The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/CS/SB 1012
INTRODUCER:	Appropriations Committee; Banking and Insurance Committee; and Senators Brandes and Young
SUBJECT:	Insurer Anti-fraud Efforts
DATE:	April 27, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Fav/CS**
2.	Sanders	Betta	AGG	**Recommend: Favorable**
3.	Sanders	Hansen	AP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1012 creates new requirements for insurance companies relating to insurance fraud prevention and reporting. The bill requires all insurers to adopt an anti-fraud plan and to establish and maintain a unit within the company to investigate possible fraudulent insurance acts or contract with others to investigate fraudulent insurance acts. The insurer must electronically file with the Department of Financial Services (DFS) a detailed description of the unit established to investigate possible fraudulent insurance acts or a copy of the contract with the company that investigates fraudulent insurance acts for the insurer and a copy of the anti-fraud plan. This filing must be made annually on or before December 1, starting in 2017.

The anti-fraud plan must include:

- An acknowledgment that the insurer has established procedures for detecting possible fraudulent insurance acts;
- An acknowledgement that the insurer has established procedures for reporting such acts to the DFS;
- An acknowledgement that the insurer provides required anti-fraud education to employees;
- A description of the anti-fraud education;
- A description of the insurer's anti-fraud unit; and
- The rationale for staffing levels and resources provided to the anti-fraud unit.

Beginning in 2019, the bill requires every insurer to annually submit anti-fraud statistics to the DFS by March 1 for the lines of business written by that insurer for the calendar year. The statistics must include:

- The number of policies in effect;
- The amount of premiums written for policies;
- 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 fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
- The number of cases referred to the DFS;
- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount of damages in cases referred to the DFS or other agencies.

Current law only requires statistical reporting from workers' compensation insurers. This bill requires all insurers to provide reports.

The bill modifies reporting requirements for workers' compensation insurers.

The bill creates a dedicated prosecutor program administered by the DFS. The DFS does not anticipate an impact to any state revenues or expenditures.[1] The program will allow state attorneys to seek grants from the DFS, subject to funding by the Legislature, to add positions to prosecute insurance fraud cases.

The bill makes stranger-originated life insurance (STOLI) contracts void and unenforceable and allows a life insurer to contest a policy obtained through a STOLI practice, notwithstanding that life insurance contracts cannot be contested two years after issuance. A 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 has no insurable interest in the insured at policy origination.

The bill makes void and unenforceable viatical settlement contracts subject to a loan secured by an interest in the insurance policy within five years from the issuance of the underlying insurance policy. This is referred to as the contestability period of the viatical settlement contract. The bill otherwise retains the existing two year contestability period under current law. Current law provides conditions that, if met, allow the execution of a viatical settlement contract during the contestability period. The bill modifies the process for doing so. The viator must provide a sworn affidavit and accompanying independent evidentiary documentation to a viatical settlement provider certifying that the viator has met a statutory exception that allows viatication of a policy during the contestability period. Current law does not require the viator to execute a sworn

[1] Email from Elizabeth Boyd, Legislative Affairs Director (April 7, 2017) (on file with the Senate Appropriations Subcommittee on General Government).

affidavit with documentation evidencing that the exception applies. The bill also revises and clarifies some of the conditions that allow viatication during the contestability period.

The bill adds as prohibited practices under the Viatical Settlement Act:
- Engaging in a fraudulent viatical settlement act;
- Engaging in a STOLI practice;
- Knowingly entering into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of the viatical settlement contract or within a contestability period unless the viator complied with s. 626.99287, F.S.; and
- Knowingly issuing, soliciting, marketing, or promoting the purchase of a life insurance policy for the purpose of, or with an emphasis on selling the property to a third party.

Violations are third-degree felonies if the insurance policy has a value less than $20,000; second-degree felonies if the insurance policy has a value of $20,000 or more but less than $100,000; and first-degree felonies if the insurance policy has a value of $100,000 or more.

Allows motor vehicle insurers an exemption from the requirement that they inspect each private passenger motor vehicle before issuing an insurance policy that provides coverage for physical damage. The inspection requirement only applies in counties with a 1988 population of 500,000 or greater. The bill requires insurers using the exemption to file a manual rule with the Office of Insurance Regulation (OIR) and allows an insurer to file with the OIR their own preinsurance inspection requirements before insuring a private passenger motor vehicle.

Except as otherwise provided, the bill takes effect upon becoming a law.

II. Present Situation:

The Department of Financial Services (DFS) regulates insurance agents, insurance agencies, and insurance adjusters. The DFS' Division of Investigative and Forensic Services (division) contains sworn law enforcement officers that investigate various types of insurance fraud including personal injury protection (PIP) fraud, workers' compensation fraud, vehicle fraud, application fraud, licensee fraud, homeowner's insurance fraud, and healthcare fraud. Florida statutes direct the division to investigate fraudulent insurance acts, violations of the Unfair Insurance Trade Practices Act, false and fraudulent insurance claims, and willful violations of the Florida Insurance Code and rules adopted pursuant to the code. The division employs sworn law enforcement officers to investigate insurance fraud and other matters within the division's jurisdiction. In Fiscal Year 2014-2015, the division received 17,392 referrals.[2]

Insurance Fraud

According to the Insurance Information Institute (III), 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,

[2] http://www.fldfs.com/Division/DIFS/resources/documents/2014-15_Annual-Report.pdf (last accessed March 29, 2017).

