



Insurance Institute of Michigan

August 18, 2009

TO MEMBERS OF THE HOUSE COMMITTEE ON INSURANCE:

On behalf of the Insurance Institute of Michigan I would like to stress our continued opposition to the 12-bill package of legislation (House Bills 4244, 4844, 4846, 5020, 5144-51) currently before the House Committee on Insurance creating new "bad-faith" causes of action that target insurance companies in our state.

In addition to the materials and testimony I provided to this committee on July 16, 2009 and the additional materials that forwarded to each member of the House of Representative this past week, I would like to also share with you the following information for your consideration:

1. The Insurance Institute of Michigan's position paper on this package of legislation which outlines our general reasoning and justification for our opposition to this legislation.
2. A copy of a letter from Mr. Robert Hartwig, President of the Insurance Information Institute to Mr. Ronald Henkoff, Editor of the Bloomberg Market regarding the September 2007 *Bloomberg Markets* cover story titled *The Insurance Hoax*. This article was recently cited by several individuals providing testimony before this Committee as justification for the proposed legislation.
3. A DRAFT Proposed Resolution for Consideration by American Legislative Exchange Council (ALEC) which was adopted by both their public and private members at the ALEC Annual Meeting and scheduled for adoption on August 27, 2009. The Resolution voices their opposition to unfair and unbalanced insurance "bad faith" legislation such as the Michigan legislation before this committee which singles out narrow classifications of industry for one-sided damage awards and the awarding of attorney fees.
4. Copies of two recent press releases from the Office of Finance and Insurance Regulation concerning regulatory actions the Commissioner has taken against insurance companies which demonstrates not only the Commissioner's authority to act against insurers engaged in illegal activity but also his willingness to act on behalf of consumers. Of specific note are the levels of civil fines available to the Commissioner to compel compliance with his orders and directives.

As always, I am available to discuss this or any other matter concerning the property and casualty insurance industry at your convenience.

Thank you for your consideration of this material.

Sincerely,

Peter A. Kuhnmuensch, Executive Director
Insurance Institute of Michigan



Insurance Institute of Michigan

Insurance Institute of Michigan Position
Bad Faith Lawsuits
House Bills 4244, 4844, 4858, 5020, 5144-5151
As of July 20, 2009

Legislation that would drive up costs for insurance policyholders by allowing insureds and third parties to sue an insurance company for excessive damages, costs and attorney fees if the company failed to act in good faith in negotiating or settling a claim is being strongly opposed by the Insurance Institute of Michigan (IIM).

This legislative package would create significant problems and costs for policyholders if it were to become law.

- A “bad faith” law would subject insurance companies to a flood of new lawsuits. Under a similar law in California, injured third-party claimants routinely filed independent actions against insurance companies alleging bad faith. In Washington, where a “bad faith” law was passed last year, needless, costly lawsuits are already up;
- The cost of insurance would increase. Under the threat of being sued for bad faith, insurance companies would be less likely to investigate suspicious claims and more likely to settle claims that would generally need further investigation. These forced settlements, combined with bad faith damages, would have an impact on the cost of insurance, as has been seen in other states that passed such measures.
- A bad faith law creates an adversarial relationship between an insurance company and its policyholders. While an insurance company has a contractual obligation to its policyholder to defend and protect the policyholders’ interests and assets, under this proposal, insurance companies would also be expected to act in the best interest of a non-premium paying third-party in negotiating and settling a claim.

The introduction of such legislation suggests that delay tactics and claims denial is a common practice in the insurance industry. However, that is not true. Overall auto insurance satisfaction level has increased, according to a 2008 study by J.D. Power and Associates. According to the study, satisfaction with auto insurance companies has increased steadily during the past five years.

While no insurance company should be excused if they act maliciously to unfairly deny claims, there is absolutely no incentive for any insurance company not to deal with every claim in a fair and reasonable manner. Unhappy customers take their business elsewhere.

