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BILL ANALYSIS

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Senate Bill 1163 (as reported with amendments)
Sponsor: Senator Michael J. Bouchard
Committee: Financial Services

Date Completed: 9-30-96

RATIONALE

The Insurance Bureau, in the Department of Consumer and Industry Services, has suggested various changes to the Insurance Code concerning reporting requirements, judicial review, the Insurance Commissioner's subpoena power, and service of process on insurers. In particular, the Bureau is required to issue an annual report on its receivership activities, and must prepare two reports annually on the state of competition in the workers' compensation insurance market and the commercial liability insurance market. According to the Bureau, the receivership report costs $50,000 to produce and is unnecessary since the receivership office is subject to audit by the Auditor General. The Bureau also reports that the workers' compensation and commercial liability insurance markets have been relatively stable, resulting in little or no change between the two biannual reports. In addition, medical malpractice and municipal liability insurers are required to report certain data to the Bureau, and the Bureau must report every two years on the claims experience in these areas. According to the Bureau, the medical malpractice data base originally was housed in the Bureau because insurers were the source of the data and assessments under the medical malpractice arbitration program, but that program has been dissolved and data are no longer supplied primarily by insurers licensed in Michigan. Further, the Bureau reports, the municipal liability data base was created in 1978 in response to an apparent lack of available municipal liability insurance; currently, however, most of this coverage is provided through other means, such as governmental pools or self-insurance.

In addition, the Insurance Code authorizes the Insurance Commissioner to apply to the Ingham County Circuit Court for an injunction against violations of the Code, and provides that anyone who violates a provision of the Code for which a specific penalty is not otherwise provided "shall be afforded an opportunity for a hearing before the Commissioner". Evidently, in September 1995, a circuit court judge ruled that, based on this language, the Commissioner had to provide an administrative hearing before he or she could seek an injunction. According to the Bureau, administrative remedies can be inadequate to protect the public, especially in cases involving unlicensed entities.

Further, the Code provides that a person aggrieved by a final order or action may seek judicial review as provided in the Administrative Procedures Act (APA). The scope of review under the APA includes a test of whether a decision was based on "competent, material and substantial evidence on the whole record". In cases in which the Commissioner makes a decision or takes an action without a hearing, however, there is no "record" for the court to review. The Bureau has suggested that people aggrieved following a contested case could seek judicial review under the APA, while others could seek review under the Revised Judicature Act, which also provides for the appeal of agency decisions.

In addition, the Code authorizes the Commissioner, with circuit court approval, to issue subpoenas for testimony or documents necessary to conduct a hearing on the refusal, suspension, or revocation of an agent's license. Since the Bureau often encounters cases of fraud and misrepresentation involving agents, it has been suggested that the Commissioner's subpoena power should not be limited in these cases. The Bureau also has pointed out that other provisions of law authorize the Commissioner to issue subpoenas without court approval.

Finally, the Code requires foreign and alien insurers (i.e., insurers not organized under

Michigan law), as well as other insurers, to appoint the Commissioner as their agent for purposes of service of process. According to the Bureau, the tracking and mailing associated with this responsibility use three-fourths of one full-time equated position to perform, and exceed the $5 fee the Bureau charges for accepting service on foreign and alien insurers. It has been suggested that service of process should be made directly upon insurers.

CONTENT

The bill would amend the Insurance Code to do the following:

- **-- Provide for direct service of a summons and complaint on an insurer, rather than requiring service of process upon the Insurance Commissioner.**
- **-- Allow the Commissioner to sue for an injunction regardless of whether administrative proceedings had been initiated.**
- **-- Authorize the Commissioner to issue subpoenas without court approval.**
- **-- Revise the amount of cash or securities that foreign insurers must deposit for a stay of a suspension or revocation order.**
- **-- Delete requirements that the Commissioner report annually to the Legislature on receivership activities of the Commissioner and the Insurance Bureau.**
- **-- Require the Commissioner to issue annual, rather than biannual, reports on the state of competition in the workers' compensation insurance market and in the commercial liability insurance market.**
- **-- Repeal requirements that professional health care liability insurers and municipal liability insurers submit certain information to the Commissioner, and that the Commissioner report on those claims experiences.**

Judicial Actions/Review

Currently, when a person violates any provision of the Code for which a specific penalty is not otherwise provided, he or she must be given an opportunity for a hearing before the Commissioner. The Commissioner may issue a cease and desist order as well as order a civil fine or license sanctions if he or she finds that a violation has occurred or if a person knowingly violates a cease and desist order. The Code also permits the Commissioner to apply to the Ingham County Circuit Court for an order enjoining a violation of the Code. Under the bill, however, notwithstanding the provisions for administrative sanctions, the Commissioner could commence an original action in the Ingham County Circuit Court for an injunctive order whether or not an administrative proceeding had been initiated. The circuit court would have to conduct any necessary fact finding and enjoin any further violation of the Code.

