FINAL BILL ANALYSIS

BILL #: CS/HB 1007

FINAL HOUSE FLOOR ACTION:
115 Y's 0 N's

SPONSOR: Rep. Bernard

GOVERNOR'S ACTION: Approved

COMPANION BILLS: CS/CS/SB 1568

SUMMARY ANALYSIS

CS/HB 1007 passed the House on April 29, 2011, and subsequently passed the Senate on May 2, 2011. The bill was approved by the Governor on June 24, 2011, chapter 2011-226, Laws of Florida, and becomes effective July 1, 2011.

The bill provides coverage by the State Risk Management Trust Fund to specified officers and employees of the Department of Financial Services (DFS) for any liability under Federal law relating to priority of claims for any action taken by them in the performance of their receivership duties.

The bill changes the responsibilities of the Division of Rehabilitation and Liquidation within DFS. It authorizes DFS to be appointed an ancillary receiver to an out-of-state insurer when it is necessary to obtain records to adjudicate the covered claims of Florida policyholders. It also subjects individuals to liability for penalties, fines, or other costs assessed against a guaranty association or the receiver that result from the individuals' refusal or delay in providing records to DFS. The bill also requires the receiver of a title insurer in rehabilitation to file a rehabilitation plan that provides for certain policies to remain in force as well as to be cancelled in certain circumstances. When a title insurer is ordered into rehabilitation, all remaining title insurers are liable for an assessment to pay outstanding claims on the insurer's policies covering real property in Florida and associated administrative expenses. The bill also limits the subsequent involvement of persons serving in an official capacity with a financially troubled title insurer.

The bill amends provisions relating to the Florida Insurance Guaranty Association and the Florida Workers' Compensation Insurance Guaranty Association by redefining "covered claims" to exclude certain claims rejected by another state's guaranty fund. With respect to the board of directors of both these associations, the bill allows for the quick termination of a member who represents, or has a material relationship with, an insurer in receivership.

For another guaranty association, the Florida Life and Health Insurance Guaranty Association, the bill specifies that the association's current immunity from bad faith lawsuits does not affect the association's obligation to pay valid insurance policy or contract claims if warranted after its independent de novo review of the policies, contracts, and claims presented to it, whether domestic or foreign, after a Florida domestic rehabilitation or liquidation.

The bill makes two other changes. It allows an insurer to request that the State Board of Administration renegotiate the terms of a surplus note issued under the Insurance Capital Build-Up Incentive Program before January 1, 2011. It also expands the list of nationally recognized statistical rating organizations that may be utilized to provide a secure financial rating for insurance companies.

Regarding coverage provided by the State Risk Management Trust Fund, the bill should have a minimal fiscal impact.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Background:

Insurer Insolvency: Rehabilitation and Liquidation

Chapter 631, F.S., relates to insurer insolvency and guaranty payments 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 department as the receiver.

Rehabilitation

The receiver of an impaired insurer, as the rehabilitator, prepares a plan to assist an insurer to resolve its difficulties, and is responsible for taking actions necessary to correct the conditions that necessitated the receivership as the court may direct. Generally, the receiver suspends all powers of the company's directors, officers, and managers.

By statute and court order:

- The receiver is authorized to conduct all business of the insurer.
- The receiver may direct, manage, hire, and discharge employees.
- The receiver is authorized to manage the property and assets of the insurer as it deems necessary.
- The receiver may file for release of the company from receivership if rehabilitation efforts are successful and grounds for receivership no longer exist.

If the receiver determines that further attempts to rehabilitate the insurer are futile or if continued rehabilitation would increase the risk of loss to policyholders, the receiver may file for liquidation of the insurer.

Liquidation

When the DFS determines that a Florida-domiciled insurer is insolvent or is operating in a financially hazardous manner, it petitions the court for an order requiring the insurer to show cause why it should not be placed into liquidation.[3] If the insurer's board of directors either joins

[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] The grounds for liquidation are set forth in s. 631.061, F.S.

in the petition or consents, a liquidation order is issued appointing DFS as receiver to liquidate the insurer; otherwise, a hearing is held to determine whether the petition should be granted.

