HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/CS/HB 1007	**FINAL HOUSE FLOOR ACTION:**	
SUBJECT/SHORT TITLE	Prohibited Insurance Acts	116 **Y's** 0 **N's**	
SPONSOR(S):	Commerce Committee; Government Operations & Technology Appropriations Subcommittee; Insurance & Banking Subcommittee; Raschein; Diamond and others	**GOVERNOR'S ACTION:**	Approved
COMPANION BILLS:	CS/HB 1009; CS/CS/SB 1012		

SUMMARY ANALYSIS

CS/CS/CS/HB 1007 passed the House on May 2, 2017. The bill was amended by the Senate on May 5, 2017. The Senate passed the bill, as amended, on May 5, 2017, and returned the bill to the House. The House concurred in the Senate amendments and passed the bill, as amended, on May 5, 2017. The bill includes CS/HB 1205 and CS/HB 1299.

The bill establishes uniform fraud prevention standards applicable to all insurers. The bill requires all insurers, regardless of size, to establish and maintain a fraud investigation unit, or contract for such services, and to submit an anti-fraud plan. An insurer must submit the plan and the description of the unit, together with the name of the employee designated to oversee fraud investigation activities, annually to the Division of Forensic Services (DIFS) within the Department of Financial Services beginning December 31, 2017. The bill creates a requirement for insurers to submit fraud-related data on an annual basis; modifies the additional requirements applicable to workers' compensation insurers; and requires the DIFS to create a report regarding fraud detection, investigation, prevention, and reporting practices.

Since 2003, insurance fraud has been prosecuted through dedicated positions within certain state attorneys' offices which are funded by state appropriation. The bill requires state attorneys' offices that receive such an appropriation to report quarterly data to the DIFS regarding their caseloads beginning September 30, 2017. The bill also requires the DIFS to report the caseload data annually to the Governor and the Legislature beginning September 1, 2018.

Stranger-originated life insurance is a scheme designed to procure life insurance on individuals, often using fraudulent means, so that an assignment or sale of a policy circumvents the insurable interest requirement, effectively making the life insurance a mere wager on the early death of the insured. The bill strengthens regulations to help prevent practices or arrangements designed to initiate a life insurance policy for the benefit of a third-party who lacks an insurable interest in the insured at the policy's inception.

Subject to certain exceptions, insurers are required to conduct preinsurance motor vehicle inspections in seven large counties. The bill allows insurers to opt out of the required inspections upon a filing with the Office of Insurance Regulation and authorizes the insurer to implement its own preinsurance inspection program at no cost to consumers.

The bill has no fiscal impact on state or local governments and an indeterminate fiscal impact on the private sector.

The bill was approved by the Governor on June 26, 2017, ch. 2017-178, L.O.F., and became effective on that date.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Insurance Fraud

Insurance fraud is a deliberate deception perpetrated against or by an insurance company or agent for the purpose of financial gain. Fraud may be committed at different points in the insurance transaction by applicants for insurance, policyholders, third-party claimants, or professionals who provide services to claimants. Insurance agents and company employees may also commit insurance fraud. Common frauds include "padding," or inflating actual claims, misrepresenting facts on an insurance application, submitting claims for injuries or damage that never occurred, and "staging" accidents.

Insurance fraud may be classified as "hard" or "soft." Hard fraud is a deliberate attempt either to stage or invent an accident, injury, theft, arson, or other type of loss that would be covered under an insurance policy. Soft fraud, which is sometimes called opportunity fraud, occurs when a policyholder or claimant exaggerates a legitimate claim. Soft fraud may also occur when people purposely provide false information to influence the underwriting process in their favor when applying for insurance.[1]

The Federal Bureau of Investigation estimates the total cost of insurance fraud, excluding health insurance fraud, at more than $40 billion per year. Thus, insurance fraud costs the average U.S. family between $400 and $700 per year in the form of increased premiums.[2]

Division of Investigative and Forensic Services

The Division of Investigative and Forensic Services (DIFS) within the Department of Financial Services (DFS) encompasses all law enforcement and forensic components residing within the DFS. The DIFS investigates a wide range of fraudulent and criminal acts including:

- Insurance Fraud
- Workers' Compensation Fraud
- Fire, Arson, and Explosives Investigations
- Theft/Misuse of State Funds
- Fire and Explosives Sample Analysis

The DIFS is directed by statute[3] to investigate fraudulent insurance acts,[4] violations of the Unfair Insurance Trade Practices Act, false and fraudulent insurance claims,[5] and willful violations of the Florida Insurance Code[6] and rules adopted pursuant to the code.[7] The DIFS employs sworn law enforcement officers to investigate insurance fraud. These officers may make warrantless arrests upon probable cause for criminal violations established as a result of an investigation.[8] The general laws applicable to arrests by state law enforcement officers apply to DIFS investigators.

The Bureau of Insurance Fraud within the DIFS investigates various types of insurance fraud including: personal injury protection, motor vehicle insurance, insurance application, licensee, homeowner's insurance, commercial insurance, disability insurance, arson, life insurance, and healthcare fraud.[9] The Bureau of Workers' Compensation Fraud within the DIFS investigates suspected criminal violations of

[1] INSURANCE INFORMATION INSTITUTE, *Fraud*, http://www.iii.org/fact-statistic/fraud (last visited Mar. 21, 2017).
[2] FBI, *Insurance Fraud*, https://www.fbi.gov/stats-services/publications/insurance-fraud (last visited Mar. 21, 2017).
[3] s. 626.989(2), F.S.
[4] s. 626.989(1), F.S.
[5] s. 817.234, F.S.
[6] chs. 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S., constitute the "Florida Insurance Code." s. 624.01, F.S.
[7] s. 624.15, F.S.
[8] s. 626.989(7), F.S.
[9] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *The Bureau of Insurance Fraud*, http://www.myfloridacfo.com/division/fraud/ (last visited Mar. 20, 2017).

Florida's workers' compensation laws. The Division of Workers' Compensation and the Bureau of Workers' Compensation Fraud work closely together to carry out their statutory duties. The Division of Workers' Compensation enforces administrative compliance with the workers' compensation law, pursuant to s. 440.107, F.S. The DIFS enforces the criminal provisions of the workers' compensation law, pursuant to s. 440.105, F.S.