> 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.[3]

The III further states that:

> 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.[4]

According to the National Insurance Crime Bureau[5] (NICB), questionable insurance claims rose from 100,201 in 2011 to 116,171 in 2012; which is a 16 percent increase.[6] Furthermore, fraud is the second most costly white-collar crime in America behind tax evasion.[7] According to the NICB, fraud leads to higher insurance rates, causes taxes to rise, and inflates prices for consumer goods.[8]

The Federal Bureau of Investigation estimates the total cost of insurance fraud, excluding health insurance fraud, at more than $40 billion per year. Insurance fraud costs the average U.S. family between $400 and $700 per year in the form of increased premiums.[9]

Anti-Fraud Requirements Imposed on Insurance Companies

Section 626.9891, F.S., requires each insurer admitted to do business in this state, if the insurer received $10 million or more in direct premiums during the previous calendar year, to establish a unit to investigate possible insurance claim fraud or to contract with others to investigate such fraud. The insurer must file a detailed description of the anti-fraud unit, or provide a copy of the contract, to the division.[10]

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[3] Insurance Information Institute, *Fraud*, http://www.iii.org/fact-statistic/fraud (last visited April 11, 2017).
[4] *Id*.
[5] The National Insurance Crime Bureau (NICB) is a not-for-profit organization that receives support from nearly 1,100 property and casualty insurance companies and self-insured organizations. The NICB partners with insurers and law enforcement agencies to facilitate the identification, detection and prosecution of insurance criminals. https://www.nicb.org/about-nicb (last visited April 11, 2017).
[6] Insurance Information Institute, *Fraud*, http://www.iii.org/fact-statistic/fraud (last visited April 11, 2017).
[7] The NICB, Insurance Fraud: Understanding the Basics, https://www.nicb.org/theft_and_fraud_awareness/fact_sheets (last visited April 12, 2017).
[8] *Id.*
[9] The Federal Bureau of Investigation, Insurance Fraud, https://www.fbi.gov/stats-services/publications/insurance-fraud (last visited April 11, 2017).
[10] Section 626.9891(1), F.S.

If the insurer received less than $10 million in direct premiums during the previous calendar year, the insurer must submit an anti-fraud plan to the division.[11] The anti-fraud plan must describe:

- 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 division;
- 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.[12]

Workers' compensation insurers are required to report the following to the DFS on or before August 1 of each year:

- 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 fraud referrals submitted to the Bureau of Workers' Compensation Fraud for the prior year;
- A description of the organization of its anti-fraud unit, if applicable;
- The rationale for the level of staffing and resources being provided for the anti-fraud unit, which may include the objective criteria such as:
  - Number of policies written;
  - Number of claims received on an annual basis;
  - Volume of suspected fraudulent claims currently being detected; and
  - An assessment of optimal caseload that can be handled by an investigator;
- The in-service anti-fraud education and training provided to personnel; and
- A description of a public awareness program focused on insurance fraud and methods by which the public can prevent it.[13]

If an insurer fails to comply with the requirements for anti-fraud units or anti-fraud plans or fails to comply other provisions of law, the DFS, Office of Insurance Regulation (OIR), or Financial Services Commission may impose certain administrative fines.[14]

Dedicated Prosecutor Program

The Dedicated Prosecutor Program (program) was created in September of 2003 and 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 program has 36 full time positions with 20 dedicated prosecutors located in Jacksonville,

[11] Section 626.9891(2), F.S.
[12] Section 626.9891(3), F.S.
[13] Section 626.9891(6), F.S.
[14] Section 626.9891(7), F.S.

Orlando, Miami-Dade, Tampa, West Palm Beach, Broward, and Ft. Myers. Four positions are devoted solely to workers' compensation fraud.[15]

Current law does not specify requirements for participation in the program. Instead, the program is authorized by proviso language in the General Appropriations Act. The 2016 proviso states "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 division has found that certain participating state attorney's 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.[16]

Viatical Settlement Contracts - Stranger-Oriented Life Insurance (STOLI)

Life Insurance – Insurable Interests

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 lost by the death of the insured.[17] A fundamental concept in life insurance is that the purchaser and beneficiary of an insurance policy must have an insurable interest—a reasonable expectation of a monetary benefit from the continued well-being of the life insured. In the context of life insurance, the insurable interest[18] prevents purchasing insurance as a form of gambling on the death of the insured, which creates a moral hazard for the purchaser who may be tempted to create a situation where he or she will be able to collect on the policy.

Florida law prohibits the procurement of "an insurance contract on the life or body of another individual unless the insurance contract benefits are payable to the insured, his or her personal representatives, or a person having an insurable interest in the insured when the contract was made."[19] Persons with insurable interest include the insured, family members and loved ones of the insured, others if the insured's life and health is of greatest benefit to them, trusts and trustees in specified circumstances, charitable organizations, and business organizations in specified circumstances.[20]

Viatical Settlement Contracts - Background

A viatical settlement contract is a written agreement entered into between the owner[21] of a life insurance policy, referred to as the viator, and a viatical settlement provider wherein the viator

[15] Department of Financial Services, *Analysis of SB 1012* (March 8, 2017) at p. 2.
[16] *Id*.
[17] Office of Insurance Regulation, *Life Insurance*, http://www.floir.com/Sections/LandH/Life/default.aspx (last visited April 14, 2017).
[18] Section 627.404, F.S., lists nine exclusive categories in which an "insurable interest" as to life, health or disability insurance are recognized.
[19] The insurable interest need not exist after the inception date of coverage under the contract. *See* s. 627.404(1), F.S.
[20] Section 627.404(2)(b), F.S.
[21] Or certificateholder if a group policy.

agrees to transfer ownership or change the beneficiary designation of a life insurance policy at a later date in exchange for compensation paid to the viator.[22] The compensation paid to the viator is generally less than the expected death benefit under the policy. Rather than retaining the policy, the provider usually sells all or part of the policy to one or more investors. In return for providing funds, these investors receive the death benefit, or a proportionate share thereof, upon the passing of the insured.

