the annual statement filed by the insurer. The minimum fee would be $250.

However, the total of the regulatory fees for health maintenance organizations (HMOs) would be determined by multiplying the actual assessment rate by 70 percent of direct underwritten premiums written by all HMOs for the preceding calendar year. Each individual HMO's fee would be determined based on number of members (by taking the total of all HMO regulatory fees divided by the total number all members of HMOs and multiplying the result by the number of members in the individual HMO). The minimum fee would be $250.

An alien insurer, one based outside of the country, would be subject to both a regulatory fee and a valuation fee through December 31, 1994. After that, an alien insurer would only be subject to the regulatory fee.

An insurer could file a protest of a fee not later than 15 days after receipt of the assessment. The insurance commissioner would have to review the grounds for the protest and hold a conference with the insurer if requested. The commissioner would then transmit the findings to the insurer with a restatement of the regulatory fee.

Unless protested, fees would be due no later than 30 days after receipt of the assessment. Fees not paid when due would bear interest at a rate equal to one percent above the average interest paid at auctions of five-year U.S. Treasury notes during the six months immediately preceding July 1 and January 1, compounded annually until paid. An insurer who failed to pay the fee could have its certificate of authority or license suspended, limited, or revoked, as the commissioner considers warranted. Overpayments would be refunded or credited against next year's fee, at the insurer's option. An overpayment of $100 or less would be credited against next year's fee unless the insurer had an overpayment of $100 or less in the previous year as well, in which case the insurer could opt to have the new overpayment refunded.

The bill specifies that a regulatory fee could not be treated by an insurer as a levy or excise upon premium but as a regulatory burden apportioned in relation to insurance activity in the state reflecting the insurance regulatory burden on the state as a result of the activity. A foreign (out-of-state) or

alien (out-of-country) insurer authorized to do business in the state could consider the fee a burden imposed by the state in calculating its liability under the reciprocal or retaliatory tax.

A regulatory fee of one-half of one percent (.5 percent) on premiums written in the state would be levied on unauthorized insurers (surplus lines). That would be in addition to the existing two percent premiums tax. The same additional fee of one-half of one percent would apply to the direct business of a risk retention group without a certificate of authority from the insurance commissioner.

Beginning June 1, 1995, and annually thereafter, the commissioner would have to report to the Senate and House standing committees on insurance issues on the revenues raised by the regulatory fees, how the fees were spread among domestic, foreign, and alien insurers; how the fees were being spent in regulating the various kinds of insurers; and whether a new regulatory policy was needed to better protect the citizens of Michigan. The bill would require that the commissioner contract for services, supplies, and materials, pursuant to Public Act 428 of 1980, which deals with minority- and woman-owned businesses and pursuant to the competitive bidding requirements of the Management and Budget Act.

To keep the fees in place, the commissioner also would have to report on receivership activities. By September 1, 1994, the commissioner would have to submit a report to the House and Senate standing committees on insurance issues and to the regulatory subcommittees of the Appropriations Committees on activities for the 1992 and 1993 calendar years. By September 1, 1995, and annually thereafter, a report would have to be made on the immediately preceding calendar year.

The report would have to contain: a) a summary schedule of all bureau expenditures for legal, accounting, and administrative expenditures made or incurred for the liquidation of insurers in receivership and paid for out of the insurer's assets; b) a detailed schedule of contractual expenditures for legal, accounting, and administrative services, including itemization of legal billings, criminal investigation expenses, travel, meals, and general office expenses; and c) a statement of the net changes in assets and liabilities of each insurer in receivership. This last statement would have to include changes due to interest rate changes, real estate values, and other investment activities, including a detailed statement of the sale of assets and the net loss or gain on those assets and a statement of the amount of assets preserved, gained, or recovered by the receiver.

