House
Legislative
Analysis
Section

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INSURANCE CODE

Senate Bill 1007 (Substitute H-1)
First Analysis (12-8-98)

Sponsor: Sen. Michael J. Bouchard
House Committee: Insurance
Senate Committee: Financial Services

THE APPARENT PROBLEM:

A number of amendments to the Insurance Code (that were contained originally in several other bills) have been proposed:

• According to some, the provisions of the Insurance Code requiring the revocation of a foreign insurer's certificate of authority due to a change in control are unfair and arbitrary. Some have proposed amendments to offer a more objective means of making the determination as to whether a change in control warrants revocation of an insurer's certificate. [For a further explanation of the provisions relating to this aspect of the bill, see the House Legislative Analysis Section's analysis of House Bill 4905 (as passed by the House) dated 8-24-97.]

• The Patient's Bill of Rights legislation required that health insurers renew or continue in force a nongroup policy or certificate at the option of the individual and a group policy or certificate at the option of the plan's sponsor. This had the effect of ending the sale of certain short-term nonrenewable policies. Insurance companies say that these policies fill an important niche in the insurance market, and it is proposed to grant an exemption to the renewal requirement for such policies. [For a further explanation of the provisions relating to this aspect of the bill, see the House Legislative Analysis Section's analysis of Senate Bill 514 (Substitute H-2) dated 8-24-97.]

• Current law requires that an associated life insurance policy or annuity contract must have a death benefit that is sufficient to cover the initial contract price of the cemetery good or services and that increases at an annual rate of no less than the consumer price index. It is suggested that the maximum initial assignable death benefit should be increased, and that consumers should be given the option to decide whether or not they wish to purchase a policy that is tied to the CPI.

• In 1997, Illinois enacted the first insurance self-audit compliance privilege law. The law created a privilege protecting insurance companies from being required to disclose certain internal auditing documents to the state insurance department and prohibiting the use of these documents as evidence in any criminal, civil, or administrative proceedings. It is argued that the creation of a self-audit privilege helps to encourage compliance with laws and regulations and that the state of Michigan should follow Illinois' lead and adopt a similar protection for its insurers.

THE CONTENT OF THE BILL:

Senate Bill 1007, as passed by the Senate, would amend the Insurance Code to allow a domestic insurer to issue capital notes. "Capital note" would mean a debt instrument that complied with the bill. The issuance of a capital note would not be subject to the prior approval of the insurance commissioner.

A capital note issued by a domestic insurer could provide for all of the following:

-- Interest payments at fixed or adjustable rates.

-- Sinking fund payments.

-- Payments and redemptions of principal under the terms of the capital note.

A capital note would have to be treated as a liability in the computation of statutory surplus and be reported as a liability on the insurer's annual statement filed with the commissioner. In a liquidation proceeding under the code, a capital note would be a "similar obligation" under Section 8142. (Section 8142 sets the priority of distribution of claims from an insurer's estate, in order of classes of claims. Class 8 includes surplus or contribution notes, or similar obligations, and premium refunds on assessable policies.)

A capital note could be included in a domestic insurer's "total adjusted capital". For a capital note to be included in the total adjusted capital, the Commissioner

could require the note to contain other features that he or she determined were adequate and appropriate to ensure that the insurer continued to be safe, reliable, and entitled to public confidence. ("Total adjusted capital" would mean the sum of an insurer's statutory capital and surplus as determined under the annual statement filed with the Commissioner.)

In addition, the House substitute for the bill proposes several changes to the Insurance Code, many of which have been proposed in other bills this session:

• The bill would add new guidelines for the requalification of certificates of authority for foreign insurers that have undergone a change of control.

Requalification after change in control. The bill would provide that a foreign insurer that had undergone a change of control would have to apply for requalification on a standard form provided by the insurance commissioner within 90 days of the change of control or its certificate of authority would automatically be revoked. A foreign insurer would be entitled to requalification for the same type of certificate of authority as the company had held prior to its change of control, unless the commissioner determined in the reasonable exercise of discretion, based upon specific findings of fact, that the insurer was not safe, reliable, and entitled to public confidence.