Viatical settlements emerged during the HIV/AIDS epidemic in the 1980s, enabling terminally ill patients with short life expectancies who could no longer work and 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,[23] who in those days were typically senior individuals who risked their savings in what was represented as a safe investment and 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.

Two consequences resulted from the insureds of viaticated policies exceeding their life expectance. The first is that some viatical settlement providers stopped brokering new viatical settlements. The second, unfortunately, is that some viatical settlement providers engaged in fraudulent practices.[24]

An example cited by the Office of Insurance Regulation (OIR) of such fraudulent activity was Mutual Benefits Corporation (MBC).[25] In 2004, the OIR suspended MBC's license and the United States Securities and Exchange Commission (SEC) filed an action in federal court seeking an injunction and the appointment of a receiver. The court-appointed receiver reported that MBC had fraudulently procured insurance policies with a total face value of approximately $1.4 billion. The SEC agreed to a $25 million settlement and referred the case to prosecutors. Federal prosecutors charged former company employees, most of whom pled guilty and were sentenced to lengthy prison terms. A factual statement filed by an MBC employee described the scheme. Mutual Benefits Corporation would falsely promise investors a fixed rate of return but was unable to keep those promises because insureds lived longer than expected and their premiums had to be paid to keep the underlying policies in force. New investor sales were used to continue to pay premiums on the previously viaticated life insurance policies. The MBC experience and other fraudulent schemes led to the Legislature comprehensively reforming the regulation of the viatical settlement industry in 2005.

Today, the viatical settlement market is not limited to the purchase of the life insurance products of the terminally ill. Viatical settlement contracts are also entered into with non-terminally ill insureds that no longer want, need, or can afford their policies. These agreements, often referred

[22] Section 626.9911, F.S.
[23] 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).
[24] Office of Insurance Regulation, *Secondary Life Insurance Market Report to the Florida Legislature* (Dec. 2013), p. 9.
[25] *See* Office of Insurance Regulation, *supra* note 5, at pg. 10.

to as life settlements, serve as an alternative to exercising a redemption or accelerated death benefit clause in life insurance policies.

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.[26]

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 Conference of Insurance Legislators (NCOIL)[27] developed model state legislation regulating the "front-end" transaction of viatical settlements in 1993 and 2007, respectively.

Regulation of the Viatical Settlement Industry

Viatical settlement providers and viatical settlement brokers are required to obtain licensure from the OIR. The Viatical Settlement Act (Act)[28] sets forth requirements for licensure, annual reporting, 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 viatical service providers and brokers; review and approval authority over the viatical settlement contracts and forms; rulemaking authority; and provided that a violation of the Act is an unfair trade practice under the Insurance Code. The Act does not authorize the OIR to regulate the rate or amount paid as consideration for a viatical settlement contract.[29]

In 2005, legislation was enacted that requires the investment transaction to be regulated as a security under ch. 517, F.S. These investments must be registered with either the OFR or the SEC. In addition, persons offering such investments must obtain licensure from the OFR and provide full and fair disclosures concerning viatical settlement investments to prospective investors. 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 viatical service provider for compensation is a *viatical settlement broker* who must be licensed with the Department of Financial Services (DFS) as a life insurance agent with a proper appointment from a viatical service provider. Viatical settlement brokers owe a fiduciary duty to the viator.[30]

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[26] 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 April 14, 2017).
[27] 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 April 14, 2017).
[28] Ch. 96-336, Laws of Fla.
[29] Section 626.9926, F.S.
[30] Sections 626.9911(9) and 626.9916, F.S.

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.[31] 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 protections for institutional purchasers in the secondary life insurance market existed and that their recommendations did not warrant legislative action at the time.[32]

Stranger-Originated Life Insurance

Stranger-originated life insurance (STOLI) is somewhat similar to a viatical transaction, but with the key difference that the individual who obtains a life insurance policy does so for the express purpose of assigning the policy in exchange for compensation. In a typical STOLI transaction, an individual (usually a senior) is encouraged to take out insurance on his or her own life, sometimes in the millions of dollars. The individual 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.

STOLI also differs from legitimate viatical settlements with 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.

