The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on General Government

BILL:	CS/SB 730
INTRODUCER:	Banking and Insurance Committee and Senator Passidomo
SUBJECT:	Insurer Insolvency
DATE:	March 28, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Fav/CS**
2.	Sanders	Betta	AGG	**Pre-meeting**
3.			AP	
4.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 730 amends Florida's Insurer's Rehabilitation and Liquidation Act to include various provisions from the National Association of Insurance Commissioners' "Insurer Receivership Model Act." The bill:

- Adds the Florida Health Maintenance Organization Consumer Assistance Plan to the list of organizations to which notice of hearings shall be delivered pertaining to the insolvency of a member insurer;
- Provides exclusive jurisdiction to the Circuit Court of Leon County over all assets and property of an insurer in receivership, regardless of whether such assets or property are located in or out of Florida;
- Creates deadlines for written responses from an insurer subject to an order to show cause pursuant to ch. 631, F.S., and establishes a deadline for commencement of a hearing to determine whether cause exists for the Department of Financial Services (DFS) to be appointed receiver;
- Exempts the Office of Insurance Regulation (OIR) from the automatic stay provisions;
- Provides that the DFS may assume or reject unexpired leases or executory contracts of an insurer and pay expenses during the pendency of a receivership under contracts, leases, and other arrangements entered by insurers before commencement of the receivership;
- Provides that officers, directors, and managers, of a liquidated insurer are discharged of authority except as may be delegated by the DFS;

- Limits certain defenses which may be raised by third parties in actions brought by or against the DFS in its capacity as receiver;
- Limits third parties from asserting or raising obligations, claims, and defenses, which were not recorded in the records of the insurer in receivership, with certain exceptions;
- Allows the court more flexibility in approving procedures for the "deem filing" of claims, or claims where the DFS deems a claim filed and can distribute funds, such as a refund of unearned premium, to the claimant without the need of a formal claim;
- Allows the court to set a deadline for the filing of claims;
- Disallows claims for post-judgment interest accrued after the liquidation date;
- Creates a process for administering large deductible workers' compensation policies and the collateral for large deductible workers' compensation policies;
- Adds all costs and expenses related to administrative supervision to Class 1 of the priority of claims to be paid in distribution;
- Adds claims related to healthcare coverage by physicians, hospitals, and other providers of a health insurer or health maintenance organization to Class 2 of the priority of claims to be paid in a distribution;
- Adds claims of residents which arise out of a continuing care contract to Class 2 of the priority of claims to be paid in a distribution;
- Adds claims of certain creditors, including claims for punitive damages, bad faith, or wrongful settlement practices to Class 6 of the priority of claims to be paid in a distribution; and
- Removes certain notice requirements related to early access distributions to guaranty associations.

The bill does not affect state revenues or expenditures.[1]

The bill has an effective date of July 1, 2017.

II. Present Situation:

Receivership is a judicial proceeding in which the Department of Financial Services (DFS) is placed in control of the insurer for the purpose of rehabilitating or liquidating the insurer. The DFS may seek to be appointed receiver[2] through a delinquency proceeding in court for the purpose of rehabilitating an impaired insurer or, if appropriate, liquidating the insolvent company. The primary goal of rehabilitation is to restore the financial solvency of the insurer[3] while the primary goal of liquidation is to secure and maximize the assets of the insolvent company for the benefit of its policyholders.[4] Over the years, the National Association of

[1] Office of Insurance Regulation, *Bill Analysis of SB 730* (March 6, 2017) (on file with Appropriations Subcommittee on General Government).
[2] The DFS Division of Rehabilitation and Liquidation acts as receiver when the DFS is appointed. *See* http://www.myfloridacfo.com/Division/Receiver/.
[3] *See* http://www.myfloridacfo.com/Division/Receiver/SummaryofRehabilitationunderChapter631PartIFloridaStatutes.htm (last accessed March 22, 2017).
[4] *See* http://www.myfloridacfo.com/Division/Receiver/LiquidationSummary.htm (last accessed March 22, 2017).