Currently, a person aggrieved by a final order, decision, finding, ruling, opinion, rule, action, or inaction provided for under the Code may seek judicial review pursuant to Chapter 6 of the Administrative Procedures Act (which provides for direct court review of a final agency decision or order after available administrative remedies have been exhausted). The bill provides that an aggrieved person could seek judicial review pursuant to Chapter 6 when appealing a final decision in a contested case and under Section 631 of the Revised Judicature Act when appealing other orders, decisions, findings, rulings, opinions, rules, actions, or inactions. (Section 631 provides for an appeal to the circuit court from an agency decision from which an appeal or other judicial review has not otherwise been provided by law.)

Judicial Stay

Under the Code, an insurer has the right to petition the circuit court for a stay of an order for the suspension, revocation, or limitation of a certificate of authority. If the court issues a stay, it cannot take effect until the insurer deposits cash or securities with the State Treasurer in amounts specified in the Code. For a foreign insurer, the amount is 100% of the aggregate sum of Michigan direct unpaid losses and unpaid loss adjustment expenses plus 100% of Michigan direct unearned premiums less the amount of any other special deposits already made with the State Treasurer for the exclusive protection of Michigan policyholders and creditors. Under the bill, the percentage of unpaid losses and loss adjustment expenses would be increased to 125%. A foreign life or health insurer, however, would have to deposit 125% of Michigan reserves and liabilities for policies and contracts for which coverage was provided by the Michigan Life and Health Insurance Guaranty Association, without respect to the limitations and exclusions provided under Chapter 77 (which governs that association).

The bill also specifies that the deposit of cash or securities with the State Treasurer would have to be increased by adjustment each quarter. A decrease could be made annually only upon a satisfactory showing by the insurer to the Commissioner that a decrease was justified.

Service of Process

Under the Code, as a condition of doing business in this State, every insurance company, association, risk retention group, or purchasing group not organized under State statute must file with the Commissioner its irrevocable written stipulation that any legal process affecting the company or group, served on the Commissioner or the Commissioner's deputies, has the same effect as if personally served on the company or group. Service upon the Commissioner must be considered sufficient service upon the company or group, and the fee for service is $5 payable at the time of service. Under the bill, these provisions would apply until July 1, 1997.

On and after that date, service of process on an insurance company, a fraternal benefit society, a risk retention group not organized under State statute, a reinsurance intermediary, a multiple employer welfare arrangement (MEWA), or an eligible unauthorized insurer, would have to be made by serving a summons and a copy of the complaint upon an officer of the company, society, intermediary, or group at the address contained on the latest financial statement filed with the Commissioner or upon a trustee of the arrangement at the trustee's business address as filed with the Commissioner. Service could be made in person or by certified mail.

As of July 1, 1997, the bill also would delete provisions under which a nonresident applicant for a reinsurance intermediary license must designate the Commissioner as agent for service of process. In addition, the Code requires each eligible unauthorized insurer and each MEWA to appoint the Commissioner as its resident agent, for purposes of service of process. Under the bill, these requirements would apply until July 1, 1997.

In addition, the bill would repeal a section of the Code requiring fraternal benefit societies to appoint the Insurance Commissioner as their lawful attorney upon whom process is to be served (MCL 500.8196).

Subpoena Power

Currently, with the approval of an Ingham County Circuit Court judge, the Commissioner or his or her designated deputy may issue subpoenas to require the attendance and testimony of witnesses and the production of documents necessary to conduct a hearing concerning the refusal, suspension, or revocation of an agent's, solicitor's, or adjuster's license. The subpoenas may be enforced upon application by the Commissioner or deputy to the Ingham County Circuit Court in contempt proceedings.

The bill would authorize the Commissioner or his or her deputy to issue subpoenas without court approval, and would delete the provision for enforcement in contempt proceedings. If the Commissioner's or deputy's subpoena were not followed, the Commissioner or deputy could request the Ingham County Circuit Court to issue an order requiring compliance with the subpoena.

Reports

Under the Code, various regulatory fees do not apply after January 1, 1996, unless the Commissioner submits an annual report to the Legislature on all receivership activities of the Commissioner and the Insurance Bureau pertaining to the liquidation of insolvent insurers for the preceding year. The bill would eliminate this reporting requirement. The bill also would repeal a separate section of the Code requiring this annual report (MCL 500.8160).