House Bill 4871 also contains an amendment to a section of the Insurance Code regarding the certificate of authorities of foreign (out-of-state) insurance companies when control of the company changed. The section currently says the certificate would be automatically revoked 90 days after a change in control without the commissioner's approval unless the insurer requalified for a certificate within the 90 days, or a longer period if the commissioner permitted. The bill would permit the entity seeking control of a foreign insurer to request of the commissioner a determination of whether the commissioner would requalify the insurer if control was acquired. The commissioner's written determination would have to be made within 90 days. If the commissioner failed to issue the determination within the 90-day period and the person making the request acquired control within 180 days after making the request, the insurer would automatically be requalified for a certificate of authority. If the commissioner did issue an affirmative determination and the change in control occurred within the 180 days, the commissioner would be prohibited from proceeding under the current provisions.

MCL 500.224 et al.

FISCAL IMPLICATIONS:

The 1993-94 appropriation for the Insurance Bureau is about $15.8 million (including some $1.6 million for computerization), but bureau officials say it will spend only $15 million at most. There is no general fund support. The bureau estimates it will receive $3,579,400 from restricted funding sources (mostly agent's fees); $800,000 from the new assessment on surplus lines; and $1,340,000 from the valuation fee to be paid by alien insurers (mostly Canadian life insurers). This requires $9,280,600 to be raised from the new regulatory fee on insurers. A bureau estimate dated 2-11-94 indicated that a maximum base assessment rate of 38 cents per 1,000 would leave the bureau $428,119 short of revenue. This was based on 1992 premium totals of just over $23.296 billion.

ARGUMENTS:

For:

The proposal provides a method of funding for the Insurance Bureau that is reliable and effective on the one hand and fair and equitable on the other. It takes the place of a funding method that would require payments only from those companies being examined and investigated in a particular year, which is both unfair and counterproductive (to the extent the companies have attracted attention because of their financial weakness). The funding method developed in this legislation is said to be much like that supporting activities of the Financial Institutions Bureau and the Public Service Commission. The bureau needs additional resources to make sure its regulatory efforts are sufficient to achieve accreditation by the National Association of Insurance Commissioners (NAIC). This accreditation will help Michigan-based companies when doing business elsewhere. The bureau needs to improve its consumer assistance programs, its regulation of surplus lines (unauthorized insurers) business, and its oversight of health care-related issues. It needs to carry out its financial surveillance responsibilities mandated by recent legislation guarding against insurance industry insolvencies. The bureau has not had the ability in recent years to carry out many of the responsibilities imposed by insurance legislation. It is said to be far behind in dealing with requests for company admissions and for approving changes in control of companies. Enhancing staffing levels, establishing new procedures and systems, and improving computer capabilities will help the bureau carry out its essential, and increasingly demanding, tasks.

Response:

Some people have expressed concern that there are no performance guarantees accompanying the budget increases and fee increases. Others have argued that a sufficient case for increases in staff and resources has not been made.

Against:

The insurance commissioner argued during the debate over the fee legislation that the maximum base assessment rate contained in the bill would be inadequate and sought a 39 cents per thousand rate instead. It should be noted that during the history of this funding proposal the industry assessment rate fell from $1 per thousand, to 75 cents, to 40 cents, and finally down to 38 cents per thousand. This could leave the bureau short of revenue to support an appropriation already approved by the legislature.

Against:

The special treatment of health maintenance organizations is not fair or in the public interest. HMOs take dollars from the public based on a contract, just like other insurance entities. And, regulators say, they are inherently weaker financially than insurance companies and highly vulnerable. New federal proposals could increase the use of HMOs, increasing the need for financial oversight.

Response:

Without the separate assessment method for HMOs, they will see an exorbitant increase in their regulatory costs. HMOs are not insurance companies; only a small portion of their business is insurance-related -- the vast majority (85-90 percent) is providing health care. Only a portion of their overall business should be subject to assessment. They are dually regulated by insurance and public health agencies. HMOs represent a very small portion of the regulated entities, perhaps one percent, and should not bear a disproportionate burden of assessments. (They will still pay an estimated $500,000 in fees for 1993-94.)

Against:

Some people argue that insurance regulation serves a sufficient public purpose to derive some of its funding from the general fund rather than entirely through industry fees and assessments.

Response:

It has been noted that, because insurers will be able to reduce other tax burdens (e.g., the single business tax) due to the new regulatory fee being imposed, the general fund will lose revenue (and thus is making a contribution).