Insurance Commissioners (NAIC) has drafted various model laws to govern insurer insolvency.[5] The NAIC adopted the Insurer Receivership Model Act in 2005.[6]

This bill amends various provisions of part I of ch. 631, F.S., governing insurer rehabilitation and liquidation in Florida. Many of the revisions are to adopt portions of the NAIC Insurer Receivership Model Act (Model Act).

Delinquency Proceedings

A delinquency proceeding is a proceeding commenced against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving the insurer.[7] The Circuit Court in Leon County has jurisdiction over delinquency proceedings.[8] Florida law provides for various guaranty associations to protect policyholders in the event an insurer becomes insolvent. Insurers are generally required to be members of the associations related to their lines of business. The DFS must give notice of all hearings pertain to the adjudication of a member insurer to the Florida Insurance Guaranty Association, the Florida Workers' Compensation Insurance Guaranty Association, and the Florida Life and Health Guaranty Association.

Section 631.031, F.S., governs the initiation of delinquency proceedings. It 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. The OIR must provide the DFS with evidence and documentation of the delinquency. The DFS may commence a proceeding by application to the court for an order directing the insurer to show cause why the relief (such as rehabilitation or liquidation) should not be granted. The DFS has noted periods of 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, s. 631.041, F.S., provides for an automatic stay. The stay prohibits:

- The commencement or continuation of judicial, administrative, or other action or proceeding against the insurer or against its assets;
- The enforcement of a judgment against the insurer obtained either before or after the commencement of the delinquency proceeding;
- Any act to obtain possession of property of the insurer;
- Any act to create, perfect, or enforce a lien against property of the insurer with specified exceptions;
- Any act to collect, assess, or recover a claim against the insurer; and
- The setoff or offset of any debt owing to the insurer with specified exceptions.[10]

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[5] Prior model acts include the Uniform Insurers Liquidation Act and the Rehabilitation and Liquidation Model Act. *See* https://www.irmi.com/articles/expert-commentary/insurer-insolvency-and-reinsurance (last accessed February 28, 2017).
[6] *See* http://www.naic.org/store/free/MDL-555.pdf (last accessed March 22, 2017).
[7] Section 631.011(6), F.S.
[8] Section 631.021(1)-(3), F.S.
[9] Department of Financial Services, *Analysis of SB 730* (February 19, 2017) (on file with Senate Appropriations Subcommittee on General Government).
[10] Section 631.041(1), F.S.

The stay applies to all persons except the DFS. According to the DFS, there has been confusion over whether the stay applies to regulatory actions taken by the OIR.[11]

Actions by and Against the Receiver

Section 112 of the Model Act prohibits third parties from raising insurer management misconduct as a defense to a claim by the receiver. 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, who stands in the shoes of the insurer, cannot prevail because the misdeeds of the insurer's management should be imputed to the liquidator.[12] Section 112 of the Model Act prohibits such defenses.

Workers' Compensation Large Deductible Policies and Insured Collateral

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.[13]

Claim Priority

Section 631.271, F.S., sets the priority order in which claims against the receivership will be paid. Class 1 claims, the first claims paid, include the receiver's costs and expenses of administration and the expenses of guaranty associations in handling claims. It does not include costs and expenses of administrative supervision.[14]

In general, loss claims under health insurance are Class 2 claims.[15] The DFS considers medical provider claims in HMO receiverships to be Class 6 claims.[16]

Current law does not specify which class claims against insurers in excess of policy limits, such as bad faith or punitive damage claims, belong.[17] Courts have issued different rulings in different