Insurer Fraud Prevention

Florida law requires every admitted insurer to have some form of fraud prevention program in place.[10] Insurers with direct written premiums of at least $10 million in the prior year must establish and maintain "a unit or division"[11] to investigate fraudulent claims, typically referred to as a special investigative unit (SIU), or contract for SIU services. These insurers are required to file with the DIFS a detailed description of their SIU or the contract for services, whichever is applicable. Insurers with direct written premiums of less than $10 million in the prior year must adopt an anti-fraud plan, or comply with the requirements applicable to larger insurers. An anti-fraud plan must be filed with the DIFS and must include:

- A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts;
- A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the DIFS;
- A description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel; and
- A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.

An insurer has 18 months from the time it obtains a certificate of authority to comply with these requirements. The required documentation need only be filed one time; the law does not require that it be updated.

An insurer that writes workers' compensation coverage is subject to additional requirements.[12] A workers' compensation insurer is required to submit a report to the DIFS by August 1 of each year on its experience in implementing and maintaining an anti-fraud investigative unit or an anti-fraud plan. The report must include:

- The dollar amount of recoveries and losses attributable to workers' compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other.
- The number of referrals to the Bureau of Workers' Compensation Fraud for the prior year.
- A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles and descriptions of staffing.
- The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria such as number of policies written, number of claims received on an annual basis, volume of suspected fraudulent claims currently being detected, other factors, and an assessment of optimal caseload that can be handled by an investigator on an annual basis.
- The in-service education and training provided to underwriting and claims personnel to assist in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities.

[10] s. 626.9891(1) - (4), F.S.
[11] A "unit or division" may include assigning fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. s. 626.9891(5), F.S.
[12] s. 626.9891(6), F.S.

- A description of a public awareness program focused on the costs and frequency of insurance fraud and methods by which the public can prevent it.

Current law gives the DFS or the Office of Insurance Regulation (OIR) authority to impose: an administrative fine of up to $2,000 per day for failing to file an acceptable anti-fraud plan or SIU description; an administrative fine for failing to implement the provisions of the plan or SIU description; or both.[13]

Effect of the Bill on Insurer Fraud Prevention

The bill establishes uniform fraud prevention standards for all insurers, regardless of size. In effect, the bill imposes two new requirements: large insurers will be required to adopt an anti-fraud plan; and smaller insurers will be required both to adopt an anti-fraud plan and to establish and maintain an SIU, or contract for SIU services. In addition, the bill requires every insurer to designate an employee who is responsible for implementing the requirements related to fraud investigation.

All insurers must electronically file the anti-fraud plan, a detailed description of the SIU or the contract for services, whichever is applicable, and the name of the designated employee with the DIFS by December 31, 2017, and each year thereafter.

The bill revises the requirements for an anti-fraud plan to include:

- An acknowledgement that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance written by that insurer. (Current law only requires descriptions of detection and investigation procedures.)
- An acknowledgement that the insurer has established procedures for mandatory reporting of fraudulent insurance acts. (Current law only requires descriptions of mandatory reporting procedures.)
- An acknowledgement that the insurer provides the required anti-fraud education and training.
- A description of the required anti-fraud education and training. (Current law only applies to workers' compensation insurers.) An insurer must provide 2 hours of initial training and 1 hour annually, thereafter, to the SIU or contractor for SIU services. The education and training must address detection, referrals, investigations, and reporting of suspected insurance fraud for the lines of insurance the insurer writes. The bill requires the initial 2-hour training to be completed by December 31, 2018.
- A description or chart of the insurer's SIU, including position titles and descriptions of staffing.
- The rationale for the level of staffing and resources being provided for the SIU. (Current law only applies to workers' compensation insurers.)

The above required acknowledgements operate as an affirmation of compliance with the law and may assist the DFS in any necessary enforcement proceeding.

The bill revises the requirements for those portions of the anti-fraud plan that are specific to a workers' compensation insurer by: deleting provisions that are separately added and made applicable to all insurers; clarifying the requirements for reports related to losses and recoveries; and adding a requirement to report, by fraud type, the number of cases referred to the DIFS.

The bill creates a new requirement for all insurers to report fraud-related data for each line of insurance written in the prior calendar year. The data must be submitted by March 1, 2019, and annually thereafter, and include:

- The number of policies in effect;
- The amount of premiums written for policies;

[13] s. 626.9891(7), F.S.

- The number of claims received;
- The number of claims referred to the anti-fraud investigative unit;
- The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;
- The number of claims investigated or accepted by the anti-fraud investigative unit;
- The number of other insurance matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
- The number of cases referred to the DIFS;
- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount or range of damages on cases referred to the DIFS or other agencies.

The bill adds noncompliance with the data reporting requirement as a basis for imposing an administrative fine.

An insurer that obtains a new certificate of authority has six months to comply with the requirement to adopt and file an anti-fraud plan, description of its SIU or contract for SIU services, and the name of the designated employee. The insurer has one calendar year thereafter to complete the required education and initial data collection and reporting.

The bill requires the DIFS to create a biennial report regarding fraud detection, investigation, prevention, and reporting practices. The first report is due December 31, 2018 and must be updated, as necessary, but at least every two years. The report must provide:

- Information on the best practices for the establishment of anti-fraud investigative units within insurers;
- Information on the best practices and methods for detecting and investigating insurance fraud and other fraudulent insurance acts;
- Information on appropriate anti-fraud education and training of insurer personnel;
- Information on the best practices for reporting insurance fraud and other fraudulent insurance acts to the DIFS and to other law enforcement agencies;
- Information regarding the appropriate level of staffing and resources for anti-fraud investigative units within insurers;
- Information detailing statistics and data relating to insurance fraud which insurers should maintain; and
- Other information as determined by the DIFS.

Dedicated Prosecutor Program

Since 2003, insurance fraud has been prosecuted through dedicated positions within certain state attorneys' offices. The first dedicated prosecutor position was jointly funded by the DFS, the Miami-Dade state attorney's office and the Florida Automobile Joint Underwriting Association. As of June 30, 2016, the dedicated prosecutor program had a total of 36 full-time positions, including 20 dedicated prosecutors. Of the 20 dedicated prosecutors, one position in Miami-Dade County, one position in Tampa, one position in West Palm Beach, and one position in Broward County are devoted solely to Worker's Compensation Fraud.[14,15] In 2016, the Legislature appropriated $1,725,519 from the

[14] The positions are allocated as follows: Jacksonville (4th Judicial Circuit-two), Orlando (9th Judicial Circuit-three), Miami-Dade County (11th Judicial Circuit-five), Tampa (13th Circuit-five), West Palm Beach (15th Circuit-two) Broward County (17th Circuit-two), and Ft. Myers (20th Circuit-one) along with accompanying support staff positions.
[15] Florida Department of Financial Services, Agency Analysis of 2017 House Bill 1007, p.2 (Mar. 14, 2017).