Under the court's supervision, the receiver as liquidator is charged with gathering (marshaling) the company's assets, converting them into cash, and distributing the cash to the insurer's claimants in accordance with the priority for claims payment established by statute.

After issuance of the liquidation order, the DFS takes possession of the insurer's offices, equipment, records and assets, and notice of the liquidation is sent to all potential claimants advising them of the liquidation and the process to follow to perfect their claim against the insurer's estate. All property and casualty insurance policies are cancelled within 30 days of the liquidation order.

After all assets have been converted to cash, claims prioritized and valued, and any objections to the valuation of claims resolved, the receiver will file a petition with the court asking for authority to distribute the cash according to the priority scheme in statute.

Payment of Claims

For insurance companies in liquidation, current law establishes the priority of distribution of claims from an insurer's estate.[4] 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 ten 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 creditors; 7) claims of state or local governments; 8) late filed claims; 9) surplus or similar obligations and premium refunds on assessable policies; and 10) claims of shareholders or other owners.

A significant problem has arisen over the years which has restricted the distribution of assets and closing of estates in receiverships. This has occurred because in these types of cases, the Federal Priority Statute [5] gives the United States government priority for payment above all other claims except policyholder level claims and administrative expenses.[6] Furthermore, Federal courts have decreed that the United States government is not subject to any claims filing deadline or statute of limitations.[7] The Federal Government can therefore file a claim in one of the estates at any time. If DFS as receiver does not have the funds to pay the claim because distribution has already been made on lower priority claims, the DFS officials performing the duties of the receiver can be held personally liable for the amount of the unpaid federal claim. Based upon this potential liability to individual DFS managers, DFS has been extremely cautious in paying claims below class 4 in any of their estates.

Overview of Title Insurance

Title insurance insures owners of real property (owner's policy) or others having an interest in real property against loss by encumbrance, defective title, invalidity, or adverse claim to title.[8]

[4] s. 631.271, F.S.
[5] 31 U.S.C. § 3713
[6] United States Department of Treasury v. Fabe, 508 U.S. 491 (1993)
[7] Ruthardt v. United States, 303 F.3d 375 (1st Cir. 2002).
[8] Section 624.608, F.S. Title insurance is also insurance of owners and secured parties of the existence, attachment, perfection and priority of security interests in personal property under the Uniform Commercial Code.

Title insurance is a policy issued by a title insurer that, after performing a search of title, represents the state of that title and insures the accuracy of its search against claims of title defects. It is usually taken out by the purchaser of property or an entity that is loaning money on a mortgage. Most lenders require title insurance when they underwrite loans for real property.[9]

Two state agencies provide regulatory oversight of the title insurance industry in Florida: the Department of Financial Services (DFS), which regulates title agents and agencies, and the Office of Insurance Regulation (OIR), which regulates title insurers, including licensing and promulgation of rates. Title insurers in Florida operate on a monocline basis, meaning that the insurer can only transact title insurance and no other type of insurance.[10]

Insurance Guaranty Funds

Florida operates five insurance guaranty funds to ensure policyholders of liquidated insurers are protected with respect to insurance premiums paid and settlement of outstanding claims, up to limits provided by law.[11] A guaranty association generally is a not-for-profit corporation created by law 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[12] to policyholders. Insurers are required by law to participate in guaranty associations as a condition of transacting business in Florida.

Two of the five guaranty funds are affected by the bill. They are the Florida Insurance Guaranty Association which is the guaranty association for property and casualty insurance, and the Florida Workers' Compensation Insurance Guaranty Association which is the guaranty association for workers' compensation insurance.

Florida Insurance Guaranty Association (FIGA)

Statutory provisions relating to FIGA, which was created in 1970, are contained in part II of chapter 631, F.S. FIGA operates under a board of directors and is a nonprofit corporation. FIGA is composed of all insurers licensed to sell property and casualty insurance in the state.

