HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 837	**FINAL HOUSE FLOOR ACTION:**	
SUBJECT/SHORT TITLE	Insurer Insolvency	117 **Y's** 0 **N's**	
SPONSOR(S):	Commerce Committee; Insurance & Banking Subcommittee; Raburn	**GOVERNOR'S ACTION:**	Approved
COMPANION BILLS:	CS/CS/SB 730		

SUMMARY ANALYSIS

CS/CS/HB 837 passed the House on April 26, 2017, and subsequently passed the Senate on May 3, 2017.

The bill amends various provisions of part I of ch. 631, F.S., governing insurer rehabilitation and liquidation in Florida. Many of the revisions are based upon portions of the National Association of Insurance Commissioners (NAIC) Insurer Receivership Model Act (IRMA).

Among its many provisions, the bill:

- Extends reciprocity in the administration of receiverships to states that have adopted the IRMA.
- Revises the requirements related to delinquency proceedings to update the list of guaranty associations that must receive notice of hearings; clarify the court's jurisdiction over assets of the insurer; provide a conflict of laws provision; establish timeframes for initiating proceedings; clarify that the automatic stay during the pendency of the proceeding does not apply to the Office of Insurance Regulation; specify contracts that may be assumed or rejected by the Department of Financial Services (DFS) and its authority for paying expenses; clarify the authority of the insurer's management subsequent to a liquidation; and specify what defenses may be raised against the DFS and the form of required evidence to assert a defense.
- Revises claim filing procedures to allow the court to approve alternatives and to allow the court to establish a filing deadline.
- Disallows claims for postjudgment interest.
- Revises the priority of claims to add claims for expenses incurred during administrative supervision and for medical providers, and revises the methodology for calculating interest allowed on claims.
- Revises the procedures applicable to early access distributions to guaranty funds.
- Establishes the process for administering workers' compensation large deductible policies during an insolvency proceeding.

The bill does not appear to have a fiscal impact on state or local government.

The bill was approved by the Governor on June 23, 2017, ch. 2017-143, L.O.F., and will become effective on July 1, 2017.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Part I of ch. 631, F.S., relates to insurer insolvency and governs the receivership process for insurance companies in Florida. Federal law specifies that insurance companies cannot file for bankruptcy.[1] Instead, they are either "rehabilitated" or "liquidated" by the state. In Florida, the Division of Rehabilitation and Liquidation of the Department of Financial Services (DFS) is responsible for rehabilitating or liquidating insurance companies.[2] This process involves the initiation of a delinquency proceeding and the placement of an insurer under the control of the DFS as the receiver. The typical causes of insurer insolvency include undercapitalization, uncollectible or inflated assets, insufficient loss reserves for risks assumed, fraudulent transactions, failure to monitor agents, and mismanagement by directors and/or officers.[3]

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Reciprocity (Section 1)

The purpose of the statement of reciprocity is to provide standards for the administration of an insolvency which affects policyholders in more than one state and to better assure interstate cooperation, consistency, and efficiency in the administration of a receivership. Under current law, Florida extends reciprocal treatment of policyholders who are affected by a receivership to those states which have enacted, in substance and effect, the NAIC Rehabilitation and Liquidation Act or the Uniform Insurers Liquidation Act.[4] The IRMA is a more recent model act drafted by the NAIC which some states have adopted.

Effect of the Bill on Reciprocity

The bill amends current law to extend reciprocity to states that have adopted the IRMA.

Delinquency Proceedings (Sections 2 - 5)

A delinquency proceeding is a proceeding commenced against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving the insurer.[5] The circuit court in Leon County has jurisdiction over delinquency proceedings. Once an order of conservation, rehabilitation, or liquidation is issued, the court has exclusive jurisdiction over the property of the insurer.[6]

Current law requires the Office of Insurance Regulation (OIR) to notify the DFS upon a determination that one or more grounds for the initiation of delinquency proceedings exist.[7] The OIR must provide the DFS with evidence and documentation of the delinquency. The DFS may initiate a delinquency proceeding by filing a petition with the court for an order directing the insurer to show cause why the relief (such as rehabilitation or liquidation) should not be granted.[8] The DFS has noted periods of

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[1] The Bankruptcy Code expressly provides that "a domestic insurance company" may not be the subject of a federal bankruptcy proceeding. 11 U.S.C. § 109(b)(2). The exclusion of insurers from the federal bankruptcy court process is consistent with federal policy generally allowing states to regulate the business of insurance. See 15 U.S.C. § 1012 (McCarran-Ferguson Act).

