

FEDERATION OF REGULATORY COUNSEL, INC.

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YOU CAN'T GET -- OR GIVE --SOMETHING FOR NOTHING

State Regulators Target Value Added Services Provided By Benefit Brokers

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The insurance industry has faced increased scrutiny in recent years. Insurance regulators in several states issued guidance recently with respect to the application of state anti-rebating statutes (collectively, the "Anti-Rebating Statutes") to "value added" services provided by producers in connection with employee benefit plans. Generally speaking, rebating is the act of offering anything of value as an inducement to purchase insurance that is not included in the terms of the insurance policy. In other words, rebates are incentives, in the form of gifts or other consideration, given to induce customers to purchase insurance coverage from a particular insurer or producer.

This article provides an overview of the Anti-Rebating Statutes, including the intended purpose and constitutional challenges against these laws aimed at consumer protection. It then summarizes recent guidance with respect to the Anti-Rebating Statutes and "value added" services provided to clients by employee benefit producers and concludes that the National Association of Insurance Commissioners ("NAIC") and state legislators should consider reforms to these arcane laws that, when strictly interpreted and enforced, arguably result in higher costs to consumers and a less efficient market.

I. BACKGROUND

A. Anti-Rebating Statutes

Forty-eight states and the District of Columbia prohibit insurers and producers from giving an insured or prospective insured anything of value not specified in the policy as an inducement to the purchase of insurance.¹ Each of these jurisdictions has enacted Anti-Rebating Statutes substantially similar to the NAIC Model Unfair Trade Practices Act (the "Act").² Section 3 of the Act prohibits engaging in any trade practice which is defined as an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.³ Section 4 of the Act provides in pertinent part:

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

...

H. Rebates. (1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or *paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the*

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contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.⁴

The most obvious rebate is a cash return of part of the premium to the policyholder, or the acceptance of an amount less than the full premium payable, ordinarily through a reduction in the producer's commission. State insurance regulators have found that other less obvious benefits tied to the sale of insurance violate Anti-Rebating Statutes, including but not limited to the following:

- providing goods or services at no cost or at a discount;
- renting office space at excessive rates from companies purchasing a substantial amount of insurance from a producer or insurer;
- joining the insurance transaction with a sale of stocks or bonds at a price lowered by the amount of the proposed rebate;
- retaining and compensating the policyholder or a representative of the policyholder for acting in a fictitious "advisor" role;
- selling shares to policyholders in proportion to the premium volume of business placed and declaring dividends⁵; and
- giving the insured a favorable interest rate on a loan used to pay the premium.⁶

It should be noted that although: (i) the Act prohibits rebating in connection with life, health, and accident insurance and annuities, many states have enacted laws extending the prohibitions against rebating to property and casualty insurance; and (ii) the prohibitions are directed at insurers and producers, many states also prohibit an insured from knowingly accepting a rebate.⁷ Violations of Anti-Rebating Statutes are generally punishable by civil and criminal sanctions, including cease and desist orders, license suspension or revocation and fines.

B. Intended Purpose of Anti-Rebating Statutes

It is often difficult to explain to clients why such a seemingly pro-consumer practice is prohibited in most states. The Anti-Rebating Statutes were enacted in the late 1800s and early 1900s to protect consumers from widespread abuses in the insurance industry occurring at that time, particularly in the sale of life insurance, by preventing discrimination in the rates payable by similarly-situated policyholders and assuring insurer solvency.⁸

Like most insurance laws and regulations, the Anti-Rebating Statutes are aimed at consumer protection by ensuring that consumers are treated fairly and that insurers possess adequate reserves to meet their obligations to policyholders. Prior to the enactment of the Anti-Rebating Statutes, insurers and agents would in some cases discriminate between similarly situated insureds by offering some insureds preferential rates, often by agreeing to return a portion of the premium received by the insurer or commission received by the agent. This would in effect allow insurers to offer coverage at less than the rates filed with and approved by the state insurance departments based on established actuarial assumptions. This practice also raised concerns regarding insurer solvency, as insurers in some cases were receiving total premiums that were less than the approved rate.

C. Constitutionality of the Anti-Rebating Statutes

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The Anti-Rebating Statutes in several states have been subject to constitutional challenges on the grounds that they have no relation to public safety or welfare and deprive consumers and insurers of property rights. In fact, in 1986, the Florida Supreme Court found that Florida's anti-rebating statutes were unconstitutional. ⁹ In *Dep't of Ins. v. Dade County Consumer Advocate's Office*,¹⁰ the Consumer Advocate's Office (the "Consumer Advocate") filed a complaint against the Florida Office of Insurance Regulation ("FOIR") alleging that Florida's anti-rebating statutes deprived consumers of their property rights because such statutes prohibited policyholder negotiations of insurance agent commissions, thereby increasing the amount policyholders paid for insurance. The FOIR argued that Florida's anti-rebating statutes guaranteed insurer solvency and prevented discrimination against policyholders in the same actuarial class. The Florida Supreme Court held that Florida's anti-rebating statutes were unconstitutional because there was "no identifiable relationship between the anti-rebate statutes and a legitimate state purpose in safeguarding the public health, safety or general welfare," and such laws "interfered with property rights by unnecessarily limiting the bargaining power of the consuming public."¹¹

In a later case, the Florida Supreme Court affirmed its decision in Dade County stating that "[t]he anti-rebate statutes...simply deprive the consuming public of a choice in the price of products or services, the choice of which is the cornerstone of a competitive, free-market economy."¹² In other states, however, courts have found that Anti-Rebating Statutes are constitutional because they bear a rational relation to public safety and general welfare, and do not deprive insurers or policyholders of property or equal protection rights.¹³

II. RECENT GUIDANCE REGARDING VALUE ADDED SERVICES

Although the practice of rebating is expressly prohibited in most U.S. jurisdictions, state regulators and attorneys general have not been very active over the years in the enforcement of violations of the Anti-Rebating Statutes. This is likely due in large part to the fact that consumers receiving rebates are receiving a benefit and, therefore, have no reason to complain to state regulators. In our experience, most complaints against producers alleging violations of Anti-Rebating Statutes are brought by competing producers that have lost business to a producer providing something of value to an insured as an inducement to the purchase of insurance.