By law, FIGA is divided into two accounts:

- the auto liability account and auto physical damage account; and
- the account for all other included insurance lines (the all-other account).[13]

[9] See, e.g., the website of the American Land Title Association, http://www.alta.org (last accessed March 27, 2011). ALTA is the national trade association of the abstract and title insurance industry.
[10] Section 627.786, F.S.
[11] The Florida Life and Health Insurance Guaranty Association generally is responsible for claims settlement and premium refunds for health and life insurers who are insolvent. The Florida Health Maintenance Organization Consumer Assistance Plan offers assistance to members of an insolvent Health Maintenance Organization (HMO) and the Florida Workers' Compensation Insurance Guaranty Association is directed by law to protect policyholders of insolvent workers' compensation insurers. The Florida Self-Insurers Guaranty Association protects policyholders of insolvent individual self-insured employers for workers' compensation claims. The Florida Insurance Guaranty Association is responsible for paying claims for insolvent insurers for most remaining lines of insurance, including residential and commercial property, automobile insurance, and liability insurance, among others.
[12] The term "unearned premium" refers to that portion of a premium that is paid in advance, typically for six months or one year, and which is still owed on the unexpired potion of the policy.
[13] s. 631.55(2), F.S.

When a property and casualty insurance company becomes insolvent, FIGA is required by law to take over the claims of the insurer and pay the claims of the company's policyholders. This ensures policyholders that have paid premiums for insurance are not left without valid claims being paid. FIGA is responsible for claims on residential and commercial property insurance, automobile insurance, and liability insurance, among others.

The maximum claim amount FIGA will pay is $300,000 but special limits apply to damages to structure and contents on homeowners', condominium, and homeowners' association claims. For damages to structure and contents on homeowners' claims FIGA pays an additional $200,000, for a total of $500,000. For condominium and homeowners' association claims FIGA pays the lesser of policy limits or $100,000 multiplied by the number of units in the association. All claims are subject to a $100 FIGA deductible, in addition to any deductible in the insurance policy.

FIGA obtains funds to pay claims of insolvent insurance companies primarily from the liquidation of assets of these companies done by the Division of Rehabilitation and Liquidation in the Department of Financial Services. FIGA also obtains funds from the liquidation of assets of insolvent insurers domiciled in other states but having claims in Florida.

In addition, after insolvency occurs, FIGA can issue two types of assessments against property and casualty insurance companies to raise funds to pay claims – regular and emergency[14] assessments. FIGA assesses member insurance companies directly for both assessments and the insurance company is allowed by law (s. 631.57(3)(a), F.S.) to pass the assessment on to their policyholders.

FIGA only pays "covered claims" as defined by s. 631.54(3), F.S. Current law provides two exclusions to the definition of "covered claims." One prevents FIGA from paying subrogation, contribution, or indemnification claims of the insolvent insurer. The other exclusion prevents FIGA from paying claims that have been rejected by another state's guaranty fund for payment because the policyholder's net worth is more than what is allowed under the other state's guaranty law. FIGA cannot pay these claims even if the claim otherwise meets the definition of "covered claim" in Florida law.

Florida Workers' Compensation Insurance Guaranty Association (FWCIGA)

The Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) was created in 1997 by merging the workers' compensation account in FIGA with the Florida Self-Insurance Fund Guaranty Association.[15] The FWCIGA pays workers' compensation and employer liability claims of insolvent insurers and group self-insurance funds licensed in Florida, as well as unearned premium claims.[16] FWCIGA does not have a coverage limit for workers' compensation claims of insolvent insurers, but has a $300,000 coverage limit for employer liability claims.

FWCIGA is largely funded by industry assessments against workers' compensation insurers and self-insurance funds insuring workers' compensation, which are collected following

[14] Emergency assessments can only be issued to pay claims of insurers rendered insolvent due to a hurricane.
[15] Ch. 97-262, L.O.F.
[16] FWCIGA does not pay claims for insolvent self-insured employers, which are covered by a separate guaranty association (s. 440.385, F.S.)

insolvencies. These assessments raise funds to pay claims and administrative and other costs related to the FWCIGA's claim paying activities.