Insurance Regulatory Trust Fund and $614,735 from the Workers' Compensation Trust Fund to the Justice Administrative Commission[16] to fund the dedicated prosecutor positions.[17]

Current law does not specify requirements for participation in the dedicated prosecutor program. Instead, it has been authorized by proviso language in the General Appropriations Act. The 2016 proviso states that "funds may not be used for any purpose other than the funding of attorney and paralegal positions that prosecute crimes of insurance fraud." The DFS indicates that, in the absence of any specific statutory requirement, participating state attorneys' offices submit voluntary, quarterly reports with general caseload data. Through analysis of the reports, the DIFS has found that certain participating state attorneys' offices are prosecuting minimal amounts of insurance fraud cases, prosecuting a majority of non-insurance fraud cases, or have had vacant positions for extended periods of time.[18]

Effect of the Bill on Dedicated Prosecutor Program

Effective July 1, 2017, the bill requires state attorneys' offices that receive an appropriation to fund attorneys and paralegals dedicated solely to the prosecution of insurance fraud to report quarterly data to the DIFS regarding their caseloads beginning September 30, 2017. The data are to be reported for each attorney funded by the appropriation and grouped by case type, including DIFS insurance fraud cases, other insurance fraud cases, and cases not involving insurance fraud. The data must include:

- The number of cases in which an information has been filed;
- The number of cases pending at pretrial or intake;
- The number of cases in which the attorney is assisting in the investigation;
- The number of cases closed or disposed of during the prior quarter;
- The disposition of the cases closed during the prior quarter; and
- The number of cases currently pending in a pretrial diversion program.

These data are the same that are reported voluntarily by some of the state attorneys' offices.

In turn, the DIFS must report the data collected for the year ending June 30, to the Executive Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate by September 1, 2018, and annually thereafter.

Continued Eligibility for a Certificate of Authority

Current law requires a health maintenance organization (HMO) to continuously comply with all requirements of part I of ch. 641, F.S., and rules adopted thereunder for an initial application in order to retain eligibility for a certificate of authority to do business in Florida.[19] By rule, the OIR requires an HMO to be actively engaged in managed care within six months of receiving a certificate of authority.[20]

Effect of the Bill on Continued Eligibility for a Certificate of Authority

The bill provides an exception that requires an HMO that is authorized exclusively to sell Medicare Advantage plans to be actively engaged in managed care within 24 months of receiving a certificate of authority, to designate and maintain a primary anti-fraud employee, and to adopt an anti-fraud plan. Failure to comply with any condition renders such an HMO ineligible to do business in Florida. The OIR is authorized to extend the period of eligibility upon written request.

[16] The Justice Administrative Commission is comprised of two state attorneys and two public defenders. Its duties include, among others, maintenance of a central office for administrative services for state attorneys and public defenders. s. 43.16, F.S.
[17] ch. 2016-66, Laws of Fla.
[18] Florida Department of Financial Services, Agency Analysis of 2017 House Bill 1007, p.2 (Mar. 14, 2017).
[19] s. 641.221, F.S.
[20] Rule 69O-191.029, F.A.C.

Life Insurance and the Insurable Interest Requirement

Life insurance allows an individual to set aside money in the present (through the payment of premiums) to provide some measure of financial security for his or her surviving beneficiaries upon his or her premature death. The proceeds allow survivors to pay off debts and other expenses and provide a source of income to replace that which was lost by the death of the insured.[21] Life insurance dates back to ancient Rome where burial clubs covered the cost of members' funeral expenses and provided monetary benefits to survivors. Modern life insurance became commercially important in the 15th century Mediterranean mercantile economies and through its introduction to England in the 16th century. Although it served a legitimate purpose of risk avoidance and mitigation, life insurance drew a strong appeal to the gambling instincts of middle-class individuals with no financial interest in the lives of popes, princes, and other prominent people and who took out insurance policies on these strangers' lives as mere wagers. To put an end to the use of life insurance contracts as wagering devices, the British Parliament enacted the Life Assurance Act of 1774, holding that any life insurance contract without an *insurable interest* in the life of the insured would be null and void.[22]

In the late 19th century, the U.S. Supreme Court defined "insurable interest" as "a reasonable expectation of advantage or benefit from the continuance of [the insured's] life"; in other words, an insurable interest is found when an individual has a greater interest in the survival of the insured than in the insured's death.[23] Subsequently, most American courts recognized the insurable interest requirement for life insurance policies, finding that life insurance policies purchased without an insurable interest violate public policy because they constitute a mere wager that creates a sinister desire for the early death of the insured.[24] Today, it is recognized that an individual has an insurable interest as to his or her own life, body, and health. In addition, an insurable interest is founded on a "love and affection" interest for persons related by blood or law, and, as to other persons, a lawful and substantial economic interest in the continued life, health, or bodily safety of the insured person,[25] such as corporate-owned insurance on the life of an officer or director. These recognized interests are intended to ensure life insurance's purpose as a financial protection tool, rather than a wagering device.

Florida's insurable interest requirement is codified at s. 627.404, F.S., which lists nine exclusive categories in which an insurable interest as to life, health, or disability insurance are recognized, including the "own life, body and health," "love and affection," and "substantial pecuniary advantage" grounds mentioned above.[26] The statute requires that an insurable interest exists at the time the insurance contract is made, but need not exist after the inception date of coverage under the contract. Thereafter, life insurance is an asset that may be freely sold, transferred, or devised, which is consistent with the parties' freedom to contract for the assignment or non-assignment of policies in s. 627.422, F.S.