In response to such complaints, state regulators have issued written guidance on the parameters of the Anti-Rebating Statutes. Insurance regulators have become increasingly focused on "value added" services commonly offered by employee benefit brokers to defray the total cost of the insurance product and provide a wider range of services to their clients to gain a competitive advantage in the market. Many large and medium-sized brokers are even willing to provide certain services not directly related to the insurance policy at no additional cost to clients in connection with the purchase of health and welfare plans, including payroll services, compliance services related to the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA") and Health Insurance Portability and Accountability Act ("HIPAA") and flexible spending account administration.¹⁴ To level the playing field, smaller brokers without the resources to provide such value added services will often complain to state insurance regulators that their larger competitors are acting in violation of Anti-Rebating Statutes.

Many would argue that providing these services free of charge or at a discount provides a benefit to the employer purchasing coverage and that the cost savings can ultimately be passed on to individual employees because the employer's overall health and welfare benefit costs are reduced. Unfortunately, the Anti-Rebating Statutes are broadly written and do not exempt benefits that can otherwise be provided in a non-discriminatory manner and without any impact on insurer solvency. In interpreting their Anti-Rebating Statutes, state regulators have consistently determined producers and insurers are prohibited from providing free or discounted value added services unrelated to the sale of the insurance, unless it is set forth in the insurance policy.¹⁵

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The New York Insurance Department ("NYID") has been by far the most active state insurance department in terms of issuing guidance with respect to the scope and application of its Anti-Rebating Statutes and has offered more than 170 Office of General Counsel Opinion Letters on the topic. Most recently, the NYID issued Circular Letter 9 which clarifies its position with respect to insurance agents and brokers offering value added services.¹⁶

Circular Letter 9 states that insurance producers may provide services to clients that are not specified in the insurance policy if the following conditions are met:

- (1) The service *directly relates* to the sale and servicing of the policy or provides general information about insurance risk reduction; and
- (2) The insurer or producer provides the service *in a fair and nondiscriminatory manner* to like insureds or potential insureds.

According to Circular Letter 9, "services that fall within the scope of services that an insurance producer may lawfully provide in connection with insurance sold by the producer if provided incidental to the insurance and in a fair and nondiscriminatory manner" include the following:

- risk assessment related services;
- insurance consulting services or other insurance-related advice;
- insurance-related regulatory and legislative updates;
- certain claims assistance services;
- tax preparation on behalf of an employer reporting information regarding insurance contract coverage, fees, and commissions, investment and annuity contracts, and welfare benefit contracts;
- information to group policy holders and members, as well as forms needed for plan administration, enrollment in a plan, insurer website links, and answers to frequently asked questions related to the insurance;
- Certain services performed pursuant to COBRA, such as billing former employees, collecting the insurance premiums, and forwarding the aggregate premiums to the employer policy or contract holder or to the insurer, when offered in connection with the provision of accident and health insurance;¹⁷ and
- Certain services provided in accordance with HIPAA, such as those pertaining to health care access, portability, and renewability, when offered in connection with the provision of accident and health insurance.

Producers may provide services that directly relate to the insurance purchased for free or at a discount without violating the New York Anti-Rebating Statutes if the services are provided in a fair and non-discriminatory manner.¹⁸

Circular Letter 9 also states that some services are too attenuated to the provision of insurance and, therefore, producers providing such services for free or at a reduced cost may be violating the Anti-Rebating Statutes if the services are not specified in the policy. Such services include, but are not limited to:

- flexible spending administration services;
- legal services;
- payroll services;
- referrals to third-party service providers through which policyholders may receive a discounted rate;
- advice regarding compliance with laws concerning human resource issues not relating to insurance purchased;

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- management of employee benefit programs not relating to insurance purchased;
- preparation of employee benefit statements listing benefits provided to employees not relating to insurance purchased;
- development of employee handbooks and training not relating to insurance purchased; and
- services related to employee compensation, discipline, job descriptions, leaves of absence, organizational development, business policies and practices, safety, staffing, and recruiting not relating to insurance purchased.

Under New York law, a broker may charge for these types of services pursuant to an agreement satisfying the requirements of § 2119 of the New York Insurance law, but an agent representing the insurance company may not.

In attempting to provide additional services to policyholders without running afoul of the Anti-Rebating Statutes, insurers have attempted to include certain ancillary services within the terms of policy forms filed with state regulators. The insurance departments in New York and Iowa have responded by declaring that the goods or services in the insurance policy must "have a legitimate nexus to the insurance coverage provided under the policy" and be "necessarily or properly incidental to the insurer's insurance business."¹⁹ If it is determined that the goods and services in the policy do not have a "legitimate nexus," then the departments will not approve such policies, regardless of whether such goods and services are available to all persons of the same class. While Circular Letter 9 attempts to delineate between permissible and impermissible services, by finding linkage to the insurance policies sold, the reality is that health and welfare benefits are inextricably entwined with the human resource services provided by most employers, and it creates great inefficiencies to impose regulations attempting to separate the permissible from impermissible activities when they are all part of an employer's overall human resource plan.

III. APPLICATION OF THE ANTI-REBATING STATUTES TO THE MODERN INSURANCE INDUSTRY

As previously stated, the Anti-Rebating Statutes are broadly written and subject to little or no interpretation by state regulators. Application of the Anti-Rebating Statutes to modern insurance products, particularly employer sponsored health and welfare plans, may produce bizarre results that are harmful to consumers. Employee benefit producers often earn large commissions on the placement of employer sponsored health plans, particularly with the steep rise in rates on health insurance products and the resulting commissions payable to producers. Due to the economic crisis and high cost of health insurance, many employers have been forced to reduce or even eliminate certain employee benefits. To gain a competitive advantage and better service their clients, producers are willing to provide a broader range of services at no cost or at a discount and even to pay third-party service providers to provide certain services to clients.

The Anti-Rebating Statutes were originally intended to protect consumers by preventing discrimination between like insureds and the risk of insurer insolvency through the rebate of premiums and payment of other valuable consideration. These same concerns do not apply to producers providing value added services to clients in connection with employee benefit plans. In cases where producers are providing services directly to clients and/or are paying for them out of commissions earned, there is no risk to insurer solvency.