FWCIGA's assessments are capped at 2 percent for insurance companies and 1.5 percent for self-insurance funds net direct premium written in Florida the prior year. The other source of funding is recoveries from receivers of the insolvent insurance companies.

Insurance Capital Build-Up Incentive Program

In 2006, the Legislature created the Insurance Capital Build-Up Incentive Program (Capital Build-Up Program or program) within the State Board of Administration (SBA) to provide insurance companies a low-cost source of capital to write additional residential property insurance. The program's goal was to increase the availability of residential property insurance covering the risk of hurricanes and to ease residential property insurance premium increases.

To accomplish its goal, the program loaned state funds in the form of surplus notes to new or existing authorized residential property insurers under specified conditions. The insurers, in turn, agreed to write an additional minimum level of premium for residential property insurance in Florida and to contribute new capital to their company. The maximum dollar amount of a surplus note was $25 million. The surplus note was repayable to the state, with a 20 year term, at the 10-year Treasury Bond interest rate (with interest only payments the first three years). The Legislature appropriated $250 million non-recurring funds from the General Revenue Fund to fund the program at its inception in 2006. Any unexpended balance reverted back to the General Revenue Fund on June 30, 2007.

As of June 28, 2007, the program issued $247,500,000 in funds to thirteen qualifying insurers. Administrative expenses for the program totaled $2,500,000. Thus, by June 2007 the entire 2006 legislative appropriation for the program was exhausted ($247.5 million in loans, and $2.5 million in administrative costs) and no funds reverted back to the General Revenue Fund.[17] Although legislation enacted in 2008 (CS/CS/SB 2860) provided an additional funding of $250 million for the program from the Citizens Property Insurance Corporation, this funding was vetoed by Governor Crist.[18]

Thirteen insurers have received surplus notes under the program. The program required the participating insurers to begin repayment of the principal loaned to the insurers in the third year of the loans. All of the insurers participating in the program have reached the three year mark and have begun making the required principal payments. Interest and principal payments made on the loans are transferred from the SBA to the General Revenue Fund in accordance with s. 215.5595, F.S. Investment earnings and late fees for the program are also transferred to the General Revenue Fund. To date, over $116 million has been transferred from the SBA to the General Revenue Fund.[19]

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[17] Information obtained from the Final Report of the Insurance Capital Build-Up Incentive Program available at http://www.sbafla.com/fsb/LinkClick.aspx?fileticket=TYIOUbPBbDM%3d&tabid=975&mid=2692 (last viewed February 1, 2011).

[18] Section 16 of CS/CS/SB 2860 which required the $250 million transfer from Citizens to the General Revenue Fund for use in the Capital Build Up Program was vetoed on May 28, 2008. CS/HB 5057 also required the $250 million transfer and this bill was vetoed on June 10, 2008. (Letter to Secretary Kurt S. Browning, Secretary of State, from Governor Charlie Crist dated June 10, 2008, on file with staff of the Insurance & Banking Subcommittee).

[19] Annual Report to the President of the Senate and the Speaker of the House of Representatives on the Insurance Capital Build-Up Incentive Program prepared by the State Board of Administration dated February 1, 2011 at page 8, available at http://www.sbafla.com/fsb/Newsroom/InsuranceCapitalBuildUpIncentiveProgram/tabid/975/Default.aspx (last viewed April 16, 2011).