Viatical Settlements: The Secondary Market of Life Insurance

In some instances, life insurance policyholders seek to sell their policies to third parties (usually private, individual investors) as a way to obtain cash for medical expenses or other needs. In these transactions, known as "viatical settlements," companies called *viatical settlement providers* would usually purchase the policy from the insured (*the viator*) for more than its cash surrender value, but less than the face value of the policy. The settlement is usually based upon the projected life expectancy of the insured, the amount of built-up cash in the policy, and other criteria, and is often negotiated by a *viatical settlement broker* on the viator's behalf. The purchaser of the policy then pays the premiums to

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[21] OFFICE OF INSURANCE REGULATION, *Life Insurance*, http://www.floir.com/Sections/LandH/Life/default.aspx (last visited Mar. 22, 2017).
[22] Susan Lorde Martin, *Betting on the Lives of Strangers: Life Settlements, STOLI, and Securitization*, 13 U. PA. J. BUS. L. 173, 174 (2010); OFFICE OF INSURANCE REGULATION, *Report of Commissioner Kevin M. McCarty: Stranger-Originated Life Insurance and the Use of Fraudulent Activity to Circumvent the Intent of Florida's Insurable Interest Law* (Jan. 2009), ("2009 OIR Report"), p. 6.
[23] *Warnock v. Davis*, 104 U.S. 775, 779 (1881); *Connecticut Mut. Life Ins. Co. v. Schaefer*, 94 U.S. 457, 460 (1876).
[24] *Warnock*, 104 U.S. at 779; *Connecticut Mut. Life Ins. Co.*, 94 U.S. at 460; *Aetna Life Ins. Co. v. France*, 94 U.S. 561 (1876) and *Grigsby v. Russell*, 222 U.S. 149 (1911).
[25] 2009 OIR Report, *supra* note 22, at 7.
[26] These grounds were added to s. 627.404, F.S., by the Florida Legislature in 2008. Ch. 2008-36, Laws of Fla.

sustain the policy until the insured's death; as a result, the sooner the viator is expected to die, the higher the settlement offer is likely to be.

Viatical settlements emerged during the HIV/AIDS epidemic in the 1980s, enabling terminally ill patients with short life expectancies who could no longer work or afford the policy premiums to sell their life insurance policies at a cash discount to pay for high medical care expenses. In the early days of the epidemic, AIDS patients generally died within months of their diagnoses, resulting in fairly quick, significant returns to investors,[27] who in those days were typically senior individuals risking their savings in what was represented as a safe investment and was marketed as a compassionate way to help dying patients. However, innovations in AIDS treatment in the early 1990s significantly improved life expectancies of AIDS patients, sometimes even outliving their investors, which disrupted mortality assumptions and diminished investor returns. As a result, some viatical settlement providers stopped brokering new viatical settlements, while others engaged in fraudulent practices, such as pyramid schemes.[28]

Because investors' expectations of returns can trigger the application of state and federal securities law, viatical settlements are widely treated as a hybrid transaction implicating both insurance law and securities law. *Insurance* law applies to protect the policy owner or viator in the "front-end" transaction with the viatical settlement provider through licensing, disclosure reporting, and other requirements. On the other hand, *securities* law applies to the "back-end" transaction to protect investors in viatical settlement investments by state securities regulators, and in some circumstances, the U.S. Securities and Exchange Commission.[29]

In response to increasing concerns over consumer protection in the viatical settlement market, several state insurance regulators, through the National Association of Insurance Commissioners (NAIC), and the National Association of Insurance Legislators (NCOIL)[30] developed model state legislation regulating the "front-end" transaction of viatical settlements in 1993 and 2007, respectively.

[27] Kelly J. Bozanic, *An Investment to Die For: From Life Insurance to Death Bonds, the Evolution and Legality of the Life Settlement Industry*, 113 PENN. ST. L. REV. 229, 233-234 (2008).
[28] OFFICE OF INSURANCE REGULATION, *Secondary Life Insurance Market Report to the Florida Legislature* (Dec. 2013) ("2013 OIR Report"), p. 9.
[29] GOVERNMENT ACCOUNTABILITY OFFICE, Report to the Special Committee on Aging, U.S. Senate: Life Insurance Settlements, GAO-10-775 (Jul. 2010), p. 9, at http://www.gao.gov/assets/310/306966.pdf (last visited Mar. 22, 2017).
[30] The NAIC is the standard-setting and regulatory support organization created and governed by the chief insurance departments that regulate the conduct and solvency of insurers in their respective states or territories. NAIC, *About the NAIC*, http://www.naic.org/index_about.htm (last visited Mar. 23, 2017).

Regulation of Viatical Settlements in Florida

In 1996, Florida enacted the Viatical Settlement Act (codified as part X, ch. 626, F.S.; "the Act")[31] as a regulatory framework for viatical settlement providers (VSPs) and viatical settlement brokers by the Department of Insurance, the predecessor agency to the OIR.[32] The Act sets forth requirements for licensure; annual reporting; certain minimum disclosures to viators; transactional procedures; adoption of anti-fraud plans; and administrative, civil, and criminal penalties. The Act also provides the OIR with examination and enforcement authority over VSPs and brokers; provides review and approval authority over the viatical settlement contracts and forms; provides rulemaking authority; and makes a violation of the Act an unfair trade practice under the Insurance Code.[33] The Act does not authorize the OIR to regulate the rate or amount paid as consideration for a viatical settlement contract.[34]

Since its inception, the Act has been substantively amended seven times to enhance consumer protections and to address changes in the viatical settlement industry.[35] For example, prior to July 1, 2005, viaticals in Florida were regulated exclusively as insurance. In 2005, following numerous consumer complaints and findings of investor harm in the "back-end transaction," the Legislature amended the Act to provide that *viatical settlement investments* are securities under the Florida Securities and Investor Protection Act (ch. 517, F.S.), which is enforced by the Office of Financial Regulation (OFR) and triggers requirements of full and fair disclosure to investors and a securities dealer license from the OFR.[36] The 2005 legislation also provides that a person or firm who offers or attempts to negotiate a viatical settlement between an insured (viator) and a VSP for compensation is a *viatical settlement broker* who must be licensed with the DFS as a life insurance agent with a proper appointment from a VSP. Viatical settlement brokers owe a fiduciary duty to the viator.[37]

Since the inception of the Act, the viatical settlement market has evolved both in terms of the types of policies transacted by viatical settlement providers and the type of investors.