Moreover, the sale of employer sponsored health and welfare plans are not subject to the same issues with respect to discrimination between like insureds as personal lines policies. In most cases, employee benefit plans involve negotiations between commercial parties, with most large employers being represented by a broker and/or an experienced risk manager. These sophisticated purchasers of insurance should be free to negotiate the best terms possible and to receive the broadest range of services for the premiums paid. Instead, the Anti-Rebating Statutes are being used as a mechanism to level the playing field between large and small brokers, which ultimately increases the expenses of employers and their employees.²⁰

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In this age of rising health insurance costs, the NAIC and state legislators and regulators should seriously consider reforms to the Anti-Rebating Statutes. One possible approach that some have suggested would be to provide some type of commercial exemption to the Anti-Rebating Statutes to allow sophisticated commercial purchasers of insurance, who do not require the same level of consumer protection as individual consumers, to negotiate the best deal possible and for producers to provide the broadest menu of services to their clients. This will lower health and welfare benefit costs and make employers more efficient in providing human resource services to their clients.

Endnotes

1. Some states have exceptions to the Anti-Rebating Statutes, such as, provision of nominal promotional and advertising materials. *See, e.g.*, Me. Rev. Stat. Ann. tit. 24-A § 2163-A (1997); Mich. Comp. Laws § 500.2024a (1989); S.D. Codified Laws § 58-33-74 (2001); Connecticut Insurance Department Bulletin S-12 (12/24/08).
2. III Nat'l Assoc. of Ins. Comm'rs, Model Laws Regulations And Guidelines, 900-1 to 900-17 (1989).
3. *Id.* at 900-2
4. *Id.* at 900-2, 900-4 (emphasis added).
5. Kimball & Jackson, *The Regulation of Insurance Marketing*, 61 Colum. L. Rev. 141, 147 (1961).
6. *See Western Union Life Ins. Co. v. Musgrave*, 25 Ariz. 219, 215 P. 536 (1923); *Johnson v. American Nat'l Ins. Co.*, 126 Ariz. 219, 613 P.2d 1275 (Ct. App. 1980) (alleged contract that insurer would make loan to insured if insured bought policy is illegal and unenforceable); *Jones v. Crawford*, 21 Ga. App. 29, 93 S.E. 515 (Ct. App. 1917); *Morris v. Ft. Worth Life Ins. Co.*, 200 S.W. 1114 (Tex. Civ. App. 1918).
7. Many states also prohibit the payment of rebates in connection with title insurance; however, such prohibitions are generally restricted to title insurance and are separate from the Anti-Rebating Statutes applicable to life and health and property and casualty insurance.
8. *Statutory Prohibitions On The Negotiation Of Insurance Agent Commissions: Substantive Due Process Review Under State Constitutions*, 51 Ohio St. L.J. 773, 777 (1990).
9. In addition, California's anti-rebating statutes were repealed by Proposition 103, an insurance reform initiative enacted by voters in 1988.
10. 492 So.2d 1032 (Fla. 1986).
11. *Id.* at 1035.
12. *Chicago Title Ins. Co. v. Butler*, 770 So. 2d 1210 (Fla. 2000).
13. *See, e.g., Katt v. Insurance Bureau*, 200 Mich App 648, 505 N.W.2d 37 (1993) (holding that Michigan anti-rebating statutes are constitutional because such statutes are reasonably related to achieving proper legislative purposes of nondiscrimination and solvency of insurance companies); *Quetnick v McConnell*, 154 Cal. App. 2d 112, 315 P.2d 718 (1957, 1st Dist) (holding that California anti-rebating statutes were constitutional and did not violate equal protection rights); *People v. Commercial Life Ins. Co.*, 247 Ill. 92, 93

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N.E. 90, error dismissed 227 U.S. 681, 33 S. Ct. 327 (1910) (holding that Illinois anti-rebating statutes are constitutional and that such statutes do not deprive insurers of property without due process of law); *Equitable Life Assur. Soc. v Commonwealth*, 113 Ky. 126, 67 S.W. 388 (1902) (holding that the Kentucky anti-rebating statute do not unconstitutionally restrain trade or prevent competition and that such statutes have a rational basis in protecting consumers); *People v. Formosa*, 131 N.Y. 478, 30 N.E. 492 (1892) (holding that New York anti-rebating statute is constitutional because such statutes bear a relation to the public's general welfare).

14. Pub. L. No, 99-272, 100 Stat. 222 (Apr, 7, 1986), codified at 26 U.S.C. § 4980(b), 29 U.S.C. §§ 1161 et seq., 42 U.S.C. §§ 300bb-1 et seq; Pub. L. No. 104-191, 110 Stat. 1936 (1996), codified at 42 U.S.C. § 201 et seq. (42 U.S.C. 1320d-2).

15. *See, e.g.*, Connecticut Insurance Department Bulletin S-12 (12/24/08); Iowa Insurance Division Bulletin 08-15, 08-16; New York Insurance Department Circular Letter 9 (3/3/09); Texas Department of Insurance Bulletin B-0004-08 (1/31/08). *See also*, N.H. Rev. Stat. Ann. § 402:41 (2008) (New Hampshire legislature amended New Hampshire's anti-rebating statutes in 2008 to prohibit insurers and producers from offering value added services unrelated to the sale of insurance unless included in the insurance policy).

16. New York Insurance Department Circular Letter 9 (3/3/09).

17. With respect to COBRA administration services, the NYID has indicated that services not related to the insurance policy may not be provided to the insured by a producer at no cost or at a discount. *See e.g.*, New York Insurance Department Office of General Counsel Opinion 98-54.

18. Similarly, New Hampshire law expressly recognizes that a producer may provide certain value added services directly related to the insurance policy, including risk assessments, risk control tools, claims assistance, legislative updates, and administrative consulting. N.H. Rev. Stat. Ann. § 402:41 (2008).

19. *See* New York Insurance Department Circular Letter 9 (3/3/09); Iowa Insurance Division Bulletin 08-15, 08-16.

20. *See, e.g.*, Connecticut Insurance Department Bulletin S-12 (12/24/08)(Conn. Gen. Stat. § 38a-825 prevents the creation of competitive disadvantages among insurers and producers by creating a level playing field for all insurance professionals); New Hampshire Insurance Department Website-For Producers and Adjusters, *Rebating and Anti-Rebating Laws and Q&A*, available at <http://www.nh.gov/insurance/producers/index.htm> ("Rebates can result in unfair market advantage for those insurers or insurance producers that can afford to or are willing to offer the most generous or desirable rebates.").