Appeals, judicial review. If the commissioner determined that the insurer was not safe, reliable, and entitled to public confidence, the insurer would be entitled to a contested case hearing under the Administrative Procedures Act before the commissioner. The hearing would be based only upon the issues specified by the commissioner in his or her original determination, unless the commissioner could show that the additional bases had been discovered since the date of the original determination. Generally, the insurer's certificate of authority would remain in effect while the contested case was proceeding; however, the commissioner could suspend or revoke the certificate upon a specific finding that policyholders, creditors, or the public would not be protected without a suspension or revocation of the insurer's certificate. After the hearing, the commissioner could confirm or modify his or her order, and that order would then become the final decision or order of the contested case. If the foreign insurer disagreed with the commissioner's final decision, the insurer could seek judicial review.

If the insurer sought judicial review of the commissioner's decision, the insurer could petition the court to have the commissioner's decision stayed. The petition would be heard on an emergency basis in the circuit court where the foreign insurer had its principal place of business in the state or in Ingham County Circuit Court. The petition would have to be disposed of within 14 days unless the insurer and the commissioner both agreed in writing to extend the period. The court could only issue a stay if it found that issuing the stay would not be hazardous to its policyholders, creditors, or the public. The burden of proving that the stay would not be hazardous would be upon the insurer.

A stay could be issued by the court on such terms as it considered reasonable and appropriate for the protection of policyholders, creditors, and the public. The commissioner would bear the burden of establishing the reasonableness and necessity of any terms that he or she suggested as a condition of the stay.

The bill's amendments to Section 405, which provides for the automatic revocation of a foreign insurer's certificate of authority upon a change of control, would be remedial and would apply to all foreign insurers that underwent a change of control on or after June 24, 1994 and had an application, administrative proceeding, or cause of action relating to requalification pending as of the bill's effective date. However, all special deposits, bonds, or financial protective conditions ordered by a court in connection with those pending applications, administrative proceedings, or causes of action before the bill's effective date would remain in effect on and after that date unless rescinded or modified.

Conditional certificate of authority. The bill would also allow the insurance commissioner to place conditions on an insurance company's certificate of authority. (Currently, the commissioner can suspend, revoke, or limit a certificate.) Under the bill, if the commissioner determined that a company is not, or does not continue to be, safe, reliable, and entitled to public confidence so that the company is not qualified to receive an unconditional certificate of authority, he or she would then have to consider if a certificate subject to conditions could be issued. The bill specifies that if the commissioner decided an insurer was only entitled to a certificate with conditions, the conditions would have to be limited to those necessary to permit the commissioner in the reasonable exercise of his or her discretion to conclude that the insurer was safe, reliable, and entitled to public confidence. The conditions could include:

-- provisions for making special deposits in reasonable amounts for the benefit of Michigan policyholders, creditors, or the public;

-- limiting the types of insurance coverage the company could market in the state;

-- limiting the insurer to issuing coverage in Michigan for clients with risks to be insured in more than one state where the policy is lawfully issued in a state other than Michigan but that also covers Michigan risks;

-- requiring the company to enter into an agreement to reinsure some or all of its Michigan business with a reinsurer acceptable to the commissioner;

-- requiring the insurer to suspend or limit the declaration and payment of dividends to its stockholders or to its policyholders unless the prior approval of the commissioner is given;

-- filing, in addition to regular annual statements, interim financial reports in the format required by the commissioner;

-- reducing or limiting the volume of business being accepted or renewed; and

-- imposing such other conditions as are reasonably tailored to permit the commissioner in the reasonable exercise of his or her discretion to conclude that the insurer is safe, reliable, and entitled to public confidence.

• The bill would provide an exception until July 1, 2001 to the requirement that certain health insurance policies must be renewed or continued in force at the option of the individual insured. The exception would apply to a short-term or one-time limited duration policy or certificate of no longer than six months.