- "Life settlements" are offered to non-terminally ill insureds that no longer want, need, or can afford their policies and as an alternative to exercising a redemption or accelerated death benefit clause in their policies. However, the Act treats life settlements the same as viatical settlements for purposes of regulation.[38]
- Additionally, instead of the private individuals who invested in viaticals during the HIV/AIDS epidemic, institutional investors (such as investment banks and hedge or pension funds) now often invest in large blocks of policies sold as a portfolio in the secondary market.[39] In 2013, the Legislature directed the OIR to review Florida law and regulations to determine whether there were adequate protections for purchasers of life insurance policies in the secondary life insurance market.[40] Following a public hearing conducted by the OIR, in which both life insurers and institutional investors participated, the OIR published a report, concluding that adequate

[31] Ch. 96-336, Laws of Fla.
[32] Following the 2003 governmental reorganization, authority over the Act was transferred to the OIR. Ch. 2003-261, Laws of Fla. Additionally, the Act requires *life expectancy providers* to register with the OIR. Life expectancy providers determine life expectancies or mortality ratings for viatical settlements. ss. 626.9911(4) and 626.99175, F.S.
[33] Section 624.01, F.S., provides that chs. 624-632, 634-636, 641-642, 648, and 651, F.S., constitute the Florida Insurance Code.
[34] s. 626.9926, F.S.
[35] Excluding reviser's bills and the 2003 governmental reorganization bill. *See* Chs. 98-164; 99-212; 2000-344; 2001-207; 2001-247; 2005-237; and 2007-148, Laws of Fla.
[36] Ch. 2005-237, Laws of Fla.
[37] ss. 626.9911(9) and 626.9916, F.S.
[38] The 2000 legislation amended the definition of "viator," who is the owner of a life insurance policy seeking to enter into a viatical settlement contract, to remove language restricting such policy to one "insuring the life of an individual with a catastrophic or life-threatening illness." *See* Ch. 2000-344, Laws of Fla.
[39] 2013 OIR Report, *supra* note 28, at 13. One participant in the 2013 OIR hearing observed that institutional investors primarily participate in the securitization of life settlements, or the nominal "tertiary" market, which feeds liquidity into the secondary life insurance market (i.e., the subsequent trading after the policy is first sold). *Id.* at Appendix A, Transcript of Public Hearing, pp. 125-126.
[40] Ch. 2013-40, §6, Laws of Fla. (2013 General Appropriations Act, p. 316).

protections for institutional purchasers in the secondary life insurance market existed and that their recommendations did not warrant legislative action at the time.[41]

Stranger-Originated Life Insurance (STOLI)

Another evolution of the viatical settlement market is a practice known as "stranger-originated (or stranger-owned) life insurance" (STOLI), which emerged in the 2000s. In a STOLI transaction, an individual (typically a senior) is encouraged to take out insurance on his or her own life, sometimes in the millions of dollars, and then assigns the policy to an investor or group of investors (the "stranger") who pay the individual a large cash settlement in exchange for the ownership rights to the policy, including the right to receive the proceeds upon the insured's death.

On the surface, STOLI may appear similar to legitimate viatical or life settlements in that a third party buys a policy from an insured in which they have no insurable interest. However, the critical difference is that in legitimate settlements, an insured initially buys life insurance with a good-faith intent to protect valid insurable interests (i.e., to protect family members or a business from the risk of a premature death), but subsequently decides to sell the policy to a third party due to a change in circumstances that may not warrant the policy (such as divorce, death of an intended beneficiary, or the need for immediate cash due to illness or other loss).

Unlike legitimate viaticals, STOLI is a scheme in which the life insurance policy is not acquired in good faith in that the parties intend at the outset that the *investors* (who lack an insurable interest in the insured) receive the proceeds, directly or indirectly.[42] STOLI is designed to procure life insurance on individuals, often using fraudulent means, such as misrepresentation, falsification, or omission of material facts in the life insurance application, so that an assignment or sale of a policy functions as a subterfuge that circumvents the insurable interest requirement. As the Uniform Law Commission noted:

> Those who benefit from STOLI transactions (typically investors in the secondary markets) claim that it is an appropriate use of life insurance consistent with applicable legal principles, including the free transferability of assets. Others, including life insurers, oppose the use of STOLI on the ground that it is a perversion of the life insurance asset and leads to the moral hazard concerns that insurable interest doctrines were intended to mitigate.[43]

STOLI also differs from legitimate viatical settlements with regard to the following common characteristics:

- Typically targets senior citizens who are induced with gifts, promises of free insurance, or monetary gain;
- Commonly financed through non-recourse "premium finance loans";
- Commonly structured through the use of an irrevocable trust, making it difficult for the life insurance company to know that the policy has been sold;
- Premiums are paid for two years (i.e., the contestable period); and
- Often involves misrepresentation, falsification, or omission of material facts (also known as "cleansheeting") in the life insurance application and inflated underwriting practices, such as the applicant's net worth, in order to obtain a policy with a high face value.

[41] 2013 OIR Report, *supra* note 28, at 50-51.
[42] AALU, NAIFA, and ACLI, *STOLI: The Problem and the Appropriate State Response*, p. 4.
[43] UNIFORM LAW COMMISSION, *Insurable Interest Amendment to the Uniform Trust Code Summary*, at http://uniformlaws.org/ActSummary.aspx?title=Insurable%20Interest%20Amendment%20to%20the%20Uniform%20Trust%20Code (last visited Mar. 22, 2017).

According to the OIR, STOLI impacts consumers (both individual investors and insureds) and insurers in a number of ways:[44]

- Seniors may exhaust their life insurance purchasing capability and not be able to protect their own family or business.
- The incentives, especially cash payments, used to lure seniors to participate in STOLI schemes are taxable as ordinary income.
- Seniors may subject themselves or their estates to potential liability in the event the life insurance policy is rescinded by an insurer who discovers fraud.
- Seniors may encounter unexpected tax liability from the sale of the life insurance policy.[45]
- The "free" insurance is not free and may be subject to tax based on the economic value of the coverage.
- Seniors have to give the purchaser, and subsequent purchasers, access to their medical records when they sell their life insurance policy in the secondary market so that investors know the health status of the insured. The investors want to know the "status" of their investment and how close they are to getting paid.
- STOLI may lead to an increase in life insurance rates for the over-65 population.
- If STOLI practices continue to proliferate, the U.S. Congress may remove the tax-free status of life insurance proceeds.