WHAT WAS HE THINKING AND WHEN DID HE THINK IT?

A Report and Comment on STOLI in Florida and Elsewhere

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The issues regarding Stranger Owned/Originated Life Insurance, referred to throughout this article as STOLI, are myriad according to the regulators of various states, including my own, Florida. What is it? Who are its victims? How are those victims harmed by it? How should the states regulate it? Is it regulated already?

In an effort to address the relevant issues, the Florida Office of Insurance Regulation convened a public hearing on August 28, 2008, to take testimony and gather information regarding STOLI. On February 5, 2009, Florida Insurance Commissioner Kevin M. McCarty released his report entitled "Stranger-Originated Life Insurance ('STOLI') and the Use of Fraudulent Activity to Circumvent the Intent of Florida's Insurable Interest Law," referred to herein as the Florida Report. (A copy of the complete report can be downloaded at: <http://www.floir.com/stoli.aspx>). What follows is a report on the Florida Report and commentary on the struggle to reconcile the irreconcilable conflict at the center of any STOLI analysis. Every regulator and court contemplating a STOLI program is required to try to balance the competing interests in insurance as an asset and the public policy against wagering contracts. Yet, the two will not balance.

The starting point for an analysis of STOLI, including that set forth within the Florida Report, is a discussion of insurable interest. The Florida Report describes the historically based reason for insurable interest laws, which is that gamblers in old England were permitted to wager on the anticipated dates of death of the seriously ill among them.¹ The British Parliament, in 1774, put an end to the use of such contracts by passing a law that any life insurance contract held by a person without an insurable interest in the life of the insured would henceforth be null and void.² Legislatures and courts since then have endeavored to establish that an interest in the continued life of the insured by the beneficiary of the life insurance is a necessary component to the issuance of a policy. The core of the public policy, codified in statutory and common law, is that if someone stands to benefit from your death, you are in danger of that someone. Inasmuch, the law seeks to protect you by requiring that only those who stand to benefit from your continued life are beneficiaries of your life insurance. The ancient public policy which underpins the entire insurable interest analysis, however, does not comport with modern reality. The use of public policy within legal analysis, as described below, is supposed to provide the "why" for a statute or a court holding, but there is no modern day evidentiary support for the theory that people who invest in strangers' life insurance policies are encouraged to kill the insured strangers.

Indeed, the statutory and common laws of most states recognize that life insurance is an asset of the insured, and the insured is free to transfer that asset. Many state laws, such as Florida's, conform to the holdings of cases such as *Grigsby v. Russell*, that an assignment is not automatically condemned when the assignee lacks an insurable interest, so long as there is no prior agreement to assign.³ It is that last clause, "so long as there is no prior agreement to assign," that cannot be reconciled with the language of the laws of many states. Florida's insurable interest law, for instance, was amended in 2008 to clarify that, "The insurable interest [necessary for the validity of a life insurance policy] need not exist after the inception date of coverage under the contract."⁴ The problem, therefore, is if an insurance policy can be transferred to one without an insurable interest in the insured at any time "after the inception date" of the policy, then how can courts invalidate a transferred policy because an insured was contemplating what the law allows him freely to do?

Courts, historically and today, base their holdings invalidating insurance transferred to strangers on the public policy against wagering contracts, noted above, opining that an insured who plans to transfer his policy will circumvent the public policy against having a stranger benefit from his death. The near universal focus of the judiciary on this topic is the "intent" of the insured when he obtained the policy. It's an easy "out" for courts considering STOLI to declare a policy invalid when the insured intended its transfer to one without an insurable interest, because the court is protecting the insured from a stranger's wager on his death. More than several courts have recently been called upon to examine a challenged STOLI transaction. The three cases

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discussed below are only a sample. Yet, in this context, a sample is enough, because the courts' analyses are mostly consistent.

The Minnesota District Court, in *Sun Life Assurance Company of Canada v. Paulson*, held that when ascertaining whether or not a STOLI transaction is an unlawful "scheme," the courts must look at the mutual intent of the parties to the transaction, the insured and the assignee.⁵ In the event it can be established that both parties intended for the original purchase of the policy to be a part of a plan to assign the policy thereafter, then the policy will be considered void *ab initio*. The case of *Life Product Clearing, LLC v. Angel*, in New York is similar in conclusion.⁶ The court there indicated that enough facts were alleged to show that the insured purchased the policy with the prior intent to transfer the policy to a person without an insurable interest. The New York court defined its purpose as having to assess whether a policy was procured with a view to its immediate assignment in order to determine whether the transaction is merely to secure a wagering policy for a stranger. And, here in Florida, *AXA Equitable Life Insurance Company v. Infinity Financial Group, LLC*, identified sufficient facts to establish a "scheme" to perpetuate a wagering policy in violation of Florida statutory and long established insurable interest case law.⁷ While the AXA case is short on analysis, it clearly indicates that, although assignments to persons without insurable interest is legal in Florida, this rule extends only to assignments made in good faith and not as a cover for sham assignments made to circumvent the public policy against wagering contracts.

Each of the three courts discussed above is focused on the intent of the insured at the time of the policy application/inception. The "intent" test seeks to ascertain the mindset of the applicant at the time the policy is purchased and declares it unacceptable for the insured to think of a policy transfer then, but it therefore acknowledges that the same mindset at another time is acceptable. And, since the law expressly allows for such transfers, should the insured's thought as to transfer be the polestar for determining whether a transfer is valid or not?

Without exception, those testifying at the Florida STOLI hearing recognized, and some even praised, "legitimate" life settlements, those in which an insured holding a life insurance policy he no longer needed, could no longer afford or no longer wanted, transfers the policy to a stranger. The legitimacy of such life settlements is established by a conclusion that the insured did not plan to transfer the policy when he obtained it. But, statutory law, specifically in Florida, allows an insured to transfer the policy at any time after he obtains it. So, why are the legitimate transfers only those that the insured was not planning on? If the answer is to keep the insurance out of the hands of a malevolent stranger who might harm the insured, the answer is fallacious, because in the event of a "legitimate" and not pre-planned life settlement, the policy ends up in the hands of a stranger just as it does when the insured planned it that way from the start.