[11] Department of Financial Services, *Analysis of SB 730* (February 19, 2017).
[12] *Thaubalt v. Chait*, 541 F.3d 512, 528 (3rd Cir. 2008); *Schacht v. Brown*, 711 F.2d 1343 (7th Cir. 1982).
[13] NAIC 2016 Workers' Compensation Large Deductible Study (http://www.naic.org/documents/committees_c_wctf_naic_iaiabc_exposure_wc_study_combined.pdf).
[14] The OIR can place an insurer in administrative supervision if it finds the insurer is in an unsound condition or other reasons. *See* s. 624.81, F.S. It may appoint a deputy supervisor to supervise the insurer during the period of administrative supervision. *See* s. 624.87, F.S.
[15] Section 631.271(1)(b), F.S.
[16] Department of Financial Services, *Bill Analysis of SB 730* (February 10, 2017) at p. 3-4.
[17] Department of Financial Services, *Bill Analysis of SB 730* (February 19, 2017) at p. 3.

cases with one court holding a bad faith claim is a Class 2 claim and another holding it is a Class 6 claim.[18]

III. Effect of Proposed Changes:

The bill makes various changes to ch. 631, F.S., relating to insurer insolvency, rehabilitation, and liquidation.

Section 1 amends s. 631.015, F.S., to provide that Florida will provide reciprocity in the treatment of policyholders in receivership with states that enact the NAIC Insurer Model Receivership Act.

Delinquency Proceedings

Section 2 amends s. 631.021, F.S., to require the DFS to give notice of hearings to the Florida Health Maintenance Organization Consumer Assistance Plan[19] that pertain to the insolvency of a member insurer. It provides that the Circuit Court in Leon County has exclusive jurisdiction over all insurer assets or property wherever located once it enters an order of rehabilitation or liquidation.[20] The bill also provides that ch. 631, F.S., constitutes the state's receivership laws, which prevail in any conflict with any other law.[21]

Section 3 amends s. 631.031, F.S., to require 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 directing an insurer to show cause.

Section 4 amends s. 631.041, F.S., to provide that the automatic stay does not apply to the OIR. This will allow OIR to continue to perform its regulatory role as necessary during a receivership.

Section 5 amends s. 631.141, F.S., to allow the DFS to assume or reject any executory contract or unexpired lease of the insurer and allow 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 Model Act and 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 section additionally provides that all officers, directors, and managers of the insurer are discharged except as provided by the DFS. This resolves any conflicts between ch. 631, F.S., and other statutes relating to the dissolution of business entities.

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[18] Department of Financial Services, *Bill Analysis of SB 730* (February 19, 2017) at p. 3.
[19] The Florida Health Maintenance Organization Consumer Assistance Plan is created to protect the subscribers of HMOs against the failure of the HMO to perform its contractual obligations due to its insolvency. *See* s. 631.812, F.S. HMOs are required to be members of the plan. *See* s. 631.815, F.S.
[20] The language in the bill is from section 105 of the Model Act.
[21] Section 102 of the Model Act.

Section 6 makes a technical change to s. 631.152, F.S.

Actions by and Against the Receiver

Section 7 creates s. 631.1521, F.S., to adopt the provisions of section 112 of the Model Act in Florida law. An allegation by the receiver of improper or fraudulent conduct against any person may not be the basis of a defense by a third party to the enforcement of a contractual obligation owed to the insurer. 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.

This section further 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 under a theory of estoppel, comparative fault, intervening cause, proximate cause, reliance, mitigation of damages, or otherwise. Section 7 further provides that 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.

Additionally, this section provides that an action or inaction by an insurance regulatory authority may not be asserted as a defense to a claim by the DFS. This will prevent, for example, an officer of the insurer from arguing that the OIR should have known of the insolvency sooner and taken steps to prevent it.[22]

Section 8 creates s. 631.1552, F.S., based on section 113 of the Model Act. It requires evidence of claims or defenses raised by certain parties other than the DFS to be recorded in the books or records of the insurer. This puts the DFS on notice of the possible claims or defenses. It provides that in a proceeding by the receiver against an affiliate, a controlled or controlling person, or a present or former officer, manager, director, trustee, or shareholder of the insurer may not assert any defense unless:

- Evidence of the defense was recorded in the books and records of the insurer at or about the time the events giving rise to the defense occurred; and
- Such events were timely reported on the insurer's official financial statements filed with the OIR, if required by statutory accounting practices and procedures.