An individual policy would be eligible provided that it met all of the following criteria:

-- It was issued to provide coverage for a period of 185 days or less, except the policy could permit a limited extension of benefits solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the policy.

-- It was nonrenewable, except that the insurer could provide coverage for one or more subsequent periods that satisfied the provision above, provided the total of the periods of coverage did not exceed a total of 185 days out of any 365-day period, plus any additional days permitted by the policy for a condition for which a covered person incurred expenses during the term of the policy.

-- It did not cover any pre-existing condition.

-- It was available with an immediate effective date, without underwriting, upon receipt by the insurer of a completed and eligible application, except that coverage that included optional benefits would not have to meet this requirement.

The bill would specify that in each calendar year, a health insurer could not continue to issue such policies if doing so meant that the collective gross written premiums of such policies totaled more than ten percent of the collective gross written premiums of all individual expense-incurred hospital, medical, or surgical policies issued in this state either directly by the insurer or through a corporation that owned or was owned by that insurer.

An insurance company that delivered, issued for delivery, or renewed a short-term or limited duration policy in this state would have to provide written reports to the insurance commissioner. The first report would be due no later than February 1, 1999. The report would disclose information regarding policies issued in Michigan during the 1996 calendar year. The report would have include the gross written premium for short-term or limited duration policies or certificates of no longer than six months and the gross written premium for all individual expense-incurred hospital, medical, or surgical policies not including those policies or certificates included in the previous category. The later reports would be due not later than March 31 in the years 1999 through March 31, 2001. These reports would disclose the gross written premium for such policies or certificates issued in the state during the preceding calendar year. The insurance commissioner would be required to compile these reports annually and to maintain copies of these reports on file with the annual statements of each reporting insurer. The annual compilation of the reports would have to be provided to relevant insurance committees in the House and Senate by June 1 of each year following the receipt of the reports.

• The bill would amend the section of the code that prohibits life or accident insurers, their agents, or employees for owning or operating a mortuary or undertaking facility and regulates the issuance of associated and nonassociated life insurance policies or annuity contracts.

The bill would provide a definition of a "limited death benefit policy" -- a life insurance policy with a death benefit equal to the sum of the premiums paid at the time of death for a period of time not to exceed two years after the policy was issued, plus ten percent interest compounded annually. A seller of such policies would be required to be provided with the

option of offering both indexed and non-indexed life insurance or annuity contracts to fund cemetery goods and services or funeral goods or services. Additionally, each associated policy or contract would have to disclose the death benefit and, if it was a limited death benefit, any reduction in the benefit.

Each application for an associated policy that would provide for a limited death benefit would have to contain an acknowledgment from the applicant that he or she had been notified of the limited death benefit and the period of the limitation. A limited death benefit period could not exceed two years.

The bill would change the conditions under which a life insurance policy or annuity contract that provided a pre-death assignment of its proceeds as payment for cemetery services or goods or funeral service or goods could be sold. The current provisions require that, in order for a nonassociated life insurance policy or annuity contract to be assigned, any increase in the price of the goods or services could not exceed the lesser of the CPI or the retail price list in effect when the death occurs, and the assignment would have to be sufficient to cover the initial contract price of the goods or services. Instead of the second requirement, the bill would provide that the assignment would have to clearly disclose that the amount assigned was enough to cover the initial contract prices of the goods or services, or if the amount was not sufficient, it would have to disclose any obligation that existed to pay the difference between the contract price and the amount assigned. The bill would also increase the maximum initial assignable death benefit from $5,000 to $15,000 for both associated and nonassociated policies and contracts.

Group life insurance could be issued in connection with prepaid funeral contracts only if it were issued as an associated life insurance policy or annuity contract allowed under the act, conformed with the act's provisions regarding such policies, and was issued to an association that covered the lives of it members or to a trustee of a group. The bill would also clarify that the commissioner is not limited to only authorizing those groups that are logically analogous in character and composition to the groups specifically defined in the act.