It does not seem that the concept of "don't think of transferring your life insurance policy to a stranger at the outset, because you might put yourself in danger," can be reconciled with "you can transfer your policy anytime after you buy it." Not only do those concepts fail reconciliation because the "danger" is simply not a reality today, but also, since the market for transferring policies exists, we cannot forbid a potential insured from thinking of it or planning to use it.

While the Florida Report does not address the dilemma discussed above per se, Commissioner McCarty smartly focused in the Florida Report on the "real" dangers to consumers. There are certainly competing views on whether the issues raised within the Florida Report are actual dangers to consumers; however, there is no dispute that consumers contemplating STOLI transactions must be made aware of these items, so they transact their business from a place of information, rather than naiveté. The Florida Report identified four harms that could befall a consumer within a STOLI transaction: capacity to purchase insurance, tax liability, non-tax liability and increasing insurance premiums.⁸

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The issue of "capacity" has been festering under the surface of the STOLI marketplace, but has only recently begun to be widely discussed by commentators and regulators. An insured's capacity to purchase life insurance has traditionally been based on an insured's net worth. Insurers carefully review the financial statements of a potential insured when issuing a large face value policy. The capacity analysis does not take into consideration who owns or who will benefit from the life insurance in force on a particular consumer, just the amount of insurance in force. Thus, when a consumer buys a policy and transfers it to another, that policy still counts against the insured's capacity and may result in the insured's inability to protect his own estate in favor of benefitting a stranger. Agents licensed in Florida are broadly obligated to explain the products they sell to potential insureds or risk being disciplined by the regulators.⁹

The Florida Report states that "the incentives used by STOLI promoters to induce seniors to apply for life insurance policies and the STOLI transaction may create an unexpected tax liability for seniors."¹⁰ The key word, however, in that sentence appears to be "may," because, as of today, the proceeds from life insurance policies remain non-taxable.¹¹ Issues were raised by some who testified at the Florida STOLI hearing about whether the non-recourse premium finance components to some STOLI programs trigger tax consequences, but no definitive answers are provided within the Florida Report.¹²

The Florida Report touched briefly on the potential non-tax liability to seniors involved in STOLI transactions that are unwound by courts declaring the subject insurance policies void.¹³

Finally, the Florida Report identified what many proponents of STOLI programs deem the most spurious argument against STOLI, which is the ultimate increase in life insurance premiums. Interestingly, what was addressed only briefly in the testimony at the Florida STOLI hearing was the argument advanced by many life insurers about lapse pricing: more policies in force to death benefit, result in higher premiums for everyone. The lapse pricing argument was advanced repeatedly during the NAIC Life Insurance A Committee hearings, but it has receded to the background in more recent discussions of STOLI. Noteworthy is that the Florida Report's treatment of increasing life insurance rates refers to lapse pricing for support.¹⁴ The Florida Report also quotes one of the hearing witnesses, who suggested that STOLI transactions reduce the availability of life insurance for people over age 70.¹⁵ There was, however, testimony at the hearing that STOLI programs actually increase life insurance sales.¹⁶ This is likely, because people view the products as their own alienable assets, rather than just traditional protection for their loved ones.

The ultimate question for Florida consumers, companies, agents and STOLI promoters is: "What will Florida do now?" Considering the body of established anti-STOLI case law and the provisions of the Insurance Code which get at the alleged evils of STOLI transactions, such as misrepresentation and "free insurance," the Florida regulators could rely on what's currently available to them. Pressure was applied on the national level for states to adopt either the NAIC Viatical Settlements Model Act or the NCOIL Life Settlements Model Act. Some, but not many, states have adopted one model or the other. During the 2009 Florida legislative session, two STOLI bills were introduced which proposed sweeping revisions to the treatment of STOLI in Florida, Senate Bills 1882 and 1924, but they were not passed. The concept and treatment of STOLI will continue to evolve and provide fodder for legislatures, courts and commentators for years to come.

Endnotes

1. Stranger-Oriented Life Insurance ("STOLI") and the Use of Fraudulent Activity to Circumvent the Intent of Florida's Insurance Interest Law; Report of Commissioner, Kevin M. McCarty, Florida Office of Insurance Regulation; January 2009; p. 6.
2. *Id.*

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3. *Id.* at 9.
4. *Id.* at 10.
5. *Sun Life Assurance Company of Canada v. Paulson*, No. 07-CIV-3877, D.Minn. 2008 WESTLAW 451054 (D.Minn., February 15, 2008) and 2008 WESTLAW 5120953 (D.Minn., December 3, 2008).
6. *Life Product Clearing LLC v. Angel*, 530 F.Supp.2d 646 (S.D.N.Y., January 22, 2008).
7. *AXA Equitable Life Insurance Company v. Infinity Financial Group, LLC, et. al.*, No. 08-80611-CIV-HURLEY, 08-80611-CIV-HOPKINS, 2008 S. Dist. Fla. 2009 WESTLAW 931011 (S.D.Fla., March 31, 2009) at page 24.
8. Stranger-Oriented Life Insurance ("STOLI") and the Use of Fraudulent Activity to Circumvent the Intent of Florida's Insurance Interest Law; Report of Commissioner, Kevin M. McCarty, Florida Office of Insurance Regulation; January 2009; pp. 17-22.
9. *Id.* at 25.
10. *Id.* at 18.
11. *Id.* at 19.
12. *Id.*
13. *Id.* at 20.
14. *Id.* at 22.
15. *Id.* at 21.
16. *Id.* at 22.

COMPLYING WITH NEW MEDICARE REPORTING REQUIREMENTS APPLICABLE TO LIABILITY INSURERS AND SELF-INSURERS

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Introduction

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)¹ amends the Medicare Secondary Payer Act (MSPA)², by imposing significant new reporting obligations upon insurers and other qualified Responsible Reporting Entities (RRE) subject to it. The objective of the new reporting requirements, which

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are *effective July 1, 2009*, is to permit Medicare to track the resolution of liability claims involving incurred, and future, medical costs that are subject to Medicare to ensure that those parties who are primarily responsible for payment of medical costs subject to Medicare pay those costs, rather than Medicare which is a secondary, rather than a primary, payer. By so doing, it is the intent of MMSEA to reduce overall costs to Medicare.³

Under the new law and associated regulations, all liability insurers (including self-insurers), no-fault insurers, workers' compensation insurers and group health plan arrangements (GHP) are required to determine whether any individual who files a claim against the insurer or any entity insured or covered by the insurer would be entitled to Medicare benefits. If so, the insurer must provide Medicare with that individual's identity and any other information that may be required by the Secretary of Health and Human Services (Secretary). This information must be furnished to Medicare within the time specified by the Secretary after the claim is resolved through settlement, judgment, award or other payment, regardless whether or not there has been an admission or determination of liability.