The bill prohibits an affiliate, a controlled or controlling person, or a present or former officer, manager, director, trustee, or shareholder of the insurer from asserting any claim unless:

- The obligations were recorded in the books and records of the insurer at or about the time the obligations were incurred; and
- If required by statutory accounting practices and procedures, the obligations were reported on the insurer's official financial statements filed with the OIR.

[22] Such an argument was made, and rejected, in *Wooley v. Lucksinger*, 61 So.3d 507 (La. 2011).

In addition, this section does not bar claims based on unrecorded or unreported transactions by the receiver against any affiliate, controlled or controlling person, or a present or former officer, manager, director, trustee, or shareholder of the insurer.

Claim Filing

Section 631.181, F.S., generally requires claimants to file a proof of claim with the DFS before receiving a distribution from the estate. There are some situations, such as returning unearned premium, where the DFS can determine the claim without requiring a claimant to submit proof. **Section 9** amends s. 631.181, F.S., to allow the court to permit alternative procedures and requirements for claim filing and proof of claims. This is consistent with section 701 of the Model Act.

This section grants specific authority to the court to set a deadline for the filing of claims.

Administration of Workers' Compensation Large Deductible Policies

Section 10 amends s. 631.131, F.S., to create a process for administering large deductible workers' compensation policies and the collateral related to those policies. The section applies to delinquency proceedings that commence on or after July 1, 2017. The bill defines a "large deductible policy" as a combination of one or more workers' compensation policies and endorsements issued to an insured, and contracts or security agreements entered into between an insured and the insurer, in which the insured has agreed with the insurer to:

- pay directly the initial portion of any claim up to a specified dollar amount or the expenses related to any claim; or
- reimburse the insurer for its payment of any claim up to the specified dollar amount of the deductible.

As defined within this section, large deductible policy also includes those policies that contain an aggregate limit on the insured's liability for all deductible claims in addition to a per-claim deductible limit. This section provides guidelines and eligibility standards for large deductible workers' compensation filings as defined by DFS. In addition, this section provides that the term "large deductible policy" does not include:

- policies, endorsements, or agreements providing that the initial portion of any covered claim must be self-insured and that the insurer has no payment obligation within the self-insured retention; and,
- polices that provide for retrospectively rated premium payments by the insured or reinsurance arrangements or agreements unless such arrangements or agreements assume, secure, or pay the policyholder's large deductible obligations.

This section provides that a large deductible claim must be turned over to the guaranty association for handling. To the extent the insured funds or pays the deductible claim pursuant to an agreement by the guaranty fund, the insured's funding or payment of a deductible claim extinguishes the obligations of the DFS and any guaranty association to pay such claim.

This section provides that, if a guaranty association pays any deductible claim for which an insurer would have been entitled to reimbursement from an insured, a guaranty association is

entitled to the amount of reimbursements received or collateral available. If a guaranty association pays a deductible claim that is not reimbursed from collateral or by insured payments, the guaranty association is entitled to assert a claim for those amounts in the delinquency proceeding.

The section provides that the DFS may collect reimbursements owed for deductible claims. The DFS must use reasonable efforts to collect such reimbursements from the insured or the party that is obligated to pay the deductible as specified in the large deductible policy. The DFS may bill insureds and others for reimbursement of deductible claims that are:

- Paid by the insurer before the commencement of delinquency proceedings;
- Paid by a guaranty association upon receipt by the DFS of notice from a guaranty association of reimbursable payments; or
- Paid or allowed by the DFS.

The section provides that the receiver must take reasonable steps to collect any reimbursements owed if the insured or other party does not make payment within the time specified in the large deductible policy or within a reasonable time, after the date of billing, if no time is specified within the policy.