[2] Typically, insurers are put into liquidation when the company is insolvent whereas insurers are put into rehabilitation for numerous reasons, one of which is an unsound financial condition. The goal of rehabilitation is to return the insurer to a sound financial condition. The goal of liquidation, however, is to dissolve the insurer. *See* s. 631.051, F.S., for the grounds for rehabilitation and s. 631.061, F.S., for the grounds for liquidation.

[3] Department of Financial Services, Agency Analysis of 2017 House Bill 837, p.2 (Feb. 20, 2017).

[4] s. 631.015, F.S.

[5] s. 631.011(6), F.S.

[6] s. 631.021, F.S.

[7] s. 631.031, F.S.

[8] s. 631.031(2), F.S.

extended delay in some cases where the insurer does not respond or the court does not hold a hearing.[9]

Once the DFS files an application or a petition for an order to show cause, the law provides for an automatic stay against all parties, except the DFS.[10] The stay prohibits legal proceedings and other actions against the insurer, its assets, or its property, thereby preserving assets for distribution through the insolvency proceeding. Courts have differed over whether the stay operates against the OIR when, in its capacity as a regulator, it pursues an administrative action against an insurer. This confusion has led to delays in necessary proceedings.[11]

The law requires the DFS to give notice to the Florida Insurance Guaranty Association, the Florida Workers' Compensation Insurance Guaranty Association, and the Florida Life and Health Guaranty Association of all hearings that pertain to the adjudication of a member insurer.[12]

Effect of the Bill on Delinquency Proceedings

The bill adds the Florida Health Maintenance Organization Consumer Assistance Plan to the list of guaranty associations that must be given notice of hearings related to a delinquency proceeding. A guaranty association generally is a not-for-profit corporation created by law and directed to protect policyholders from financial losses and delays in claim payment and settlement due to the insolvency of an insurance company. A guaranty association accomplishes its mission by assuming responsibility for settling claims and refunding unearned premiums to policyholders. Insurers are required by law to participate in guaranty associations as a condition of transacting business in Florida.

The bill updates the jurisdiction of the court to expressly include assets that may be located in another state.

The bill adds a conflict of laws provision that states ch. 631, F.S., prevails in the event of a conflict with another law. In a related provision, the bill expressly states that all officers, directors, and managers of the insurer are discharged except as provided by the DFS. This resolves a conflict with other statutes relating to the dissolution of business entities.

The bill requires an insurer subject to an order to show cause to file a response to the order, together with any defenses it may have, no later than 20 days after service of the order to show cause. The response must be filed at least 15 days before the date of the hearing set by the order to show cause. The hearing to determine whether cause exists for the DFS to be appointed receiver must be commenced within 60 days. This will help to minimize unnecessary delay in the proceedings.

The bill allows the DFS to assume or reject any executory contract or unexpired lease of the insurer and allows the DFS to pay any expenses under contracts, leases, employment agreements, or other arrangements entered into by the insurer before receivership. These provisions are from sections 114 and 116 of the IRMA. They give the DFS the flexibility to review contracts and other obligations and determine how to proceed based on the best interest of the receivership.

The bill clarifies that the OIR is not subject to the automatic stay. This eliminates any confusion regarding the OIR's authority to continue acting in its capacity as a regulator while a proceeding is pending.

Actions by and Against the Receiver (Sections 7 - 8)

[9] Department of Financial Services, Agency Analysis of 2017 House Bill 837, p.4 (Feb. 20, 2017).
[10] s. 631.041, F.S.
[11] Department of Financial Services, Agency Analysis of 2017 House Bill 837, p.3 (Feb. 20, 2017).
[12] s. 631.021(3), F.S.

The DFS steps into the shoes of the insurer in receivership[13] and often pursues litigation to recover assets of the receivership estate. Current law does not address whether the actions or inactions of the insurer, or conduct of the OIR (for example, in failing to identify conduct of the insurer that led to the delinquency proceeding) may be asserted as a defense against a claim by the DFS. For example, there have been cases where the insurer's managers set up a scheme to issue high-risk policies without sufficient funds to cover claims. When the insurer became insolvent, the liquidator sued auditors for negligently failing to discover the scheme. The auditors argued that the liquidator (receiver), who stands in the shoes of the insurer, cannot prevail because the misdeeds of the insurer's management should be imputed to the liquidator (receiver).[14]