Penalties for Noncompliance

In keeping with its stated goals, the MMSEA imposes severe penalties for noncompliance:

If an insurer or other Responsible Reporting Entity fails to notify Medicare in accordance with these guidelines, a civil penalty of \$1,000 per day will be charged per claimant.⁴

Not only are there substantial monetary penalties, but Medicare now has the right to audit. MMSEA provides no specific guidance regarding audit criteria or how an RRE will be selected for audit. Although it is contemplated, the Centers for Medicare & Medicaid Services (CMS), the federal agency which is responsible for collecting data from qualified Responsible Reporting Entities, has not yet published the identifiable factors which might make an RRE at risk for non-compliance.

Registration Requirements

The new requirements obligate an RRE to register on the secure website for Coordination of Benefits Contractor (COBC) appointed by CMS on or before September 30, 2009. An RRE includes not only liability insurers (including self-insurers), but also no-fault insurers, workers' compensation insurers and GHPs.

Importantly, although the reporting obligation commences between January 1, 2010 (the date when electronic reporting will be enabled) and March 31, 2010, depending on when the RRE completes file testing, the required quarterly production report to be first submitted is *retroactive to July 1, 2009*, regardless of the date of the RRE's first assigned file submission window.

In addition, unlike liability insurers, for a GHP, reporting responsibilities became effective January 1, 2009.⁵

Public Policy Considerations

The purpose of the new law is to obligate those parties who are primarily responsible for payment of medical costs subject to Medicare to pay those costs, rather than Medicare itself. This has the potential to save Medicare billions of dollars and to reduce the large, and still growing, Medicare deficit.⁶

The new mandatory Section 111 reporting requirements are in addition to current methods for obtaining information regarding situations where Medicare is appropriately a secondary payer. They do not replace or

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eliminate existing obligations under the MSPA provisions for any entity. For example, Medicare beneficiaries who receive a liability settlement, judgment, award or other payment are obligated to refund conditional payments within 60 days of receipt. The Section 111 reporting requirements do not eliminate this obligation.

The new law thus not only imposes significant new obligations, but may also influence the settlement of workers' compensation claims as well, given the mandatory establishment of a Medicare Set Aside Account (MSA) to pay claims for future medical expenses arising out of a workers' compensation claim.⁷

By law,⁸ primary payers, and an entity that receives payment from a primary plan, are obligated to reimburse Medicare for conditional payments when it is demonstrated that a primary plan "has or had a responsibility" to make payment.⁹

Under the MSPA, Medicare is afforded broad enforcement rights on several levels. For example, Medicare has a direct right against all primary payers responsible for making payment and any entity that received a primary payment, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer.¹⁰

Medicare and Impact of the MMSEA

Medicare is the federal health insurance program for:

- People age 65 and older
- People under age 65 with certain permanent disabilities
- People of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

Overall, the MMSEA imposes strict reporting requirements whenever there is a recovery for a liability claim encompassing medical costs, including mental health treatment, subject to Medicare, including future costs, regardless of whether by settlement or judgment.

Which Insurers Must Register and Report

All insurers, including but not limited to alien, non-admitted insurers writing on an excess/surplus line basis, captive insurers and risk retention groups, who issue coverage, including no-fault insurance that pays for health care services resulting from injury to an individual in an accident, regardless of fault, must comply with the registration and reporting requirements where the injured party is a Medicare beneficiary and the *date of incident is on or after July 1, 2009*. A newly-organized liability insurer must be compliant just as any other insurer. It will be up to their attorneys to advise them of these requirements, and it is likely that the plan of operation of any new carrier will have to discuss its plan to comply with the MMSEA registration and reporting requirements.

Under the MMSEA, liability insurance (including self-insurance) is defined to be coverage that indemnifies, or pays on behalf of the policyholder or self-insured entity, against third party claims for negligence that results in injury or illness to an individual. Liability includes, among others, homeowners' liability, automobile liability, uninsured or underinsured motorist liability, product liability, malpractice liability and workers' compensation.¹¹ The key to determining whether a liability insurer must register is if there is a reasonable expectation that covered claims will be resolved that include a payment by the insurer for medical costs subject to Medicare. Medicare, and thus RRE submissions, extend to costs for physical injuries as well as mental health costs.

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For purposes of RRE submissions, the term "*claim*" is used to refer to the overall claim for liability insurance (including self-insurance), no-fault insurance, or workers' compensation rather than a single claim for a particular medical item or service regardless of whether the coverage is first-dollar or the coverage is excess over another insurer or over a self-insured retention. Where there are multiple carriers involved in a settlement, reporting is necessary for each individual party under which there is a payment responsibility, not one per person. To date, it appears, based on CMS pronouncements, that all settlements, even those viewed as "nuisance value" settlements, must be reported.

"Self-insurance" is defined to include individuals/entities engaged in a business, profession, or trade to the extent that they have not purchased liability insurance coverage. This includes responsibility for deductibles.

Where an entity is self-insured for a deductible, but the payment of that deductible is made through the insurer, then the insurer is responsible for including the deductible amount in the amount it reports as a settlement, judgment, award, or other payment. Although the MMSEA does not address claims paid under a self-insured retention, caution may dictate these be reported whenever possible.

When Registration and Account Setup Must Be Completed

The registration process requires RREs to notify COBC of their intent to report data to comply with Section 111 of MMSEA. Registration by the RRE is required and must be completed before the testing between the RRE and the COBC can begin. Liability, no-fault and workers' compensation RREs must register on the Coordination of Benefits Secure Website (COBSW) from *now through September 30, 2009* using an interactive website designed for this purpose. Registration is currently accessible via <https://www.section111.cms.hhs.gov>. All submissions, both registration and reporting data submissions, will be received electronically on this website.

CMS also provides a guide to registration requirements at:
<https://www.cms.hhs.gov/MandatoryInsRep/Downloads/RegistrationOverview.pdf>.