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 is a perversion of the life insurance asset and leads to the moral hazard concerns that insurable interest doctrines were intended to mitigate.[33]

Stranger-originated life insurance may appear similar to a viatical or life settlement. The critical difference is that in viatical or life settlements, an insured initially buys life insurance in a good-

[31] Ch. 2013-40, s. 6, Laws of Fla. (2013 General Appropriations Act, p. 316).
[32] *See* Office of Insurance Regulation, *supra* fn. 5, pp. 50-51.
[33] 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 April 13, 2017).

faith intent to protect valid insurable interests (i.e., to protect family members or a business from the risk of a premature death). The individual 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). In a STOLI, the policy is intentionally purchased for the benefit of persons (usually investors) who lack an insurable interest at the time the life insurance contract is entered into. These investors ultimately receive the proceeds, directly or indirectly.[34] The Uniform Law Commission has noted that the beneficiaries of STOLI transactions argue that it is an appropriate use of life insurance consistent with applicable legal principles, including the free transferability of assets. Life insurers oppose the use of STOLI, arguing that it is a perversion of the concept of life insurance and leads to the moral hazard concerns that insurable interest doctrines are intended to mitigate.[35]

Transactions involving STOLI often use fraudulent means to procure life insurance on individuals, such as misrepresentation, falsification, or omission of material facts in the life insurance application. The fraud is conducted so that an assignment or sale of a policy functions as a subterfuge that circumvents the insurable interest requirement. STOLI transactions generally target senior citizens and are often financed through non-recourse "premium finance loans." It is common for STOLI to be structured through the use of an irrevocable trust, which conceals from the life insurance company that the policy was sold. The insured pays premiums during the contestable period to prevent the insurer from discovering a possible violation of the insurable interest requirement.

According to the OIR, STOLI impacts consumers (both individual investors and insureds) and insurers in a number of ways:[36]

- 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.[37]
- 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.

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[34] AALU, NAIFA, and ACLI, *STOLI: The Problem and the Appropriate State Response*, p. 4, (on file with the Senate Committee on Banking and Insurance).

[35] 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 March 22, 2017).

[36] Office of Insurance Regulation (OIR), *2017 Agency Legislative Bill Analysis of HB 1205*, pg. 5 (March 12, 2017). Additionally, s. 626.9923, F.S., requires viatical service providers to disclose certain risks to viators, such as tax and Medicaid eligibility consequences.

[37] *See* IRS Rev. Ruls. 2009-13 and 2009-14, regarding taxation of proceeds from settlements as capital gains ordinary income and taxation on a post-settlement basis.

- 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.

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, criminal and regulatory enforcement actions, both nationally[38] and in Florida.[39]

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, there are no criminal penalties and an action for rescission by the life insurer is the only civil penalty available. 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.[40] Finally, the Unfair Insurance Trade Practices Act in s. 626.9541, F.S., lists several unfair methods of 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" and "churning" are first-degree misdemeanors, while willfully submitting false signatures on an application is a third-degree felony.[41]

Current law does not specifically define STOLI, nor does it have a specific regulatory prohibition on STOLI or life insurance policies lacking an insurable interest at inception. Life insurers engage in insurable interest litigation to combat STOLI, usually relying on the insurable interest statute in s. 627.404, F.S., to rescind the policies transferred in a STOLI transaction for a lack of insurable interest when the policy was initially entered into. This argument is sometimes opposed with arguments seeking the application of the incontestability statute, s. 627.455, F.S., which requires life insurance policies to include a provision barring the insurer from challenging the policy after it is in force for two years.

The OIR may use several legal, criminal or regulatory remedies to address STOLI transactions:

- *The Viatical Settlement Act* (Act) authorizes the OIR to impose fines of up to $2,500 for nonwillful violations and up to $10,000 for willful violations, or to suspend, revoke, deny, or refuse to renew the license of any viatical settlement provider 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.[42]

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[38] OIR, *STOLI Criminal Cases Against Agents May Be on Upswing*, http://www.floir.com/siteDocuments/ACLI17Feb28STOLICriminalCasesAgainstAgentsMayBeUpswing.pdf (February 28, 2012) (last visited April 14, 2017).
[39] 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 April 14, 2017) and 2013 OIR Report, *Appendix C: Florida Regulatory and Enforcement Actions Pertaining to Viatical Settlement Providers*.
[40] Sections 626.611, 626.6115, 626.6215, and 626.621, F.S.
[41] Section 626.9541, F.S.
[42] Sections 626.9914 and 626.99272, F.S.

- *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.[43]
- *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 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"[44] and "churning"[45] are first-degree misdemeanors, while willfully submitting false signatures on an application is a third-degree felony.[46] While viatical settlement providers (VSP) are subject to s. 626.9541, F.S., by way of s. 626.9927, F.S., 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.[47]

Insurers and investors have relied on two dueling statutes that 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,

[43] Sections 626.611, 626.6115, 626.6215, and 626.621, F.S.

[44] 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."

[45] "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.

[46] Section 626.9541, F.S.

[47] OIR Agency Analysis, *supra* note 24, at 2.

arguing that a tardy challenge is barred regardless 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.[48] These appeals were consolidated to the U.S. Court of Appeals for the Eleventh Circuit (Eleventh Circuit). The Eleventh Circuit noted that there are no cases decided by Florida courts that specifically addressed whether a party can challenge an insurance policy as being void ab initio [to be treated as invalid from the beginning][49] 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.[50]
- In September 2016, the Florida Supreme Court considered the Eleventh Circuit's certified questions and 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."[51] 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 after the two-year contestability period established by section 627.455 because of its creation through a STOLI scheme?"[52] 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."[53]

Preinsurance Inspection of Private Passenger Motor Vehicles

Section 627.744, F.S., requires insurers to perform preinsurance inspections of private passenger motor vehicles. The inspection must include:

- Taking a physical imprint of the vehicle's vehicle identification number or otherwise recording the vehicle identification number in a manner prescribed by the Financial Services Commission (the commission).
- Recording the presence of accessories required by the commission to be recorded.
- Recording the locations of and a description of existing damage to the vehicle.