In 2009, two insurers participating in the program made voluntary principal payments to pay off their surplus note in full.[20] In 2010, an insurer made an additional principal payment of $12.5 million to partially pay down its surplus note.[21] Thus, 11 insurers still have loans from the state under the program and one of the 11 has repaid the state over half of the loan amount. As of January 15, 2011, the aggregate outstanding principal balance for the program is $188.7 million.[22] Additionally, as of February 1, 2011, no insurer with an outstanding surplus note is in default on the note.[23]

Quarterly, the SBA adjusts the interest rate for the term of the surplus notes based on the 10-year Constant Maturity Treasury rate. Total interest paid by insurers in the program since inception of the program is almost $49 million.[24] The interest rate for the first quarter of the program (which ended on 9/30/2006) was 5.22 percent. The interest rate for the latest quarter of the program (which ended December 31, 2010) was 2.52 percent.[25]

Current law allows the SBA to charge additional interest to insurers failing to meet the minimum writing ratio and/or the minimum required surplus set out in s. 215.5595, F.S. The additional interest charged is 25 or 450 basis points, depending on the degree the insurer is out of compliance with the statutorily required writing ratio and/or surplus.[26] The minimum writing ratio required by law is 2:1 for net written premium and 6:1 for gross written premium. Several insurers were not able to meet the required minimum writing ratio and have paid additional interest charges on the surplus note.[27] For the quarter ending in September 2010, 6 of the 11 insurers in the program paid penalty interest for not meeting the required writing ratios. Four of the five insurers paid penalty interest of 450 basis points, and one paid 25 basis points.[28] Over the four years the program has been active; all 11 insurers have paid penalty interest at some point for not meeting the required writing ratios.[29] No minimum writing ratio is required for insurers that write property insurance for only manufactured housing, two insurers participating in the program, so no penalty interest has been collected from these two insurers.[30]

As a condition of the surplus note, each insurer must maintain a minimum surplus of $50 million ($14 million for insurers writing only manufactured housing policies) which includes the surplus note proceeds and new capital. In 2009, two of the 13 insurers participating in the program had surplus below the minimum required for one or more quarters and additional penalties were assessed on these insurers. Both insurers have now repaid their surplus notes in full.[31] Two other insurers paid penalties in 2010 for failing to meet the minimum surplus requirements. The total penalty amount collected in 2010 was almost $300,000.[32] As of February 1, 2011, there are no insurers with an outstanding surplus note in default with the minimum required surplus provision of the note.[33]

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[20] *Id.* at page 3.
[21] *Id.*
[22] *Id.*
[23] *Id.* at page 5.
[24] *Id.* at page 4.
[25] *Id.*
[26] *Id.* at page 5.
[27] *Id.*
[28] *Id.* at pps. 9-10.
[29] *Id.*
[30] *Id.*
[31] *Id.* at pg. 6.
[32] *Id.*
[33] *Id.*

Effect of the Bill:

Receivership Proceedings

Currently, DFS may be appointed, under certain conditions, to be an ancillary receiver to liquidate the business and assets of a foreign insurer which has assets, business, or claims in this state. This can occur upon the appointment of a receiver in the domiciliary state of such of an insurer when the purpose is to liquidate the insurer.[34] The appointment of DFS to be an ancillary receiver is also predicated upon DFS finding that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver, or if ten or more Florida residents having claims against the insurer file a petition with the DFS or the Office of Insurance Regulation (OIR) requesting the appointment of an ancillary receiver.[35]

The bill adds a third basis for DFS seeking to be appointed an ancillary receiver. It allows DFS to petition for appointment if necessary to obtain records to adjudicate the covered claims of Florida policyholders.

Another aspect of current law is modified relating to the delinquency proceedings of foreign insurers. Currently, in the event that initiation of delinquency proceedings (whether involving a domestic or foreign insurer) does not result in appointment of the DFS as receiver, or in the event that the funds or assets of an insurer for which DFS is appointed as receiver are insufficient to cover the cost of certain administrative expenses there is appropriated, upon approval of the Chief Financial Officer and of the Legislative Budget Commission from the Insurance Regulatory Trust Fund to the Division of Rehabilitation and Liquidation, a sum that is sufficient to cover the unreimbursed costs.[36] The bill makes these same provisions apply to the unreimbursed costs for ancillary proceedings opened for the purpose of obtaining records necessary to adjudicate the covered claims of Florida policyholders.