It should be noted, however, that although the reporting obligation commences between January 1, 2010 and March 30, 2010, the quarterly production reporting that is required to be submitted is retroactive to July 1, 2009, regardless of the date of the RRE's first assigned file submission window.

In summary, CMS has established the following mandatory timetable for registration and initial reporting by RREs:

- Now through September 30, 2009 all RREs register on the COBC secure website
- July 1, 2009 to March 30, 2010 RREs submit test records and correct any errors
- January 1, 2010 to March 30, 2010 each RRE submits its initial report according to an assigned file submission window.

Impact on Medicare Set Aside Requirements

Under the Medicare Secondary Payer Act (MSPA)¹², CMS already requires separate funding of a Medicare Set Aside Account (MSA) to pay for future medical expenses arising from a workers' compensation claim that would otherwise be eligible for coverage under Medicare. At its core, an MSA is a portion of settlement proceeds set aside, or allocated, to pay for future Medicare covered services. The MSA must be exhausted prior to Medicare paying for any future care.¹³

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Importantly, CMS has explicitly stated that it does not presently obligate liability and other non-workers' compensation insurers to coordinate payment of an MSA if settlement does not involve a claim for future medical expenses arising out of a workers' compensation claim. As such, settlement of pure liability claims does not currently give rise to any requirement to fund an MSA. Currently, liability insurers, GHPs and other non-workers' compensation insurers normally do *not* need to fund an MSA as part of any settlement. Nevertheless, simultaneous settlement of liability and a workers' compensation insurer's obligations to cover future medical expenses may require an MSA. Given the often layered and overlapping relationship between settlement of liability and workers' compensation claims, an insurer must carefully consider any possible MSA funding requirements.

CMS must review and approve an MSA if the workers' compensation claimant is a Medicare beneficiary, or may become a Medicare beneficiary during the lifetime of the settlement, and the total settlement amount is greater than \$25,000. In addition, if the claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000, then the Medicare set aside arrangement must be reviewed and approved by CMS. Approval of any MSA application depends upon whether the settlement is "reasonable."

Conclusion

For practitioners of workers' compensation and liability insurance law, Medicare compliance, at least with respect to reimbursement of conditional payments, is nothing new. However, the new notice and reporting obligations of Section 111 of the MMSEA will have a significant impact on clients.

For practitioners of insurance regulatory law, notifying clients and assisting them to understand and comply with the new notice and reporting obligations and/or defending them against allegations of failure to comply and notices of the imposition of penalties will have a significant impact on clients.

While requiring reporting of all resolved liability claims encompassing medical costs subject to Medicare should enable the federal Medicare program to realize considerable savings is simple, compliance with MMSEA's requirements is not. The reporting format from a technical perspective requires an insurer not just to register as required, but also to determine if registration by an individual issuing company or for the company as a whole is best suited to it. In addition, insurers must now track all claims where Medicare is implicated, gather detailed information about a claimant, and report as required under the MMSEA in a specified, electronic format. With the detailed registration and reporting requirements, and strict time deadlines imposed by MMSEA, clearly an insurer must exercise diligence to avoid what can be costly civil fines.

Endnotes

1. Public Law No. 110-173.
2. Section 1862(b) of the Social Security Act, 42 U.S.C. §1395y(b).
3. The New York Times on May 13, 2009 reporting on the current recession, stated that the Medicare fund that pays hospital bills for older Americans is expected to run out of money in 2017, two years earlier than projected last year. Labor Secretary Hilda L. Solis noted that with 5.7 million jobs lost in the recession since December 2007, the government collects less in payroll taxes, a major source of funding for Medicare as well

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as Social Security.

4. 42 U.S.C. §1395y(b)(8)(E). This is in addition to any other penalties available under the law.
5. Although Section 111 of MMSEA also contains new amendments to MSPA regarding reporting by Group Health Plans, this article, due to space limitations, only discusses amendments applicable to liability insurers and self-insurers.
6. Quoting the trustees of Medicare and Social Security, the May 13, 2009 New York Times article, see above fn.3, reports that in coming years Medicare spending will increase faster than either workers' earnings or the economy overall.
7. The Centers for Medicare & Medicaid Services (CMS) has the right to seek recovery against any entity, including a beneficiary, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment, directly or indirectly, where a third party payer, rather than Medicare, should have paid injury-related medical expenses. A right of reimbursement exists whether or not the settlement acknowledges liability or the manner in which the settlement and release specifies disbursement is to be made. 42 U.S.C. §1395y(b) (2) (B) (iii) (2000 and Supp. 2004).
8. 42 U.S.C. § 1395y(b)(2)(B)(ii)
9. A primary plan's "responsibility" may be "demonstrated" by a "judgment" or "a payment conditioned upon a recipient's compromise, waiver and release." 42 U.S.C. § 1395y(b)(2)(B)(ii). A "settlement" or "contractual obligation" further evidences "responsibility" under the MSPA. *See* 42 C.F.R. § 411.22 (b)(3). It is important to note that this obligation applies "whether or not there is a determination or admission of liability." 42 U.S.C. § 1395y(b)(2)(B)(ii). Thus, even denied claims are included under the statute.
10. 42 C.F.R. § 411.24(g). Medicare also has a subrogation right, as well as rights of joinder and intervention. *See* 42 C.F.R. § 411.26.
11. 42 C.F.R. §411.50.
12. 42 U.S.C. § 1395y.
13. The MSPA provisions state that Medicare is always secondary to workers' compensation and other insurance, including no-fault and liability insurance. Medicare's authority to review liability settlements arises under the same law. 42 U.S.C. §1395y (b)(1) and (2).

SURPLUS LINES REGULATION IN FLORIDA â• PART II

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Opinions issued by the Florida Supreme Court and the Eleventh Circuit Court of Appeals in late 2008 created ambiguity regarding the scope of regulation of surplus lines insurers in Florida, particularly in the area of policy form and rate approval. Historically, surplus lines insurers writing such policies in Florida have not

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been subject to policy form and rate regulation applicable to authorized insurers under Chapter 627, Florida Statutes. In response to these opinions and the uncertainty created by them concerning Florida's limited regulatory role in relation to surplus lines insurers and their policies, the Florida Legislature passed Committee Substitute for House Bill 853 (2009) ("CS for HB 853") to clarify that insurance policies issued pursuant to Florida's Surplus Lines Law¹ are exempt from the requirements of Chapter 627.