In Michigan, laws are already in place to govern unfair claims practices. If insurance companies engage in such conduct, they subject themselves to 12 percent interest penalties on overdue claims payments, possible license revocation and monetary penalties up to \$25,000. The Michigan Office of Financial and Insurance Regulation, the state insurance regulator, also has tools available to pursue and put out of business, companies that are not abiding by the law.

Permitting bad faith lawsuits would impose a blanket approach to solving a small number of problems with claim cases dealt with each year by insurance companies. In reality, the system is in good shape now. It discourages fraud while at the same time encourages insurance companies to settle claims promptly and efficiently.

For more information, contact Peter Kuhnmuensch at 517/371-2880

July, 2009

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August 15, 2007

Mr. Ronald Henkoff
Editor
Bloomberg Markets
731 Lexington Avenue
Floor 4E
New York, NY 10022

Dear Mr. Henkoff,

I am writing to express my serious concern about the September 2007 *Bloomberg Markets* cover story titled *The Insurance Hoax*. The article is based on a faulty premise which the authors try to substantiate with the use of selective or erroneous facts. Given my organization's long history of credible cooperation with Bloomberg journalists, the malicious nature of this story is shocking. On behalf of the Insurance Information Institute member companies mentioned in the article, I would like to arrange an in-person meeting between you, a representative from each company and myself. In addition to a meeting with you, we are seeking correction, retraction and an apology.

Regarding the recent article authored by David Dietz and Darrell Preston, I find it baffling that a sophisticated business-oriented magazine that is part of one of the most respected names in business information services chose to publish such a biased, inaccurate and intellectually shabby story. This article seriously calls into question Bloomberg's reputation for objective, fact-based reporting. Also, because virtually identical storylines have appeared previously in several other media outlets and at least one book, the fact that your article is presented as original journalism and research by your reporters raises questions about journalistic standards and editorial oversight at Bloomberg.

The data, research and even the originality of the Dietz and Preston article are highly suspect. As editor of *Bloomberg Markets* you should be seriously concerned that in a number of instances detailed below, your "facts," calculations, assertions, and consequently your conclusions, are entirely wrong. But the most serious problem with the article is the misinformation it spreads.

The article leaves our customers with the false impression that insurers routinely seek to avoid their obligations to them at their time of greatest need. Such untruths, utterly unsupported by the facts, are not only a disservice to the public and your readership but are an insult to the millions of insurance industry employees who work hard every day to help people recover from disaster whenever and wherever it occurs.

Below I have highlighted some of the key problems with your story, beginning with the title.

Anecdote and Unsubstantiated Assertions Offered as Fact

The very title of your story *The Insurance Hoax*, sets the tone for the entire piece, calling into question the very premise of insurance and portraying it as an elaborate scheme designed to deceive and defraud. Never mentioned in your story is the fact that property/casualty insurers annually pay out hundreds of billions of dollars on tens of millions of claims. Hundreds of millions of claims and trillions of dollars have been paid fairly and expeditiously during the 15 or so years spanned by your article.

Your article wastes little time in making the quantum leap from anecdote to presumed industry practice. Indeed the article's two lead paragraphs include a discussion of precisely one claimant, the Tunnells, which by the third paragraph morphs into the entirely unsubstantiated assertion that insurers "...routinely pay less than what policies promise." The error of this flat out false statement is compounded in the very next (and also incorrect) sentence, "Insurers often pay 30-60 percent of the cost of rebuilding a damaged home—even when carriers assure homeowners they're fully covered..." This type of leap from anecdote to overgeneralization to misrepresentation of facts occurs several times throughout the piece.

Selective Use and Omission of Data

Your article on many occasions makes selective use of data or omits data to support its seemingly pre-determined conclusions. For example, your article on several occasions compares financial figures such as 1994 or 1996 with 2006 and conveniently omits any reference to the three record years of catastrophe losses in between: 2001, 2004 and 2005 (see p. 37). Consequently, your piece fails to mention the \$81 billion in hurricane losses insurers paid to 5.5 million policyholders through the record hurricane seasons of 2004 and 2005 or the extraordinary performance of insurers in the wake of the 9/11 terrorist attacks, which produced \$32 billion in insured losses.