The requirement 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 exceptions for:

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[48] *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).
[49] BLACKS LAW DICTIONARY, http://thelawdictionary.org/article/ab-initio-big-deal-contract-law/ (last visited April 13, 2017).
[50] *Pruco Life Ins. Co. v. Wells Fargo Bank, N.A.*, 780 F.3d 1327 at 1336 (11th Cir. C.A. 2015).
[51] *Wells Fargo Bank, N.A. v Pruco Life Ins. Co.*, 200 So. 3d 1202, 1206 (Fla. 2016). The appeal will go back to the Eleventh Circuit for final disposition.
[52] *Id.* at 1206-07.
[53] *Id*. at 1203.

- New, unused motor vehicles purchased or leased from a licensed motor vehicle dealer or leasing company;[54]
- 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 ten years old or older;
- Renewal policies;
- Vehicles or policies exempted by rule of the commission;
- Vehicles garaged too far from a contracted inspection facility;
- Vehicles on a commercial rated policy with five or more insured vehicles;
- When an insurance producer transferring a book of business from one insurer to another; and
- When an individual insured's coverage is being transferred and initiated by a producer to a new insurer.

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 $5.[55]

In 2016, the Legislature required the Department of Financial Services (DFS) to provide a report on preinsurance inspections in the state.[56] The report was issued on December 22, 2016.[57] The required elements and reported data[58] 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
- 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 NICB by preinsurance inspectors during the past five years.

[54] The insurer may require a bill of sale, buyer's order, or lease agreement, or copy of title or registration that establishes transfer of ownership from the dealer or leasing company and the window sticker. See s. 627.744(2)(b), F.S.
[55] Section 627.744(4), F.S.
[56] Chapter 2016-133, L.O.F.
[57] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF INVESTIGATIVE & FORENSIC SERVICES, s. *627.744(8)(a), F.S. Motor Vehicle Pre-Inspection – Reporting Requirements* (Dec. 22, 2016). (on file with the Senate Committee on Banking and Insurance.)
[58] The survey and data request summarized in the report included responses received from 157 insurers (39 provided data).

- 626 referrals made to NICB.[59]

Many insurers argue based on the findings of this report that the mandatory cost for such inspections does not justify the potential cost avoidance. However, vendors that provide these mandatory inspections argue, when taking into account the average cost of repair to vehicles along with the number of vehicles noted as having damage at time of inspection, the total cost avoidance from potential fraud should be much higher than what has been reported.

III. Effect of Proposed Changes:

Anti-Fraud Requirements Imposed on Insurance Companies (Section 1)

Section 1 amends s. 626.9891, F.S., to create more uniform requirements for insurers to create anti-fraud units and anti-fraud plans than those that exist in current law. This section requires every insurer to designate at least one employee responsible for meeting the requirements of s. 626.9891, F.S. As an administrative expense for ratemaking purposes, insurers must include the additional cost incurred in creating an anti-fraud unit, hiring additional employees, or the cost of contracting with another entity to fulfill the requirements of this act.

"Anti-fraud investigative unit," as used in this section, means the designated anti-fraud unit or division, or contractor authorized to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

This section requires all insurers to establish and maintain a designated anti-fraud unit or alternatively, to contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

Additionally, under this section, insurers are required to adopt an anti-fraud plan. The anti-fraud plan must 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;
- An acknowledgment that the insurer has established procedures for the mandatory reporting of possible fraudulent insurance acts to the division;
- An acknowledgment that the insurer provides the required anti-fraud education and training to the anti-fraud unit;
- A description of the required anti-fraud education and training;
- A description or chart of the insurer's anti-fraud investigative unit including position titles and descriptions of staffing; and
- The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria, such as:
  - The number of policies written;
  - The number of claims received on an annual basis;
  - The volume of suspected fraudulent claims detected on an annual basis; and

[59] DFS also reports that 4,065 referrals were made by insurers to the Division of Investigative & Forensic Services (formerly the Division of Insurance Fraud) during the same period.

- An assessment of the optimal caseload that one investigator can handle on an annual basis.

Insurers must establish the anti-fraud units and anti-fraud plans (or enter into an appropriate contract) by December 31, 2017. Furthermore, the insurer must electronically file with the Department of Financial Services (DFS), on an annual basis, the anti-fraud plan or executed contract together with the name of the employee designated as responsible for implementing the requirements of this act.

This section requires every insurer to provide at least two hours of initial anti-fraud training to the designated anti-fraud investigative unit or contractor by December 31, 2018. Each insurer must also provide an annual one-hour refresher course that addresses detection, referral, investigation, and reporting of suspected insurance fraud for the types of insurance lines written by the insurer.

This section requires every insurer to submit anti-fraud statistics by March 1, 2019, and annually thereafter, for the lines of business written by that insurer for the prior calendar year. The statistics must include:

- The number of policies in effect;
- The amount of premiums written for policies;
- 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 fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
- The number of cases referred to the Division of Investigative and Forensic Services (division);
- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount of damages in cases referred to the division, or other agencies.

Current law only requires statistical reporting from workers' compensation insurers. This section requires all insurers to provide reports by March 1, 2019, and annually thereafter. The bill requires the DFS to adopt rules to administer the reporting requirements of the bill.