• The bill would provide that insurance compliance self-audit documents would be privileged and confidential information and, unless one of exceptions were met, could not be used as evidence in any civil, criminal, or administrative proceeding. In addition, the privilege would also extend to any individual who had been involved in preparing such an audit or audit documents, and such persons would not be subject to examination regarding the audit or audit documents in any civil, criminal, or administrative proceeding.

An insurer would be able to submit an audit document to the commissioner or his or her designee as a confidential document without waiving the self-evaluative audit privilege. The commissioner could compel disclosure of an audit document, but any such document would remain confidential and could not be divulged to any person unless it met one of the exceptions.

The privilege would have the following exceptions:

* It could be expressly waived by the insurer that prepared or caused the preparation of the audit or audit documents.

* A court could, after review, require that the document be disclosed in a civil or administrative proceeding, provided that the court determined one or more of the following:

-- That the privilege had been asserted for a fraudulent purpose.

-- That the material was not subject to the privilege.

-- That the material, even though subject to the privilege, shows noncompliance with state or federal law, rule, regulation, or order and the insurer failed to undertake reasonable corrective action or to eliminate the noncompliance within a reasonable time.

* A court could, after review, require that the document be disclosed in a criminal proceeding after determining one or more of the following:

-- That the privilege had been asserted for a fraudulent purpose.

-- That the material was not subject to the privilege.
-- That the material, even though subject to the privilege, showed noncompliance with state or federal law, rule, regulation, or order and the insurer failed to undertake reasonable corrective action or to eliminate the noncompliance within a reasonable time.

-- That the material contained evidence relating to the commission of a criminal offense under the Insurance Code, the attorney general had a compelling need for the information, it was not otherwise available, and the attorney general could not obtain the substantial equivalent of the information without incurring unreasonable cost and delay.

When a court determined that material should be disclosed in a civil, criminal, or administrative proceeding, it could only compel disclosure of the portions of a document that were relevant to issues in the underlying proceeding. Even so, information that was required to be disclosed could not be considered a public document.

An insurer that asserted the privilege would have the burden of demonstrating the applicability of the privilege. Once the insurer had met this burden, the party seeking disclosure would have the burden of proving that the court should require disclosure.

The bill would define "insurance compliance self-evaluative audit" to mean a voluntary, internal evaluation, review, assessment, or audit that was not expressly required by state or federal law, rule, regulation, order, or professional standard and designed to identify and prevent noncompliance with those laws or standards. Such an audit could be conducted by the insurer, its employees, or independent contractors.

An "insurance compliance self-evaluative audit document" would include any document or other information that had been prepared as a result of or in connection with an insurance compliance self-evaluative audit. The definition of such documents would also include an audit report prepared by an auditor that contained the scope of the audit, information gained in the audit, conclusions and recommendations, exhibits, appendices, memoranda, and documents analyzing portions or all of the audit report and disclosing potential implementation issues; an implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing further noncompliance; and analytic data generated in the course of the audit. The following would be expressly excluded from the definition of an "insurance compliance self-evaluative audit document": 1) any document, communication, data, report, or other information that was created as a result of a personal injury or workers' compensation claim; 2) any documents or other information required to be collected, reported, or otherwise made available to a regulatory agency under the Insurance Code, or other federal or state law, rule, regulation, order, or professional standard; 3) information obtained by observation or monitoring by any regulatory agency; and 4) information obtained from a source that was independent of the insurance compliance self-evaluative audit.

MCL 500.150 et al.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

The House Committee substitute encompasses language from several bills regarding changes to the Insurance Code. The bill was reported from the House Committee on Insurance, in spite of reservations about and even outright aversion to the portions of the current language, in hopes that compromises on at least some of the facets of the bill could be reached prior to the conclusion of the 1997-98 session.

POSITIONS:

The Insurance Bureau opposes the bill as written. (12-3-98)

The Michigan Insurance Federation opposes the bill as written. (12-7-98)

Analyst: W. Flory

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.