In addition, the law currently does not specify what evidence is required for certain parties to assert a defense or claim against the DFS. As a result, defenses and claims that are not recorded in the books and records of the insurer or reported on the insurer's financial statements that are given to the OIR are often raised for the first time during litigation.[15]

<u>Effect of the Bill on Actions by and Against the Receiver</u>

Section 112 of the IRMA prohibits third parties from raising insurer management misconduct as a defense to a claim by the receiver. It also disallows a defense based on the action or inaction of an insurance regulatory authority. The bill adopts Section 112 of the IRMA. The bill does not bar a third party from raising a defense that the conduct was materially and substantially related to the contractual obligation for which enforcement is sought. This will limit the ability of third parties to avoid contractual obligations based on improper conduct by, for example, officers of the insurer that is unrelated to the contractual obligation.

The bill provides that a prior wrongful or negligent action of any present or former officer, manager, director, trustee, owner, employee, or agent of the insurer may not be asserted as a defense to a claim by the receiver. However, the affirmative defense of fraud in the inducement may be asserted against the receiver in a claim based on a contract. Evidence of fraud in the inducement is admissible only if it is contained in the records of the insurer. These provisions will make it easier, for example, for the DFS to bring claims of professional negligence against accountants or auditors that should have discovered the insurer's insolvency earlier.

Section 113 of the IRMA requires evidence of claims or defenses raised by certain parties other than the receiver to be recorded in the books or records of the insurer or reported in the financial statements provided to the insurance regulatory authority. The bill adopts Section 113 of the IRMA.

The bill clarifies that claims brought by the DFS based on unrecorded or unreported transactions of the insurer are not barred.

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[13] This is based on the theory of *in pari delicto*, which is a doctrine of law that holds that a receiver stands in the shoes of dishonest or fraudulent officers and director, whose bad acts are imputed to the receiver. The DFS cites multiple cases where the issue has been raised successfully and unsuccessfully against receivers.

[14] *Thaubalt v. Chait*, 541 F.3d 512, 528 (3rd Cir. 2008); *Schacht v. Brown*, 711 F.2d 1343 (7th Cir. 1982).

[15] Department of Financial Services, Agency Analysis of 2017 House Bill 837, p.4 (Feb. 20, 2017).

Claim Filing (Section 9)

The law generally requires claimants to file a proof of claim with the DFS before receiving a distribution from the estate.[16] However, there are some situations, such as returning unearned premium, where the DFS can determine the claim without the need to require a claimant to submit proof.[17] A delinquency proceeding under ch. 631, F.S., is in equity.[18] As such, the court has allowed the deem filing of certain claims when it is in the best interests of the claimant; however, there is no specific statutory authority for this practice.

The law contemplates claims that are timely and claims that are late-filed. The statutes are silent, however, on whether or not the DFS can establish a date after which no additional claims may be filed. The DFS reports instances where claims have been allowed many years after the receivership was initiated, resulting in delay in the distribution of assets and closure of the estate.[19]

Effect of the Bill on Claim Filing

The bill authorizes the court to allow alternative procedures and requirements for claim filing and proof of claims. This is consistent with section 701 of the IRMA. This enables the DFS to expedite claims payment in these circumstances.

The bill authorizes the DFS to petition the court to set a date before which all contingent or unliquidated claims are final and to set a claim filing deadline. This allows for greater finality in the resolution of a receivership.

Workers' Compensation Large Deductible Workers' Compensation Policies (Section 10)

Some employers use what is referred to as a large deductible workers' compensation policy to fulfill workers' compensation insurance requirements. Under a large deductible policy, the insurance carrier is obligated to pay the claim in full; however, the carrier seeks reimbursement from the employer for the deductible amount for each claim. Employers provide collateral to secure the payment of the deductible. Employers use these policies to obtain lower premiums from the carrier. Issues have arisen over how to disburse the collateral used to secure the payment of large deductible claims and how to deal with large deductible policies when a company is placed in receivership. The NAIC has released a draft study regarding large deductible workers' compensation policies. The study recommends that states enact legislation that governs the rights and duties of the various parties regarding deductible claims in insolvencies.[20]

Effect of the Bill on Large Deductible Workers' Compensation Policies

The bill implements the recommendation of the NAIC study by creating a definition of "large deductible policy"; establishing a procedure for dealing with large deductible claims of an insolvent insurer; and specifying the rights and responsibilities of the guaranty association and the DFS in handling claims that are within the fund's deductible amount. In effect, the bill clarifies that these claims are to be paid from the collateral provided by the policyholder to fund the deductible. If the collateral is insufficient and the guaranty association pays the claim, then the guaranty association is entitled to assert a claim for reimbursement in the delinquency proceeding. If the claim was paid by the insurer prior to the delinquency proceeding, then the DFS is authorized to seek reimbursement from the collateral.