The Code requires the Commissioner annually to issue tentative reports detailing the state of competition in the workers' compensation insurance market and in the commercial liability insurance market, and delineating specific classifications, kinds or types of insurance, if any, in which competition does not exist. A person who disagrees with a report may request a contested hearing within 60 days after issuance of the report. Each year, the Commissioner also must issue final reports that include a final certification of whether competition exists in the workers' compensation insurance market or in the commercial liability insurance market. Under the bill, the Commission would be required to issue only one annual report for each market. If a person requested a contested hearing on a report concerning the workers' compensation insurance market, or if the Commissioner found that the conclusions of the report no longer applied to the workers' compensation insurance market, the Commissioner would have to issue a supplementary report. This report would have to

consider the same factors as the initial report, as well as the Commissioner's findings after the contested hearing, if any, and any changes in the workers' compensation insurance market since the initial report. The supplementary report also would have to include a final certification of whether competition existed in that market.

The bill would repeal sections of the Code that require the submission of data to the Insurance Commissioner from insurers providing professional liability insurance to physicians, dentists, optometrists, chiropractors, and hospitals (MCL 500.2477); from municipal liability insurers (MCL 500.2477a); from persons, other than insurers, paying a municipal liability claim or a professional liability claim against a health care provider (MCL 500.2477b); and from attorneys who represent a party in regard to a municipal liability claim or a professional liability claim against a health care provider (MCL 500.2477c). The bill also would repeal a section requiring the Commissioner, every two years, to publish a report containing information about specific claims experiences filed pursuant to those sections, describing the condition of the medical malpractice insurance market in this State, and making recommendations concerning that market (MCL 500.2477d).

Policy Notices

Section 3008 of the Code requires each liability insurance policy to provide that notice given by or on behalf of the insured to any authorized agent of the insurer within this State, with particulars sufficient to identify the insured, must be considered notice to the insurer. The bill would add, "regardless of whether the policy contains a provision to the contrary".

Section 3008 also requires each liability insurance policy to provide that failure to give any notice required to be given by the policy within the time specified in it does not invalidate any claim made by the insured if it is shown that giving notice within the prescribed time was not reasonably possible and that notice was given as soon as was reasonably possible. Under the bill, failure to give notice would not invalidate a claim made under these circumstances, but a policy would not have to contain such a provision.

The bill specifies that these amendments to Section 3008 would not affect the Michigan Supreme Court's 1984 holding in *Stine* v *Continental Casualty Co.* (419 Mich 89). (The issue in that case was whether, under a professional liability policy, the insurer was required to defend the insured in a malpractice action brought after the policy expired for claims that arose during the period of the policy. The Supreme Court held that indemnity was not available under such a "claims made" policy; that Section 3008 did not apply to the policy in this case because the defense was not based on the policy's notice provisions; and that claims made policies are not void for public policy reasons.)

Rules

The Code requires the Commissioner to promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems on file with the Commissioner, which must be used by property and casualty insurers in recording and reporting their loss and countrywide expense experience. The bill would permit, rather than require, the Commissioner to promulgate these rules and plans.

MCL 500.150 et al.

ARGUMENTS

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

Supporting Argument

The bill would eliminate unnecessary responsibilities of the Insurance Bureau, reduce costs to insurers, and improve protection of the public. By eliminating the receivership report and the reporting requirements concerning medical malpractice and municipal liability insurance, and by requiring only one annual report each on the workers' compensation and commercial liability insurance markets, the bill would delete unnecessary or obsolete reporting requirements. The bill also would make it clear that the Commissioner could seek an injunction without first providing an administrative hearing, and could issue subpoenas without court approval. In addition, the bill would make it clear that aggrieved parties could seek judicial review when no administrative hearing had been held. By allowing direct service of process upon insurers, the bill would reduce the Bureau's costs and responsibilities.

Legislative Analyst: S. Margules

FISCAL IMPACT

This bill provides for a number of changes to current practice. First, it would allow a complainant to serve a summons on any company directly as opposed to the current practice of serving the Commissioner. This change would reduce the number of summonses served on the Commission and therefore would reduce the amount of revenue for the Department of Consumer and Industry Services as each complainant is charged a $5 service fee. This change should have no real fiscal impact on the Department as this fee was established to cover the administrative costs associated with the processing, mailing, and tracking of these summonses.

Second, the bill would eliminate the compiling, copying, and mailing of the second report detailing the state of competition in the commercial liability insurance market, and the second report detailing the state of competition in the workers' compensation insurance market. Only one report would be issued annually for each topic. The elimination of this second report would save the Department approximately $1,000 annually ($500 per report) by reducing its printing and mailing costs.

Finally, this bill would eliminate the report by the Commissioner detailing the insurance issues and all receivership activities of the Commission. The estimated cost for publishing the report is $50,000, which is billed back to those companies in receivership. By eliminating this reporting requirements, the bill would reduce the charges billed to these companies and the administrative responsibilities of the Department.

Fiscal Analyst: M. Tyszkiewicz

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