Currently, individuals with control over the affairs of an insurer must fully cooperate with DFS or OIR in any rehabilitation or liquidation proceeding. An integral part of this requirement is to promptly respond to inquiries, make available and deliver specified documents and provide access to all data processing records and facilities. Failing to cooperate subjects the party to a first degree misdemeanor charge and possible fine.[37]

The bill adds another consequence for refusing to cooperate in providing requested records. Any person so refusing is made liable for any penalties, fines or other costs assessed against a guaranty association or the receiver that result from the refusal or delay to provide records.

Payment of Claims by DFS

The bill creates a new section of law to require the State Risk Management Trust Fund to cover DFS officers, employees, agents, and other representatives for any liability under the Federal Priority of Claims Act from any action taken by those individuals in the performance of their powers and duties under chapter 631, F.S.

[34] s. 631.091, F.S.
[35] s. 631.152, F.S.
[36] s. 631.141 (7)(b), F.S.
[37] s. 631.391, F.S.

Extending coverage to protect DFS employees from this personal liability would allow those employees to timely administer and distribute an estate without fear that a federal claim will arise later and they will be subjected to personal liability for having paid that claim. Although the receiver has had some modest success obtaining releases from the U.S. Department of Justice, a federal claim can arise from any of the many federal agencies, and the federal government has no one source that can adequately verify that there is not any federal agency that has a claim.

This provision would, in effect, only become operable where an insolvent insurer's estate: 1) had funds available to pay beyond class 4 claims; 2) those claims beyond class 4 were paid by an estate distribution, in full or in part; and 3) subsequently a claim was filed by the federal government which, because of its "super priority status" as a federal claim, was not barred by the state court ordered deadline to file claims.

Title Insurers Ordered into Rehabilitation

The bill requires the receiver of a title insurer in rehabilitation to review the insurer's condition, and file a rehabilitation plan, subject to court approval, that provides for the following:

- Title insurance policies covering real property in Florida are to remain in force, unless assessments on other title insurers would be insufficient to pay the insurer's claims in the ordinary course of business.
- Title insurance policies covering real property in other states ("out-of-state policies") that do not statutorily provide for payment of future losses of title insurers in receivership may be cancelled as of a date proposed by the receiver (if approved by the court); with a claims filing deadline proposed for out-of-state policies that are cancelled.
- A proposed percentage of the remaining estate assets to fund out-of-state claims where policies have been cancelled, with any unused funds returned to the general assets of the insurer's estate.
- A proposed percentage of the remaining estate assets to fund out-of-state claims where policies remain in force.
- That funds allocated to pay claims on out-of-state policies are to be based on the pro-rata share of premiums written in each state over each of the 5 calendar years preceding the date of the order of rehabilitation.

Assessments

As a condition of doing business in the state, Florida title insurers are liable for an assessment to pay all unpaid title insurance claims on policies covering real property in Florida, and the expenses of administering and settling such claims, of a title insurer ordered into rehabilitation. The OIR, upon request of the receiver, is required to order an annual assessment in an amount the receiver considers sufficient to pay known claims, loss adjustment expenses, and the cost of administration of rehabilitation expenses. In requesting an assessment, the receiver is required to consider the remaining assets of the insurer in receivership. Annual assessments may be made until the insurer in rehabilitation does not have any policies in force or the potential for future liability has been satisfied. Assessments are to be based on each title insurer's pro-rata share of direct title insurance premiums written in Florida in the previous calendar year as reported to the OIR.

The assessment levied against a title insurer cannot exceed 3 percent of an insurer's surplus to policyholders at the end of the previous calendar year or 10 percent of an insurer's surplus to policyholders over any consecutive 5-year period. The 10 percent limitation is to be calculated as the sum of the percentages of surplus to policyholders assessed in each of those 5 years. An emergency assessment may also be ordered, if requested by the receiver. However, the total of the emergency assessment and any annual assessment to be paid by a title insurer in a single calendar year cannot exceed the cap applicable to the annual assessment alone. The OIR may exempt a title insurer from, or limit payment of, the assessment when such payment would reduce the insurer's surplus to policyholders below the minimum required for the insurer to maintain its certificate of authority in another state. Assessments are payable within 90 days or under a quarterly installment plan approved by the receiver, accompanied by applicable finance charges.