While some focus on 2006 is reasonable given that it is the most recent year for which data are available, insurance is a highly volatile and cyclical business. This means that a proper analysis requires a detailed examination of data over an extended period of time. Cherry picking a year such as 2006, one which represents a cyclical peak in the industry's performance, while ignoring years like 2001, 2004 and 2005 is, at best, further evidence of deliberate bias in your article and, at worst, represents a profound lack of understanding about an industry that the authors purport to understand intimately. Blinded by bias or ignorance, the authors seem to miss a very obvious point: that it is imperative for insurers to earn healthy profits in years like 2006 in order to accumulate the financial resources necessary to pay losses in years like 2001, 2004 and 2005.

Factual Errors

Bloomberg Markets' blatant bias does your readers an injustice by providing them with inaccurate information about one of the most world's most important industries. The factual errors you make in the story reflect badly on your magazine and the Bloomberg organization as a whole. Below are several examples:

- Page 38: Apparently arithmetic is not the authors' strong suit. First, you state that in 2006, carriers paid out 55 percent of the \$435.8 billion in premiums collected, attributing those figures to data obtained from the Insurance Information Institute. The correct ratio is 65 percent. You will see at the link below the \$435.8 billion in premiums that the authors refer to on the first line in the table at the end of the write-up. The second line shows "Incurred Losses" of \$283.7 billion. Dividing \$283.7 by \$435.8 is 65.1 percent, not 55 percent as the authors assert. If general expenses of \$117.5 billion are included, then that ratio rises to 92 percent. This gross error means that one of your principal allegations—that "*claims payouts across the entire property-casualty insurance industry have decreased in the past decade*"—is entirely wrong and is merely the product of your own arithmetic errors. The authors go on to compare the 2006 figure to a 64 percent payout ratio in 1996. The correct figures actually indicate that the claims payout ratio *increased* in 2006 relative to 1996—precisely the opposite conclusion to that reached by the authors.

LINK: <http://www.iii.org/media/industry/financials/2006yearend/>

- Page 38: Reinforcing the observation that arithmetic skills were in short supply when this piece was written and (presumably) edited and fact checked is the statement that, "*The industry increased profits by an annual average of 46 percent since 1994.*" This statement, too, is factually incorrect. Industry net income after taxes (profit) in 1994 was \$10.87 billion. In 2006 net income totaled \$63.695 billion (see link above). The compound average annual growth rate in profits over this period is 15.9 percent—barely one-third the figure asserted by Bloomberg. It is a mystery to me how the authors could be so far off.
- Were the 46

- percent growth rate to be true, profits in 2006 would have exceeded \$1 trillion, given initial 1994 profits of \$10.87 billion. Considering that total industry premiums were \$435.8 billion that year, profits of that magnitude are obviously impossible to achieve. Clearly the assertion of a 46 percent average annual growth in profits over a 12-year period should have set off alarm bells with your editors. Working backwards from the \$63.695 billion actual net income figure, a 46 percent average annual growth rate implies that profits in 1994 were just \$679 (rather than the actual amount of \$10.87 billion). Apparently nobody at Bloomberg seemed to believe that checking the authors' calculations was worth their time, even though these calculations form the foundation of the arguments made in the story.
- Page 43: You incorrectly claim that Hurricane Katrina killed 16,000 people. That number is wildly inaccurate. The actual number is 1,833 deaths, 89 percent fewer than claimed by Bloomberg (see <http://www.wunderground.com/hurricane/at2005.asp>).
- Page 50: You incorrectly insinuate that states have no prosecutorial power over insurance companies and also incorrectly state that the federal government has no oversight authority, leaving readers with the false impression that insurers operate in a regulatory vacuum and are free to do whatsoever they wish. The reality is that property/casualty insurers are among the most stringently regulated industries in the United States. Individual states do in fact have prosecutorial power over insurers, and insurance departments can levy fines and administrative sanctions. Insurers are also subject to federal oversight in a wide variety of areas, including antitrust.
- Page 52: Your entire article is dedicated to property/casualty insurance issues, but you then cite \$98 million in lobbying expenditures in 2006. This figure includes the lobbying activities of health insurers and life insurers, both of which are much larger than the property/casualty segment. Your article therefore provides erroneous and exaggerated information since it inaccurately includes lobbying activities unrelated to those that are the subject of your article.
- Page 52: Your assertion that the federal flood insurance program "*...helped the insurance industry increase profits by 25 percent in 2005*" is flat out wrong. The performance of the private insurance industry is (and has always been) entirely independent of the federal flood program's finances and exposure. Whether the flood program pays \$0 in claims or \$100 billion has no impact on insurers. Since 1968 the National Flood Insurance Program (NFIP) has offered subsidized flood insurance coverage to people living in flood-prone areas. This is not a market insurers have ever participated in and consequently insurers have never charged a dime in premium for flood-related losses. How the authors manage to attribute a 25 percent increase in profits to an independent federal insurance program for which private insurers collect no premium is beyond my understanding, other than the likelihood that the authors simply do not understand how the federal flood program operates.