Legislative, Regulatory, and Litigation Approaches to STOLI

Over 30 states currently prohibit STOLI, generally through some combination of the NAIC and NCOIL model acts, in addition to common law or statutory insurable interest laws. STOLI has resulted in significant litigation as well as criminal and regulatory enforcement actions, both nationally and in Florida.[46]

Below are several of the grounds for litigation, criminal, or regulatory actions related to STOLI transactions:

- *Grounds for disciplinary action under the Act*: Currently, the Act authorizes the OIR to impose fines between $2,500 to $10,000, or to suspend, revoke, deny, or refuse to renew the license of any VSP found to be engaging in certain acts, such as fraudulent or dishonest practices, dealing in bad faith with viators, or violating any provision of the Act or the Insurance Code. The OIR may also impose cease and desist orders and immediate final orders for violations of the Act.[47]
- *Consequences of misrepresentation on an application*: Currently, s. 627.409, F.S., provides that misrepresentation, omission, concealment of fact, or incorrect statements on an application for an insurance contract "may prevent recovery" in certain cases. However, this remedy is viewed as inadequate, because there are no criminal penalties and the only civil penalty available is an action for rescission by the life insurer.
- *Agent regulation*: Various provisions of the Insurance Code authorize the DFS to suspend or revoke the license or appointment of licensees, agencies, or appointees on various grounds, such as using fraudulent or dishonest practices in the conduct of business under the license.[48]
- *Unfair Insurance Trade Practices Act*: Part IX of ch. 626, F.S., contains a number of unfair insurance trade practices. In particular, s. 626.9541, F.S., lists several unfair methods of

[44] Office of Insurance Regulation, Agency Analysis of 2017 House Bill 1205, p. 5 (Mar. 12, 2017). Additionally, s. 626.9923, F.S., requires VSPs to disclose certain risks to viators, such as tax and Medicaid eligibility consequences.
[45] *See* IRS Rev. Ruls. 09-13 and 09-14, regarding taxation of proceeds from settlements as capital gains ordinary income and taxation on a post-settlement basis.
[46] For a listing of OIR enforcement actions, see OIR, *Viatical Criminal, Civil and Regulatory Actions*, http://www.floir.com/sections/landh/viaticals/ccr_actions.aspx (last visited Mar. 22, 2017) and 2013 OIR Report, *supra* note 28, at *Appendix C: Florida Regulatory and Enforcement Actions Pertaining to Viatical Settlement Providers*.
[47] ss. 626.9914 and 626.99272, F.S.
[48] ss. 626.611, 626.6115, 626.6215, and 626.621, F.S.

competition and unfair or deceptive acts or practices. Each violation of this statute can result in fines ranging from $5,000 to $75,000, depending on the willfulness and particular violation. In addition, "twisting"[49] and "churning"[50] are first-degree misdemeanors, while willfully submitting false signatures on an application is a third-degree felony.[51] While VSPs are subject to the Unfair Trade Practices Act[52] and STOLI transactions do share some components of these practices, the statute was written for the initial sale of an insurance policy to an insured, thereby making it difficult to apply the statute to secondary sales of life insurance policies.[53]

- *Insurable interest litigation by life insurers*: Insurers and investors have relied on two dueling statutes which are not in the Act.
    - As noted above, Florida expanded its insurable interest statute, s. 627.404, F.S., in 2008 to clarify when an insurable interest may be validly recognized for life insurance purposes. Life insurers have relied on this statute in filing suit to rescind the policies subsequently transferred in a STOLI transaction for a lack of insurable interest at the time of the policy.
    - However, another statute, s. 627.455, F.S., requires insurers to include an incontestability clause in their policies that bars a challenge to the policy after it has been in force for two years. Securities intermediaries (acting for the institutional investors) have relied on this statute as a kind of statute of limitations to seek dismissal of insurers' rescission cases, arguing that a tardy challenge is barred regardless of whether the policy was made with an insurable interest at inception.
    - In separate cases, the U.S. District Court for the Southern District of Florida reached different interpretations on the interplay of these statutes.[54] These appeals were consolidated to the U.S. Court of Appeals for the Eleventh Circuit, which noted that there are no cases decided by Florida courts that specifically address whether a party can challenge an insurance policy as being void ab initio for lack of an insurable interest if the challenge is made after the two-year contestability period, and, if so, whether the individual with the required insurable interest must procure the policy in good faith. As a result, the Eleventh Circuit certified questions to the Florida Supreme Court for a determination of Florida law on the conflict between these two statutes.[55]
    - The Florida Supreme Court considered the Eleventh Circuit's certified questions and, in September 2016, concluded that "[b]ecause the STOLI policies like the . . . policies at issue have the insurable interest required by section 627.404(1) at their inception, they become incontestable two years after their issuance under the plain language of section 627.455."[56] The Florida Supreme Court rephrased the certified question and answered the following in the negative: "Can a party challenge the validity of a life insurance policy

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[49] As defined in s. 626.9541(1)(l), F.S., "twisting" means "knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer."

[50] "Churning" by an insurer or an agent is an unfair method of competition and an unfair or deceptive act or practice. As defined in s. 626.9541(1)(aa), F.S., "churning" is:

> the practice whereby policy values in an existing life insurance policy or annuity contract, including, but not limited to, cash, loan values, or dividend values, and in any riders to that policy or contract, are directly or indirectly used to purchase another insurance policy or annuity contract with that same insurer for the purpose of earning additional premiums, fees, commissions, or other compensation:
>
> a. Without an objectively reasonable basis for believing that the replacement or extraction will result in an actual and demonstrable benefit to the policyholder;
> b. In a fashion that is fraudulent, deceptive, or otherwise misleading or that involves a deceptive omission;
> c. When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract, if this is the case; or
> d. Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due, if this is the case.

[51] s. 626.9541, F.S.

[52] Section 626.9927, F.S., provides that a violation of the Viatical Settlement Act is an unfair trade practice under ss. 626.9521 and 626.9541, F.S.

[53] Office of Insurance Regulation, Agency Analysis of 2017 House Bill 1205, p. 5 (Mar. 12, 2017).

[54] *Pruco Life Ins. v. Brasner*, 2011 WL 134056 (S.D. Fla. Jan. 7, 2011), and *Pruco Life Ins. Co. v. U.S. Bank*, 2013 WL 4496506 (S.D. Fla. Aug. 20, 2013).

[55] *Pruco Life Ins. Co. v. Wells Fargo Bank, N.A.*, 780 F.3d 1327 at 1336 (11th Cir. C.A. 2015).