This section also requires workers' compensation insurers to report the following information each year:

- The estimated dollar amount of losses attributable to workers' compensation fraud delineated by the type of fraud, including: claimant, employer, provider, agent, or other type;
- The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including: claimant, employer, provider, agent, or other type; and
- The number of cases referred to the division, delineated by the type of fraud, including: claimant, employer, provider, agent, or other type;

This section provides that an insurer who obtains a certificate of authority has six months to establish the anti-fraud unit or enter into an appropriate contract. During the same six months, the insurer must adopt an anti-fraud plan and must designate an employee responsible for complying with s. 626.9891, F.S. The section further provides that the insurer has one calendar year thereafter, to file the anti-fraud plan with the DFS and comply with relevant reporting requirements. Administrative fines may be assessed if an insurer fails to comply with s. 626.9891, F.S.

The bill requires the division to create a report detailing best practices for the detection, investigation, prevention, and reporting of insurance fraud and other fraudulent insurance acts. The report must be completed by 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 division 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 division.

Dedicated Prosecutor Program (Section 2)

Section 2 creates s. 626.9896, F.S., to create the Insurance Fraud Dedicated Prosecutor Program (program).

Legislative Intent

This section provides legislative intent to address the increasing problem of insurance fraud, the need to adequately investigate and prosecute insurance fraud and the need to create a program dedicated to the prosecution of insurance fraud. The Legislature recognizes the division can efficiently and effectively monitor the program, can direct and reallocate resources as insurance trends change and demand for prosecutorial resources shift between judicial circuits.

Purpose of the Program

This section creates a grant program within the DFS to fund the program. The purpose of the program is to provide grants to state attorneys' offices to fund attorney and paralegal positions for the exclusive prosecution of insurance fraud. The program will consist only of funds appropriated specifically for the program.

Grant Applications

Beginning in 2018, a state attorney's office seeking grant funds must submit an application to the division detailing the proposed number of dedicated prosecutors and paralegals requested for the prosecution of insurance fraud. Applications must be received by July 1 of each even-numbered year and shall identify funding needs for two years. Grant awards are contingent upon legislative appropriation and subject to renewal by the DFS. The division is required to compile and review the timely submitted applications to establish its legislative budget request for the program for the upcoming two years.

Award of Grants

The section authorizes the division to award grants to state attorneys' offices using a formula adopted by rule. The rule must be based on metrics and data compiled by the division that allocates funds to the judicial circuits based on trends in insurance fraud and the performance and output measures reported to the division. A grant is subject to s. 215.971, F.S., and may only be used to fund attorney and paralegal positions that are dedicated exclusively to the prosecution of insurance fraud. The division shall establish the annual maximum grant amount based on funds appropriated to the DFS for funding the program.

Reporting

The section requires the division to track and report on the effectiveness and efficiency of each state attorney's office's use of the awarded grant funds. To help complete the report, each state attorney's office that is awarded a grant must submit performance and output information to the division. The report must be provided to the Executive Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate by September 1, 2020, and annually thereafter. The report must include, but is not limited to, the following:

- The amount of grant funds received and expended by each state attorney's office;
- A description of the purposes for which the funds were expended, including payment of salaries, expenses, and any other costs needed to support the delivery of services; and
- The results achieved from the expenditures made, including the number of complaints filed, the number of investigations initiated, the number of arrests made, the number of convictions, and the amount of restitution or fines paid as a result of the cases presented for prosecution.

Rules

The section provides that the DFS may adopt rules for the administration and implementation of the program, including procedures, forms, formulas and standards.

Viatical Settlement Agreements – Stranger- Oriented Life Insurance (STOLI) (Sections 3-10)

Defining a "Fraudulent Viatical Settlement Act" and a "Stranger-originated Life Insurance Practice" (Section 3)

Section 3 creates two new subsections in s. 626.9911, F.S. The new subsection (2) defines "fraudulent viatical settlement acts" as an act or omission committed by a person who

knowingly, or with intent 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:

- Presenting, causing to be presented, or preparing false or concealed material information concerning specified material facts, such as:
  - 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;
  - 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 related to viaticated policies for the purpose of perpetrating fraud;
- Engaging in a stranger-originated life insurance 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 its detection;[60]
- Embezzling, stealing, or misappropriating funds or other property of an insurance policyholder, insured, insurer, viator, viatical settlement provider, or any person engaged in the business of viatical settlement contracts 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 on false or concealed information to defraud the policy's issuer, a viatical settlement provider, or a viator;
- Facilitating the viator's change of state to avoid the provisions of this 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 this 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; and
- Attempting to commit, assisting, aiding, abetting, or conspiring to commit an act or omission that meets the definition of a "fraudulent viatical settlement act."

Subsection (9) is created for the purpose of defining a "stranger-originated life insurance practice." It is an act, practice, arrangement or agreement to initiate a life insurance policy for the

[60] Such acts include removing, concealing, altering, destroying, or sequestering from the OIR the assets or records of a licensee or other person engaged in viatical settlements; misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person; transacting business relating to viatical settlement contracts in violation of the Viatical Settlement Act; and filing with the OIR or the insurance regulator in another jurisdiction false information or concealing information about a material fact.

benefit of a third party investor who has no insurable interest in the insured at policy origination.[61]

Contestability Periods for Viaticated Policies and Stranger-Originated Life Insurance (Sections 4, 7 and 9)

Section 4 amends s. 626.9924, F.S., to require the viatical settlement provider to give the documents required under s. 626.99287, F.S., to the life insurer that issued a life insurance policy within 20 days of an agreement to viaticate the policy during the five-year contestability period. The documents must accompany the notice required under current law. The required documents support the affidavit executed by the viator that an exception applies allowing the creation of a viatical settlement contract within five years after the issuance of the viaticated insurance policy.