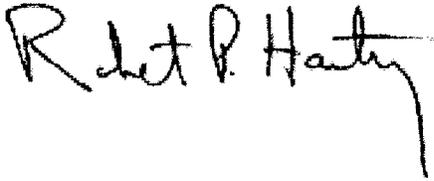
The gross errors detailed above are very damaging to the story's premise that insurers routinely pay just a fraction of a claim's true value. Not only is the allegation wrong, but the facts that allegedly prove it are wrong. Bloomberg, quite frankly, should be embarrassed to have its otherwise good name and reputation associated with this shoddy piece of journalism. It is clear that the only "hoax" perpetrated here is the repeated misrepresentation of truth throughout your article, most which is based on unsubstantiated assertions, anecdote and error-strewn calculations.

Mr. Ronald Henkoff
August 15, 2007
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We believe that the *Bloomberg Markets* article's blanket indictment of an entire industry is fatally flawed and fraught with factual errors that do a disservice to your readers and the reputation of the Bloomberg organization. It is appropriate to arrange an in-person meeting between you, Insurance Information Institute member companies mentioned in the article and myself in the very near future. We also would like you to refer our concerns to the magazine's ombudsman or public editor. If you do not have one, we should jointly explore seeking an analysis by an unbiased third party. Please contact me as soon as possible so we can make arrangements with our members to meet with you and your staff for a frank, honest and constructive discussion of the unsupported allegations made in your magazine.

If you have any questions or comments, please feel free to call me at 212-346-5520 or to email me at bobh@iii.org.

Sincerely,

A handwritten signature in black ink that reads "Robert P. Hartwig". The signature is written in a cursive style with a long, sweeping tail on the letter "y".

Robert P. Hartwig, Ph.D., CPCU
President

DRAFT Proposed Resolution for Consideration by ALEC

**RESOLUTION OPPOSING UNFAIR AND UNBALANCED INSURANCE
“BAD FAITH” LEGISLATION**

This resolution is responsive to efforts by the plaintiff’s bar, represented by the Association of American Justice (formerly the Association of Trial Lawyers of America) and its state-level affiliates, to enact legislation that undermines settled principles of contract law by unreasonably expanding the liability of insurance companies for so-called “bad faith” in claims handling and processing. These efforts seek to create new or expansive private causes of action, lower existing viable and fair standards that need to be met in order to file an action, and allow for recovery of additional penalties, including damages multipliers, punitive damages and one-way attorneys’ fees. The plaintiffs’ bar has been successful in getting such legislation passed in a few states and has actively advocated for passage in many more.

PURPOSE: Urging state legislatures to adhere to traditional principles of contract law and oppose unfair and unbalanced legislation designed to create new or expansive private causes of action, dilute existing standards for so-called “bad faith” insurance claims handling, and provide for recovery of new extra-contractual damages, including damages multipliers, punitive damages and one way awards of attorneys’ fees.

WHEREAS, some state legislatures have enacted laws unreasonably expanding the ability of insureds and claimants to recover damages from insurers in excess of contractual remedies for so-called “bad faith” or allegedly unfair practices in handling and settling insurance claims.