The section requires the DFS to use collateral, when available, to secure the insured's obligation to fund or reimburse deductible claims or other secured obligations or payment obligations. The guaranty association is entitled to collateral to the extent needed to reimburse a guaranty association for the payment of a deductible claim. The section requires the DFS to draw down collateral to the extent necessary if the insured fails to:

- Perform its funding or payment obligations under any large deductible policy;
- Pay deductible claim reimbursements within the time specified in the large deductible policy;
- Pay amounts due to the estate for preliquidation obligations;
- Timely fund any other secured obligation; or
- Timely pay expenses.

The section provides that claims that are validly asserted against the collateral must be satisfied in the order in which such claims are received by the DFS. If more than one creditor has a valid claim against the same collateral and the available collateral and other funds are together insufficient to pay each creditor in full, the DFS must prorate payments. Payments must be based upon the relationship the amount of claims each creditor has paid bears to the total of all claims paid by all such creditors. The bill provides that excess collateral may be returned to the insured.

The section allows the DFS to deduct from the collateral or from the deductible reimbursements reasonable and actual expenses incurred in connection with the collection of the collateral and deductible reimbursements.

Claim Priority

Section 12 amends s. 631.271, F.S., to provide that the deputy supervisor's costs and expenses of administration are Class 1 claims. All claims related to a patient's healthcare coverage by physicians, hospitals, and other providers of a health insurer or health maintenance organization are Class 2 claims. The bill provides that interest on allowed claims accrue from the date of

liquidation until the receivership court approves the distribution. The interest rate is the statutory rate calculated according to s. 55.03, F.S.

Miscellaneous Provisions

Section 11 amends s. 631.192, F.S., to provide that claims for postjudgment interest accrued after the date of liquidation are not allowed.

Section 13 amends s. 631.391, F.S., to require former officers, directors, managers, trustees, agents, adjusters, employees, independent contractors, or a controlling person of an insurer or affiliate to cooperate with the DFS or OIR in any proceeding under ch. 631, F.S., or any investigation preliminary or incidental to the proceeding.

Section 631.395, F.S., provides that an order of liquidation must direct the DFS to coordinate the operation of the receivership with the relevant insurance guaranty fund. The authorization must include authorization to release copies of claim files or other documents related to claims on file with the insolvent insurer. **Section 14** amends s. 631.395, F.S., to provide that the DFS may release the original documents to the guaranty fund.

Section 631.397, F.S., deals with "early access" distributions by the DFS to guaranty associations to allow the associations to begin paying claims without the need to assess member insurers. Current law requires the DFS to propose a plan to the court within 120 days of the determination of insolvency and give notice of the plan to other insurance commissioners at least 15 days before filing the plan with the court. **Section 15** amends s. 631.397, F.S., by eliminating the 120-day requirement and the notice to other insurance commissioners. In practice, the DFS coordinates early access distributions with the appropriate guaranty associations so the DFS believes the requirements are not necessary.[23]

Section 16 provides a July 1, 2017, effective date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[23] Department of Financial Services, *Bill Analysis of SB 730* at p. 6-7.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 730 does not affect state revenues or expenditures.[24]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 631.015, 631.021, 631.031, 631.041, 631.141, 631.152, 631.181, 631.191, 631.192, 631.271, 631.391, 631.395, and 631.397.

This bill creates the following sections of the Florida Statutes: 631.1521 and 631.1522.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on March 6, 2017:
The CS creates a process for administering large deductible workers' compensation policies and the collateral for large deductible workers' compensation policies. It also removes provisions from the bill prohibiting the payment of claims in excess of policy limits and provisions placing bad faith claims, punitive damages claims, and wrongful settlement practices claims in Class 6.

B. Amendments:

None.

[24] Office of Insurance Regulation, *Bill Analysis of SB 730* (March 6, 2017) (on file with Appropriations Subcommittee on General Government).