Section 7 amends s. 626.99287, F.S., and makes void and unenforceable viatical settlement contracts entered into within five years from the issuance of the underlying insurance policy if the policy is subject to a loan secured directly or indirectly by an interest with the policy. This is the contestability period of the viatical settlement contract. The bill otherwise retains the two-year contestability period for viatical settlement contracts under current law.

Current law provides conditions that, if met, allow the execution of a viatical settlement contract during the contestability period. This section modifies the process for doing so. The viator must provide a sworn affidavit and accompanying independent evidentiary documentation to a viatical settlement provider certifying that the viator has met a statutory exception that allows viatication of a policy during the contestability period. Current law does not require the viator to execute a sworn affidavit with documentation evidencing that the exception applied.

This section revises two of the conditions allowing viatication during the contestability period. Currently, the limitation on viaticating a policy does not apply the life insurance policy was issued upon the owner's exercise of conversion rights arising out of a group or term policy. The bill limits this condition by requiring that the policy has been in effect for at least 60 months.[62] This section clarifies the exception for insureds or viators with illnesses by requiring them to provide evidence of a "terminal" or "chronic" illness, terms that are more precise in meaning than the current law. Current law refers to an illness that is catastrophic, life threatening, or requires at least three years of long-term care or home health care.

The bill allows the viator to enter into a viatical settlement contract more than two years after the policy's issuance date if at all times prior to two-years after policy issuance, the viator met three conditions. The viator must continuously fund the policy premiums exclusively with the viator's unencumbered assets.[63] There must not be an agreement or understanding with another person to

[61] The bill states that stranger-originated life insurance practices include the purchase of a life insurance policy with resources or guarantees from or through a person who, at the time of the policy's inception, is not lawfully able to execute an arrangement or agreement to transfer the ownership or benefits of the policy to a third party. It also includes creating 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.

[62] The 60-month period is calculated without regard to any change in insurance carriers if coverage has been continuous and under the same group sponsorship.

[63] May include the net surrender value of the life insurance policy being financed.

guarantee any liabilities related to the policy or to purchase the policy. Neither the insured nor policy were evaluated for settlement.

Section 9 creates s. 626.99291, F.S., to allow a life insurer to contest a life insurance policy that was obtained by a STOLI practice, notwithstanding s. 627.455, F.S., which provides that life insurance and annuity contracts are not to be contestable for the initial two years.

Prohibiting Fraudulent Viatical Settlement Acts and Stranger Originated Life Insurance (Sections 6 and 8)

Section 6 amends s. 626.99275(1), F.S., to add to the list of prohibited practices:

- Knowingly entering into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of the viatical settlement contract or during the two-year contestability period specified in s. 626.99287(1)F.S., or the five-year contestability period specified in s. 626.99287(2), F.S., unless the viator provides a sworn affidavit and accompanying evidence pursuant to;
- Engaging in a fraudulent viatical settlement act, as defined in s. 626.9911, F.S.;
- Knowingly issuing, soliciting, marketing, or promoting the purchase of a life insurance policy for the purpose of, or with an emphasis on selling the property to a third party; and
- Engaging in a stranger-originated life insurance practice, as defined in s. 626.9911, F.S.

The prohibited practices are subject to criminal penalties, which remain unchanged. Violations are third-degree felonies if the insurance policy has a value less than $20,000; second-degree felonies if the insurance policy has a value of $20,000 or more but less than $100,000; and first-degree felonies if the insurance policy has a value of $100,000 or more.[64]

Section 8 creates s. 626.99289, F.S., to make void and unenforceable any contract or agreement entered into for the furtherance or aid of a STOLI practice.

Notice to Insureds (Section 10)

Section 10 creates s. 626.99292, F.S., to require a life insurer to provide an individual life insurance policyholder with a statement informing him or her that a policyholder considering changes in the status of a policy should consult with a licensed insurance or financial advisor. The statement must also advise the policyholder that he or she may contact the Office of Insurance Regulation (OIR) for more information and include a website address or other manner by which the policyholder may contact the OIR. The statement may accompany or be included in notices or mailings otherwise provided to the policyholder.

Miscellaneous Provisions (Section 5)

Section 5 amends s. 626.99245, F.S., to correct a cross reference. This section provides viatical settlement providers doing business from this state must obtain a viatical settlement license from the OIR. The term "doing business from this state" within this subsection, includes effectuating viatical settlement agreements from offices in this state, regardless of the state of residence of the viator.

[64] Section 626.99275(2), F.S.

Preinsurance Inspection (Section 11)

Section 11 allows motor vehicle insurers to opt out of the requirement that they inspect each private passenger motor vehicle before issuing an insurance policy that provides coverage for physical damage, including collision and comprehensive coverages.

An insurer who elects to opt out of inspection requirements must file a manual rule with the OIR indicating it will not participate in the inspection program under s. 627.744, F.S. The insurer may establish its own preinsurance inspection requirements as a condition to issuing a private passenger motor vehicle insurance policy, and such requirements must be included in the manual rule filed with the OIR. Insurers may not charge applicants for the cost of an inspection if the insurer has opted out of the inspection requirements under s. 627.744, F.S.