WHEREAS, several other state legislatures have actively considered such legislation.¹

WHEREAS, such legislation frequently creates new or expansive private causes of action for first-party insureds and/or third-party claimants where none previously existed, and lowers viable and fair existing standards required to be met in order to bring a private action.

WHEREAS, any standard for “bad faith,” whether statutory or at common law, should, at a minimum, reflect the ordinary and common-sense meaning of the term which includes an element of intentional or reckless insurer conduct.

WHEREAS, the majority of jurisdictions which allow a cause of action under common law or statute apply a reckless or intentional conduct standard to so-called “bad faith” insurer actions.

¹ In 2009, bad faith bills were introduced in the following jurisdictions: Colorado (SB-103), Connecticut (SB-763), Florida (S-962), Georgia (HB-450), Iowa (SSB-1137), Maine (LD-1305), Montana (HB-345), New Mexico (SB-157), Nevada (AB-224), New Jersey (S-132), New York (A-3698), Oregon (HB-2791), Pennsylvania (SB-746), Rhode Island (H-5196), and Washington, DC (B18-103).

WHEREAS, legislation which creates or heightens extra-contractual damages that are punitive in nature, such as a damages multiplier, regulatory penalty, interest penalty, or express provision to allow punitive damages, would be unfair and unreasonable where the insurer conduct was not malicious or otherwise intentional.

WHEREAS, legislation to provide additional penalties such as attorneys fees, expert fees or court costs would be unfair and unreasonable where the insurer conduct was not malicious or otherwise intentional.

WHEREAS, legislation should not impose one-way attorney fee shifting.

WHEREAS, a strong presumption should exist that unjust insurer actions should and can be effectively remedied by the action of state regulatory authorities acting under and according to statutes passed by the legislature.

WHEREAS, state statutes and regulations already can and do establish procedures that provide necessary safeguards and remedies for the proper protection of insurance consumers.²

WHEREAS, unwarranted expansion of insurer liability for bad faith and unfair claims practices through the creation of new or expansive tort causes of action can be expected to result in an unnecessary and significant increase in the frequency of litigation.

WHEREAS, unwarranted expansion of insurer liability for bad faith and unfair claims practices through the creation of new or expansive tort causes of action puts improper pressure on the claims settlement process, thereby hindering insurers' ability to detect, investigate and deny fraudulent claims, and potentially leading to the payment of meritless claims.³

WHEREAS, unwarranted expansion of insurer liability for bad faith claims practices is likely to result in both larger damage payments and higher settlement values.

WHEREAS, the resulting increase in the volume of litigation, the payment of meritless claims, and unreasonably high damage awards and settlement values can be expected to produce costs that will inevitably be passed on to insureds and other consumers of insurance services.⁴

² The National Association of Insurance Commissioners' model law governing insurance claim practices, which is adopted by the vast majority of state jurisdictions, states a clear intent for exclusive state regulatory enforcement by providing that the Act "is inherently inconsistent with a private cause of action." UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 1, *reprinted in* NAT'L ASS'N OF INS. COMM'RS MODEL LAWS, REGULATIONS AND GUIDELINES 900-01 (1991).

³ See *First-Party Insurance Bad Faith Liability: Law, Theory, and Economic Consequence*, National Association of Mutual Insurance Companies, at www.namic.org/insbriefs/080926BadFaith.pdf (finding evidence suggesting that "allowing tort liability for insurance bad faith results in reduced insurer incentives to challenge disputable claims, and in higher claims costs as a result").

⁴ See *The Impact of First-Party Bad Faith Legislation on Homeowners Insurance Claim Trends in Washington State: Interim Findings*, Insurance Research Council, April 2009 (estimating that bad faith

THEREFORE, BE IT RESOLVED, that the American Legislative Exchange Council opposes insurer “bad faith” legislation that undermines or whose purpose is to undermine the settled law of contracts, expand the liability of insurers by creating new or expansive private rights of action, lower statutory standards required to bring actions, and/or provide for recovery of unwarranted extra-contractual damages.