[56] *Wells Fargo Bank, N.A. v. Pruco Life Ins. Co.*, 200 So. 3d 1202, 1206 (Fla. 2016).

after the two-year contestability period established by section 627.455 because of its creation through a STOLI scheme?"[57] Answering in the affirmative would essentially create a STOLI-policy exception to the two-year contestability period in s. 627.455, F.S. The Florida Supreme Court noted that, "[w]hile such an exception might be wise public policy, that decision is for the Florida Legislature, not this Court."[58]

In summary, current law does not specifically define STOLI and does not specifically prohibit practices or arrangements designed to initiate a life insurance policy for the benefit of a third-party who lacks an insurable interest in the insured at the policy's inception.

Effect of the Bill on Stranger-Originated Life Insurance

The bill defines fraudulent viatical settlement acts, defines STOLI, and adds prohibited practices. The bill also amends provisions relating to the contestability and enforceability of viaticated policies and STOLI policies. These provisions are largely based on a combination of model viatical settlement legislation from the NAIC and the NCOIL.

The bill creates the following definitions in s. 626.9911, F.S.:

- *Fraudulent viatical settlement act* means an act or omission committed by a person who knowingly, or with intent to defraud for the purpose of depriving another of property or for pecuniary gain, commits or allows an employee or agent to commit any of the following acts:
    - Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by another person, false or concealed material information as part of, in support of, or concerning a fact material to:
        - An application for the issuance of a viatical settlement contract or a life insurance policy;
        - The underwriting of a viatical settlement contract or a life insurance policy;
        - A claim for payment or benefit pursuant to a viatical settlement contract or a life insurance policy;
        - Premiums paid on a life insurance policy;
        - Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or a life insurance policy;
        - The reinstatement or conversion of a life insurance policy;
        - The solicitation, offer, effectuation, or sale of a viatical settlement contract or a life insurance policy;
        - The issuance of written evidence of a viatical settlement contract or a life insurance policy; or
        - A financing transaction for a viatical settlement contract or life insurance policy.
    - Employing a plan, financial structure, device, scheme, or artifice relating to viaticated policies for the purpose of perpetrating fraud.
    - Engaging in a STOLI practice.
    - Failing to disclose, upon request by an insurer, that the prospective insured has undergone a life expectancy evaluation by a person other than the insurer or its authorized representatives in connection with the issuance of the life insurance policy.
    - Perpetuating a fraud or preventing the detection of a fraud by:
        - Removing, concealing, altering, destroying, or sequestering from the OIR the assets or records of a licensee or other person engaged in the business of viatical settlements;
        - Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;

[57] *Id.* at 1206-07.
[58] *Id*. at 1203.

        - Transacting in the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority to transact such business; or
        - Filing with the OIR or the equivalent chief insurance regulatory official of another jurisdiction a document that contains false information or conceals information about a material fact from the OIR or other regulatory official.
    - Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or other person engaged in the business of viatical settlements or life insurance.
    - Entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained based on information that was falsified or concealed for the purpose of defrauding the policy's issuer, viatical settlement provider, or viator.
    - Facilitating the viator's change of residency state to avoid the provisions of the Act.
    - Facilitating or causing the creation of a trust with a non-Florida or other nonresident entity for the purpose of owning a life insurance policy covering a Florida resident to avoid the provisions of the Act.
    - Facilitating or causing the transfer of the ownership of an insurance policy covering a Florida resident to a trust with a situs outside this state or to another nonresident entity to avoid the provisions of the Act.
    - Applying for or obtaining a loan that is secured directly or indirectly by an interest in a life insurance policy with intent to defraud, for the purpose of depriving another of property or for pecuniary gain.
    - Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiring to commit, an act or omission specified above.
- *Stranger-originated life insurance practice* is an act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include, but are not limited to:
    - The purchase of a life insurance policy with resources or guarantees from or through a person who, at the time of such policy's inception, could not lawfully initiate the policy and the execution of a verbal or written arrangement or agreement to directly or indirectly transfer the ownership of such policy or policy benefits to a third party; and
    - The creation of a trust or other entity that has the appearance of an insurable interest in order to initiate policies for investors, in violation of insurable interest laws and the prohibition against wagering on life.

The bill adds the following to the list of prohibited practices under the Act:

- Knowingly entering into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of a viatical settlement contract or during an applicable period specified in s. 626.99287(1) or (2), F.S., unless the viator provides a sworn affidavit and accompanying independent evidentiary documentation in accordance with s. 626.99287, F.S.;
- Engaging in a fraudulent viatical settlement act;
- Knowingly issuing, soliciting, marketing, or otherwise promoting the purchase of a life insurance policy for the purpose of or with an emphasis on selling the policy to a third party; and
- Engaging in a STOLI practice.

The prohibited practices are accompanied by criminal penalties, which are not changed by the bill. The severity of the penalties varies depending on the value of the insurance policy. If the value of the insurance policy is valued at:

- Less than $20,000, then the violation is a third-degree felony;
- $20,000 or more but less than $100,000, then the violation is a second-degree felony;

- $100,000 or more, then the violation is a first-degree felony.

The bill amends s. 626.99287, F.S., which contains the contestability requirements for viaticated life insurance contracts. Generally, a life insurance policy cannot be viaticated during the contestability period, as such viatical settlement contracts are void and unenforceable. The bill expands the contestability period for viaticated life insurance contracts from two years to five years if a viatical settlement policy is subject to a loan secured directly or indirectly by an interest in the policy. However, a viatical settlement contract may be entered into during the contestability period, if the viator provides a sworn affidavit and accompanying independent evidentiary documentation certifying to the viatical settlement provider that one or more specified exceptions were met during the applicable contestability period.

The bill makes the following changes to such specified exceptions for viatication of a life insurance policy prior to the expiration of the applicable contestability period:

- For a policy issued upon the owner's exercise of conversion[59] rights arising out of a group or term policy, the bill requires that the total time covered under the prior policy be at least 60 months. The time covered under a group policy must be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.
- The fact that the owner of the policy is not a natural person or that the viatical settlement contract was entered into before July 1, 2000, are no longer exceptions permitting viatication of a life insurance policy prior to the expiration of the applicable contestability period, as these exceptions are deleted by the bill.
- The bill amends the exception for illness such that the viator is required to be terminally or chronically ill. Currently, this exception requires a diagnosis of an illness or condition that is catastrophic, life threatening, or requires a course of treatment of at least three years or home health care. The bill maintains the requirement that the condition must not have been known to the insured at the time the life insurance contract was entered into.
- The bill creates an exception for a viatical settlement contract entered into more than two years after the policy's issuance date if, with respect to the policy, at all times before the date that is two years after policy issuance, the following conditions were met:
    - Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed only to the extent of its net cash surrender value, provided by, or fully recourse liability incurred by, the insured;
    - There is no agreement or understanding with any other person to guarantee any such liability or to purchase, or stand ready to purchase, the policy, including through an assumption or forgiveness of the loan; and
    - Neither the insured nor the policy has been evaluated for settlement.