Other Provisions (Sections 12 and 13)

Section 12 amends s. 641.3915, F.S., to make technical changes.

Section 13 provides that except as otherwise provided in this act, the bill is effective upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Anti-Fraud Efforts

The fiscal impact is indeterminate. However, insurance companies may incur cost associated with implementing the provisions of this act. In addition, insurance companies may incur some costs compiling and providing statistical data to the Department of Financial Services (DFS).

Viatical Settlement Agreements – Stranger-Oriented Life Insurance (STOLI)

Policyholders, particularly senior adults, will benefit from the prevention fraudulent viatical settlement acts and STOLI practices that deprive them of property or are created for the pecuniary gain of the party that becomes the new beneficiary or owner of the underlying life insurance policy.

C. Government Sector Impact:

The DFS anticipates no fiscal impact on state revenues or expenditures.[65] The DFS may experience minimal costs associated with rulemaking; however, those costs can be absorbed within existing resources.

The Justice Administrative Commission indicates the bill will have an indeterminate fiscal and policy impact, as the administrative needs of the Offices of the State Attorney, associated with the creation of the program, are not predictable at this time.[66]

VI. Technical Deficiencies:

Section 3 of the bill defines "fraudulent viatical settlement acts" as various actions done by a person "knowingly, or with intent to defraud for the purpose of depriving another of property or for pecuniary gain." On lines 452-455 the prohibition against "applying for or obtaining a loan that is secured directly or indirectly by an interest in a life insurance policy" needlessly duplicates the clause "with intent to defraud, for the purpose of depriving another of property, or for pecuniary gain." The redundant language on lines 454-455 is unnecessary.

Section 10 of the bill requires insurers to provide a notice to policyholders considering making changes in the status of a life insurance policy. On line 652, it requires the notice to include information for contacting the Office of Insurance Regulation. It may be more appropriate for the notice to include information on how to contact the Division of Consumer Services at the Department of Financial Services.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 626.9891, 626.9911, 626.9924, 626.99245, 626.99275, 626.99287, and 641.3915.

This bill creates the following sections of the Florida Statutes: 626.9896, 626.99289, 626.99291, 626.99292, and 627.744.

[65] Email from Elizabeth Boyd, Legislative Affairs Director, Department of Financial Services (April 7, 2017) (on file with Senate Appropriations Subcommittee on General Government).
[66] Justice Administrative Commission, *Senate Bill 1012 Fiscal Analysis* (February 23, 2017) (on file with the Senate Appropriations Subcommittee on General Government).

IX. Additional Information:

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

CS/CS by Appropriations on April 25, 2017:
The committee substitute:

- Defines the terms "fraudulent viatical settlement agreements" and "stranger-oriented life insurance."
- Requires viatical settlement providers to provide required documents to the life insurer within 20-days of an agreement to viaticate the policy during the five-year contestability period.
- Makes the viatical settlement agreement, entered within five years of issuance, void and unenforceable if the policy is subject to a loan directly or indirectly by an interest with the policy.
- Revises conditions allowing viatication during the contestability period.
- Allows viatication under certain conditions.
- Allows a life insurer to contest a life insurance policy obtained by a STOLI practice under certain conditions.
- Adds the following to the list of prohibited practices:
  - Knowingly entering into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of the viatical settlement contract or during the two-year contestability period specified in s. 626.99287(1) or the five-year contestability period specified in s. 626.99287(2), F.S., unless the viator provides a sworn affidavit and accompanying evidence pursuant to.
  - Engaging in a fraudulent viatical settlement act, as defined in s. 626.9911, F.S.
  - Knowingly issuing, soliciting, marketing, or promoting the purchase of a life insurance policy for the purpose of, or with an emphasis on selling the property to a third party.
  - Engaging in a stranger-originated life insurance practice, as defined in s. 626.9911, F.S.
- Specifies that a life insurer may contest a life insurance policy obtained by a STOLI practice, notwithstanding that life insurance contracts are incontestable two years after issuance.
- Requires a life insurer to provide a statement to policyholders advising the policyholder to consult with a licensed insurance or financial advisor and provides contact information for the Office of Insurance Regulation in the event the policyholder is considering policy changes.
- Corrects a cross-reference.
- Allows motor vehicle insurers to opt out of the requirement to inspect each private passenger motor vehicle before issuing a physical damage policy.
- Allows insurers to establish their own preinsurance inspection requirements prior to issuing a private passenger motor vehicle insurance policy.
- Requires insurers who opt out of the inspection requirements to:
  - File a manual rule with the OIR indicating its non-participation.
  - Provide preinsurance inspection requirements established by the insurer to be included in the manual rule filing.

- Provides that insurers may not charge applicants for the cost of an inspection if the insurer has opted out of the inspection requirements under s. 627.744, F.S.
- Provides unless otherwise expressed, the bill is effective upon becoming a law.

CS by Banking and Insurance on April 3, 2017:

- Removes a provision related to the reversion of funds from the Justice Administrative Commission to the Workers' Compensation Trust Fund.
- Requires all insurers, regardless of the amount of premium written, to submit anti-fraud plans (or contracts) to the DFS. It modifies insurer reporting requirements.
- Requires a report to the Governor, President, and Speaker regarding the effectiveness of the dedicated prosecutor program.

B. Amendments:

None.