Proceeds of assessments may be used by the receiver in an effort to keep in force title policies on Florida real property, including purchasing reinsurance or otherwise providing for the assumption of policy obligations by another insurer. When an assessment has been ordered, the insurer in rehabilitation is barred from issuing new title insurance policies until it is released from rehabilitation. An insurer may not be released from rehabilitation until all title insurers have received full reimbursement for assessments paid.

Surcharges

To reimburse title insurers for assessments paid, the OIR is required to order a surcharge on all subsequently issued title insurance policies on Florida real property. The surcharge cannot exceed $25 per transaction for each impaired title insurer and the surcharge must be in an amount estimated to be sufficient to recover all amounts assessed within 7 years. If additional title insurers become impaired, the OIR is required to order an increase in the surcharge amount to reflect the aggregate surcharge. The surcharge is to be paid by the party responsible for payment of the title insurance premium, unless otherwise agreed between the parties. Title insurance agents and agencies are required to collect and remit the surcharges to the title insurer upon which a policy is written within 60 days. No surcharge is due or owing as to any policy of insurance issued at the simultaneous issue rate. The surcharge is to be considered a separate governmental assessment to be separately stated on any settlement statement, and is not subject to premium tax or reserve requirements. Title insurers are required to provide the OIR with an accounting, by March 1st of each year, of assessments paid and surcharges collected during the previous calendar year. Any surcharges collected by an insurer in excess of the assessment paid are to be paid into the Insurance Regulatory Trust Fund.

Foreign Title Insurers in Receivership[38]

When a foreign title insurer with policies in Florida is placed in receivership by its domiciliary state, the DFS may apply to the court for an order appointing it as ancillary receiver for the purpose of making assessments. The proceeds of such assessments may be used for the payment of claims, to acquire reinsurance, or otherwise provide for the assumption of Florida policy obligations by another insurer. If the assets in Florida are insufficient to pay the administrative costs of the ancillary receivership, the receiver may request additional funds from the Insurance Regulatory Trust Fund.

[38] "Foreign insurer" is defined in s. 624.06, F.S., as an insurer formed under the laws of any state, district, territory, or commonwealth of the United States other than Florida.

Guaranty Funds Provisions

The bill expands the current exclusions to what is considered a covered claim for the purposes of what cannot be paid by FIGA or FWCIGA. It deletes the specific exclusion from coverage of a claim rejected by another state's guaranty based on the grounds that an insured's net worth is greater than that allowed under that state's guaranty law.[39] The bill replaces it with a broader exclusion. It excludes any claim that would otherwise be a covered claim that has been rejected or denied by any other state guaranty fund based upon that state's statutory exclusions including, but not limited to, those based on coverage, policy type, or an insured's net worth. This change will reduce the likelihood of Florida having to make its coverage dependent upon the decisions of the legislatures of other states. For example, currently other states have enacted legislation excluding large deductible policies from coverage by their guaranty funds and Florida might have to pay those claims if a nexus with Florida could be established. The bill seeks to diminish this effect.

Also regarding FIGA and FWCIGA, the bill adds provisions which will allow for the immediate termination of board members. For FIGA, it states that any board member representing an insurer in receivership shall be terminated from the board effective as of the date of the entry of the order of receivership. For FWCIGA, the bill provides that any board member that is employed by, or has a material relationship with, an insurer shall be terminated as a board member, effective as of the date of the entry of the order of receivership. Currently for FWCIGA, the law allows the Chief Financial Officer to remove any board member for cause whereas the FIGA provisions for removal from the board are silent. The effect of these changes will mean that immediate action can occur to eliminate any potential conflict of interest on the board.