BE IT FURTHER RESOLVED, that the American Legislative Exchange Council supports efforts to improve the landscape of so-called “bad faith” laws through clarity in statutory standards and reduction of improper litigation or excessive awards, and strongly opposes legislation that would unreasonably and unfairly expand “bad faith” laws under principles set forth in this Resolution.

legislation enacted in December of 2007 may have increased homeowners insurance claim costs in the first three quarters of 2008 by \$58 million).

JENNIFER M.
GRANHOLM
GOVERNOR

STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE
REGULATION
DEPARTMENT OF ENERGY, LABOR & ECONOMIC
GROWTH
STANLEY "SKIP" PRUSS, DIRECTOR

KEN ROSS
COMMISSIONER

OFIR Orders Insurance Company to Stop Doing Business in State

FOR IMMEDIATE RELEASE

August 18, 2009

Contact: Jason Moon 517-335-1700

LANSING - The Office of Financial and Insurance Regulation (OFIR) has ordered Novus Centuriae, Inc., a fraudulent insurance company incorporated in the Island of Nevis in the Caribbean, to immediately cease and desist from the sale of any line of insurance in Michigan. Novus violated the Michigan Insurance Code by selling fraudulent certificates of surplus lines of insurance to Michigan companies and consumers.

"Any Michigan consumer or company that purchased insurance policies from Novus needs to get proper coverage immediately," OFIR Commissioner Ken Ross said.

Consumers can contact OFIR to find out if a company is licensed to sell insurance in Michigan. OFIR can be contacted by calling (877) 999-6442 or through its website www.michigan.gov/ofir.

Failure to comply with OFIR's order will subject Novus to one or more of the following:

- A civil penalty of not more than \$1,000 for each violation, not to exceed a total of \$30,000.
- A civil penalty of not more than \$25,000 for each knowing violation, not to exceed an aggregate civil fine of \$250,000.
- Complete restitution to all persons in the state damaged by the violation.

To view OFIR's order, visit:

http://www.michigan.gov/documents/dleg/Novus_Centurie_Inc_Cease_and_Desist_288409_7.pdf

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JENNIFER M.
GRANHOLM
GOVERNOR

STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE
REGULATION
DEPARTMENT OF ENERGY, LABOR & ECONOMIC
GROWTH
STANLEY "SKIP" PRUSS, DIRECTOR

KEN ROSS
COMMISSIONER

OFIR Charges Insurance Company, Agency with Selling Fraudulent Health Policies

FOR IMMEDIATE RELEASE

August 3, 2009

Contact: Jason Moon 517-335-1700

LANSING - The Office of Financial and Insurance Regulation (OFIR) has ordered American Consumers Insurance (ACI), an entity claiming to be a legitimate health carrier and Real Benefits Association (RBA), an entity claiming to be a legitimate insurance agency to immediately cease and desist from the sale of any line of insurance in Michigan. The entities violated the Michigan Insurance Code by selling fraudulent health insurance policies and doing business without an insurance agency license.

"Any Michigan consumer who purchased health policies from these companies needs to get proper coverage immediately," OFIR Commissioner Ken Ross said. "Consumers should not hesitate to contact our office if they have a complaint against an insurance company, agency or agent."

RBA has locations in Arkansas, New Jersey and New York. Consumers can contact OFIR to find out if an agency is licensed to sell insurance in Michigan. OFIR can be contacted by calling (877) 999-6442 or through its website www.michigan.gov/ofir.

Failure to comply with OFIR's order will subject ACI and RBA to one or more of the following:

- A civil penalty of not more than \$1,000 for each violation, not to exceed a total of \$30,000.
- A civil penalty of not more than \$25,000 for each knowing violation, not to exceed an aggregate civil fine of \$250,000.
- Complete restitution to all persons in the state damaged by the violation.

To view OFIR's order, visit:

http://www.michigan.gov/documents/dleg/Real_Benefits_Assc._American_Consumers_Insurance_-_Order_to_Cease_and_Desist_287429_7.pdf