Allowance of Claims (Section 11)

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[16] s. 631.181, F.S.
[17] Department of Financial Services, Agency Analysis of 2017 House Bill 837, p.4 (Feb. 20, 2017).
[18] s. 631.021(1), F.S.
[19] Department of Financial Services, Agency Analysis of 2017 House Bill 837, p.4 (Feb. 20, 2017).
[20] NAIC, *2016 Workers' Compensation Large Deductible Study*, p.2, (http://www.naic.org/documents/committees_c_wctf_naic_iaiabc_exposure_wc_study_combined.pdf) (last visited Mar. 15, 2017).

Generally, a claim based on an insurance contract is allowed only if the covered event occurred prior to the date of liquidation. The statute is silent with respect to claims for postjudgment interest that accrues after the liquidation date.

Effect of the Bill on Allowance of Claims

The bill disallows claims for postjudgment interest that accrues after the order for liquidation is entered.

Claim Priority (Section 12)

Current law establishes the priority of distribution of claims from an insurer's estate.[21] Claims are categorized into classes and every claim in each class must be paid in full or adequate funds must be retained for such payment before the members of the next class can receive any payment. The priority schedule is comprised of eleven classes of claims. In essence, claims are paid in the following order for: 1) administrative expenses; 2) policyholder losses; 3) unearned premiums; 4) claims of the Federal government; 5) debts due to employees; 6) claims of general creditors; 7) claims of state or local governments; 8) late filed claims; 9) surplus or similar obligations and premium refunds on assessable policies; 10) interest on allowed claims of Classes 1 through 9; and 11) claims of shareholders or other owners.

Effect of the Bill on Claim Priority

The bill adds the following:

- Class 1: Costs and expenses incurred by a deputy supervisor as a result of administrative supervision under part VI of ch. 624, F.S.
- Class 2: Claims by medical providers related to a patient's healthcare coverage.

In addition, the bill revises how the rate of interest as set forth in Class 10 will accrue and be calculated. By creating express authority to pay claims for medical providers, the bill resolves a disparity attributable to past litigation that has resulted in the DFS paying claims related to insolvent health insurers as Class 2 claims and claims of insolvent health maintenance organizations as Class 6 claims.[22]

Miscellaneous Provisions (Sections 6, 13 - 15)

The bill:

- Conforms a cross-reference.
- Expands the duty of specified managers, employees, and other persons with executive authority to cooperate with the DFS to include former managers and employees and provides a definition of "person" to include one who has direct or indirect control through a holding company.
- Specifies that the DFS will provide original records, not copies, as may be required to the relevant guaranty fund.
- Eliminates the notice requirement to other states' insurance commissioners as a precondition to early access distributions and the 120-day deadline for distributions. Early access distributions are made to the relevant guaranty fund. By eliminating the notice, the bill expedites distributions for payment of policyholder claims.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

[21] s. 631.271, F.S.
[22] Department of Financial Services, Agency Analysis of 2017 House Bill 837, pp.3-4 (Feb. 20, 2017).

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The DFS does not anticipate any increase in revenues as a result of the bill.

2. Expenditures:

   The DFS does not anticipate any increase or decrease in expenditures as a result of the bill. Current law permits expenses of the DFS as receiver to be reimbursed as Class 1 claims.[23] Thus, the DFS' costs are generally recoverable. The bill adds costs and expenses of administrative supervision incurred by the deputy supervisor appointed by the OIR under part VI of ch. 624, F.S., to be reimbursed as Class 1 claims, as well. Thus, the OIR may see a reduction in its expenditures.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Many provisions of the bill are intended to improve the efficiency and efficacy of solvency proceedings. Thus, the bill may increase the amount of assets that are available for distribution from an estate because more assets are collected and with less expense. By prohibiting certain claims for postjudgment interest, the bill may also increase the overall amount of assets that are available for distribution, or available for distribution to policyholders and other creditors above Class 6. Health care providers and health care facilities that have treated subscribers of an HMO that becomes insolvent will benefit from the provision of the bill that raises their claims from Class 6 (claims of a general creditor) to Class 2 (claims of a policyholder).

D. FISCAL COMMENTS:

None.

[23] s. 631.271(1)(a), F.S.