Insurance Capital Build-Up Incentive Program

The bill allows an insurer to request the SBA to renegotiate the terms of a surplus note issued under the Insurance Capital Build-Up Incentive Program before January 1, 2011. The insurer's request must be submitted to the board by January 1, 2012. If the insurer agrees to accelerate the payment period of the note by at least 5 years, the board must agree to exempt the insurer from the required premium-to-surplus writing ratios. If the insurer agrees to an acceleration of the payment period for less than 5 years, the board may, after consultation with the Office of Insurance Regulation, agree to an appropriate revision of the required premium-to-surplus writing ratios if the revised ratios are not lower than a net premium to surplus of at least 1:1 and, alternatively, a gross premium to surplus of at least 3:1.

Reinsurance

Currently, credit for reinsurance must be allowed a ceding insurer[40] as either an asset or a deduction from liability only when the reinsurer meets specified regulatory and solvency related criteria. In some instances the Commissioner of OIR may allow credit, but only if the reinsurer holds surplus of $100 million and has a secure financial strength rating from at least two nationally recognized statistical rating organizations deemed acceptable by the commissioner[41].

[39] s. 631.54, F.S.
[40] A ceding insurer is an insurance company that passes the part or all of its risks from its insurance policy portfolio to a reinsurance firm.
[41] s. 624.610, F.S.

The bill makes two changes. First, it increases the reinsurer's required surplus from in excess of $100 million to in excess of $250 million. Second, it removes the requirement that the statistical rating organization be "nationally recognized" and instead requires those organizations to have experience and expertise in rating insurers doing business in Florida, including, but not limited to, Standard & Poor's, Moody's Investors Services, Fitch Ratings, A.M. Best Company, and Demotech.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Indeterminate. See FISCAL COMMENTS

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will allow DFS to distribute the marshaled assets of liquidated companies to claimants on a timelier basis and to close estates more expeditiously.

Florida title insurers will be liable for assessments to pay all outstanding title insurance claims and expenses of administering and settling claims on real property in Florida when a title insurer is ordered into rehabilitation. Except as otherwise provided, title insurance policies on real property in Florida will remain in force when the insurer that issued the policy is ordered into rehabilitation. The bill clarifies that the title insurer's expenses and loss adjustment expenses would be part of the assessment. The financial impact of an assessment would be offset by the ability of title insurers to collect a surcharge on future policies until it had recovered the amount of the assessment paid.[42] The surcharge cannot exceed $25 per transaction for each impaired title insurer and must be sufficient to repay all assessments within 7 years.

D. FISCAL COMMENTS:

[42] Florida Department of Financial Services, Analysis of HB 1229 dated 4/11/2011, on file with the Government Operations Appropriations Subcommittee.

According to DFS, the amount of any Federal claim that the change provided by this bill might impact should be minimal. In information provided by DFS the following statement was made:

> There is no certainty as to the number or amounts of claims that would be paid in the future if this legislation passes, simply because there is very little claims history available to use for predicting future results. But there are two indicators that provide some assurance that the frequency and severity of claims will be minimal:
>
> 1) In the forty or so years of DFS administering receiverships there has only been one instance where a federal claim was filed very late. In that instance a full distribution had been made of estate assets, but luckily additional unexpected funds came in later to the estate that allowed the federal claim to be paid. The claim was for about $40,000. In all other instances federal claims were filed in plenty of time before a final distribution, which normally takes 7 to 10 years to be made from the date an estate was opened. Therefore the frequency of these claims should be extremely low.
>
> 2) Just like any other person or public or private entity, the federal government pursues large claims more vigorously than smaller claims, and if they have a claim of for example $500,000 they are likely to make the stronger effort to determine where to file the claim, particularly if it involves a claim against an insurance company. Because of the length of time it takes to administer an estate, the federal government will have at least 7 to 10 years to find where they should file their claim. Therefore, it is likely that all large claims will be filed sooner and that the only claims that may come in very late are small claims. As mentioned above, the only late claim received after a distribution was for only about $40,000. Therefore, the average severity as to the amount of any claims should be less than $50,000.[43]

[43] Electronic correspondence sent March15, 2011, on file with the Insurance & Banking Subcommittee.