In response to the *Pruco* case from the Florida Supreme Court,[60] the bill creates ss. 626.99289 and 626.99291, F.S., in order to create a STOLI-policy exception to the two-year contestability period in s. 627.455, F.S.,[61] which applies to all life insurance contracts. Notwithstanding the two-year contestability period established by s. 627.455, F.S.,

- Any contract, agreement, arrangement, or transaction entered into for the furtherance or aid of a STOLI practice is void and unenforceable; and
- A life insurer may contest a life insurance policy if the policy was obtained by a STOLI practice.

[59] Conversion occurs when the insured converts life insurance under a group policy to an individual policy, often because the insured no longer qualifies for the group policy.
[60] *Pruco*, 200 So. 3d at 1203 & 1206-07.
[61] "Every insurance contract shall provide that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of 2 years from its date of issue except for nonpayment of premiums and except, at the option of the insurer, as to provisions relative to benefits in event of disability and as to provisions which grant additional insurance specifically against death by accident or accidental means." s. 627.455, F.S.

Effect of the Bill on Notice Requirements for Life Insurance

The bill creates s. 626.99292, F.S., to require that a life insurer provide an individual life insurance policyholder with a statement informing him or her that if he or she is considering making changes in the status of his or her policy, he or she should consult with a licensed insurance or financial advisor. The statement may accompany or be included in notices or mailings otherwise provided to the policyholder. The statement must also advise the policyholder that he or she may contact the DFS for more information and include a website address or other location or manner by which the policyholder may contact the DFS.

Preinsurance Inspection of Private Passenger Motor Vehicles

Insurers are required to perform preinsurance inspections of private passenger motor vehicles.[62] The requirement generally applies to a policy issued on a private passenger motor vehicle principally garaged in counties with a 1988 population of 500,000 or greater. These counties are Duval, Palm Beach, Broward, Dade, Orange, Hillsborough, and Pinellas. There are various exemptions from the required preinsurance inspection, including for new, unused motor vehicles "purchased" from a licensed motor vehicle dealer or leasing company when the insurer is provided with the bill of sale, buyer's order, or copy of the title and certain other documentation.[63]

Despite the exemptions, an insurer may require a preinsurance inspection of any motor vehicle as a condition of issuance of physical damage coverage. Physical damage coverage may not be suspended during the policy period due to the applicant's failure to provide the required documents. However, claim payments are conditioned upon, and are not payable until, the required documents are received by the insurer. Applicants for insurance may be required to pay the cost of the preinsurance inspection, not to exceed five dollars.

In 2016, the Legislature required DFS to provide a report on preinsurance inspections in the state.[64] The report was issued on December 22, 2016.[65] The required elements and reported data[66] for 2012-2016 are:

- Total cost incurred by insurers and policyholders in order to comply with the inspections.
  - Insurers: $12,062,089 Policyholders: None
- Total cost incurred by insurers to have motor vehicles inspected.
  - $12,062,089
- Total premium savings for policyholders as a result of the inspections.
  - $35,640

[62] Section 627.744(5), F.S., requires that the inspection include:
- Taking an imprint or record of the vehicle identification number in a manner set by rule,
- Recording of accessories, as specified by rule, and
- Recording the location and description of damaged areas.

[63] Section 627.744(2), F.S, provides the following additonal exemptions:
- Vehicles added by policyholders continuously insured for two or more years,
- Temporary substitute motor vehicles,
- Motor vehicles leased for less than six months, contingent upon certain documentation,
- Vehicles 10 years old or older,
- Renewal policies,
- Vehicles or policies exempted by rule,
- Vehicles that are garaged too far from a contracted inspection facility,
- Vehicles on a commercial rated policy with five or more insured vehicles,
- Upon transfer of a book of business among insurers, and
- When coverage is transferred by an individual insured to a new insurer.

[64] Ch. 2016-133, Laws of Fla.

[65] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF INVESTIGATIVE & FORENSIC SERVICES, *627.744(8)(a), F.S. Motor Vehicle Pre-Inspection – Reporting Requirements* (Dec. 22, 2016).

[66] The survey and data request summarized in the report included responses received from 157 insurers (39 provided data). *Id.* at 2.

- Total number of inspected motor vehicles that had preexisting damage.
    - 125,787 motor vehicles inspected.
- Data on potential fraud within the first 125 days after issuance of a new policy.
    - 6,166 potential fraud claims.
- Total number of referrals to the National Insurance Crime Bureau (NICB) by preinsurance inspectors during the past 5 years.
    - 626 referrals made to NICB.[67]

Effect of the Bill on Preinsurance Inspection of Private Passenger Motor Vehicles

Effective January 1, 2019, the bill authorizes insurers to opt out of required preinsurance inspections. When opting-out, the insurer must file a manual rule with the OIR stating that the insurer will not be participating in the statutory inspection program and will not require such inspections. An insurer that has opted-out may establish its own preinsurance inspection requirements as a condition to issuing a private passenger motor vehicle insurance policy. An insurer may not require payment from the consumer if the insurer implements their own preinsurance inspection program.

Miscellaneous Provisions

The bill also makes several changes to statutory citations to conform to changes made by the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[67] DFS also reports that 4,065 referrals were made to the Division of Investigative & Forensic Services (formerly the Division of Insurance Fraud) during the same period. *Id.* at 7.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Insurance companies may incur additional costs in implementing the new requirements for their fraud-prevention programs and the required data reporting. However, these costs may be more than offset if compliance results in more effective fraud prevention and enforcement.

Policyholders and insurers may experience reduced costs if the insurers elect not to require preinsurance inspections while maintaining control over claim fraud through currently available or lower cost alternative methods. Preinsurance inspection providers may see a decrease in referrals if insurers choose to opt out of required inspections.[68]

D. FISCAL COMMENTS:

None.

[68] CARCO Group, Inc., which is a service provider, provided data that was included in the DFS report. For 2012-2016, CARCO reported $5.6 million in total costs incurred by 34 clients over the period. *Id.* at 4.