I. Discussion of Florida Case Law Creating Ambiguity in Regulation of Surplus Lines Insurance²

The Florida Supreme Court in *Essex v. Zota*, 985 So. 2d 1036 (Fla. 2008), decided a certified question from the United States Court of Appeals for the Eleventh Circuit concerning the interpretation of Florida law requiring delivery of a copy of the insurance policy to the insured.³ In holding that the delivery of the surplus lines insurance policy to the insurance broker was sufficient under Florida law, the Court analyzed the legislative history of several provisions within Chapter 627, Florida Statutes, including section 627.021(2), which exempted surplus lines insurers from certain requirements applicable to admitted carriers.⁴ Applying rules of statutory construction, the Court determined that section 627.021(2)'s exemption for surplus lines insurers applied only to Part I of Chapter 627, which deals with rates and rating organizations.⁵ Therefore, the Court held that surplus lines insurers are subject to all other parts of Chapter 627, including policy form regulation that admitted carriers must comply with - a significant departure from the limited regulation of surplus lines insurers and their policy forms in Florida for at least the past twenty years. Shortly thereafter, the Eleventh Circuit Court of Appeals issued its opinion in *CNL Hotels & Resorts, Inc. v. Twin City Fire Insurance Company*, 291 Fed. Appx. 220, 2008 WL 3823898 (11th Cir. 2008), finding that policy form review and approval requirements applicable to authorized insurers under section 627.410, Florida Statutes, applied to surplus lines insurance based upon *Essex*.⁶

II. Legislative Action in Response to Essex and CNL Opinions

During the 2009 Regular Session of the Florida Legislature,⁷ CS for HB 853 was passed to exempt surplus lines insurers from Chapter 627,⁸ and impose certain requirements on surplus lines insurers that admitted insurers must comply with⁹ or that the Florida state and federal courts have determined also apply to surplus lines insurers.¹⁰ CS for HB 853 has been enrolled and sent to Florida's governor for signature.¹¹ Every bill passed by the Florida Legislature must be presented to the governor for approval and shall become a law if the Governor approves and signs it, or fails to veto it within seven consecutive days after presentation.¹²

The provisions of this bill and potential impacts are discussed in further detail below:

A. Retroactive Exemption for Surplus Lines Insurers from Chapter 627 and Severability Clause

CS for HB 853 amends section 626.913, Florida Statutes, to expressly state that the provisions of Chapter 627 do not apply to surplus lines insurance authorized under Florida's Surplus Lines Law except as may be specifically stated.¹³ The exemption is remedial and operates retroactively from October 1, 1988, which is the effective date of section 627.012.¹⁴ ¹⁵ However, lawsuits filed on or before May 15, 2009 are not subject to the October 1, 1988 retroactive date.¹⁶

This retroactive exemption of surplus lines from Chapter 627 conforms to Florida Statutes and Florida case law concerning retroactive application of statutes. Section 624.21, Florida Statutes, requires amendments to the Florida Insurance Code to operate prospectively, unless a contrary legislative intent is specified, which CS for HB 853 does. CS for HB 853's specific language regarding its remedial nature and non-application to suits filed before or on May 15, 2009, is designed to ensure that due process of asserted substantive rights is not adversely affected or abolished.¹⁷ Finally, CS for HB 853 includes a severability clause ¹⁸ to cure any possible constitutional encroachment resulting from CS for HB 853 or its application. It and the

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corresponding judicial doctrine of severability are designed to: 1) recognize the obligation of the judiciary to uphold the constitutionality of legislative enactments where possible and to strike only the unconstitutional portions; and, 2) to show great deference to the legislative prerogative to enact laws.¹⁹

B. Notice and Disclosure Requirements

Section 626.924, Florida Statutes, was amended to require surplus lines policies issued on or after October 1, 2009 to have stamped or printed on the face of the policy the following notice in at least 14-point, boldface type:

**SURPLUS LINES INSURERS' POLICY RATES AND FORMS ARE NOT APPROVED BY ANY
FLORIDA REGULATORY AGENCY.²⁰**

Section 626.9371 was created to establish requirements for payment of premiums and claims for surplus lines insurance contracts issued on or after October 1, 2009 in Florida or covering risks located in Florida. This provision is substantially similar to existing section 627.4035 on the same subject; however, unlike section 627.4035, section 626.9371 does not impose premium payment plan options or approval requirements of such plans for personal and commercial residential property policies.²¹

Section 626.0372, Florida Statutes, was created to establish disclosure statements for certain information concerning liability coverage under surplus lines policies issued on or after October 1, 2009. Section 626.0372 is substantially similar to existing section 627.4137 on the same subject. The disclosure statement information to be provided under section 626.0372 is the same as section 627.4137:

- (a) the name of the insurer;
- (b) the name of each insured;
- (c) the limits of the liability coverage;
- (d) a statement of any policy or coverage defense that such insurer reasonably believes is available to such insurer at the time of filing such statement; and;
- (e) a copy of the policy.²²

However, section 626.0372 does not enact the same response and amendment periods imposed by section 627.4137. ²³ Instead, section 626.0372 establishes a sixty day period for surplus lines insurers to comply with a claimant's request for information or amend any prior disclosures upon discovery of facts meriting such an amendment. ²⁴

Section 626.9373, Florida Statutes, was created to impose attorneys' fees penalties against surplus lines insurers upon entry of a judgment or decree by a Florida court against a surplus lines insurer under a policy or contract executed by the insurer on or after the effective date of CS for HB 853. It is similar to section 627.428(2) and (3)²⁵ ²⁶ and states in pertinent part:

(1) Upon the rendition of a judgment or decree by any court of this state against a surplus lines insurer in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer on or after the effective date of this act, the trial court or, if the insured or beneficiary prevails on appeal, the appellate court, shall adjudge or decree against the insurer in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the lawsuit for which recovery is awarded.

2) If awarded, attorney's fees or compensation shall be included in the judgment or decree rendered in the case.

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Finally, Section 626.9374, Florida Statutes, was created to impose disclosure requirements concerning hurricane or wind deductible and coinsurance provisions within surplus lines policies insuring personal lines residential property insurance policies after October 1, 2009.²⁷ These disclosures must appear on the face of the policy and be in at least 14-point boldface type.²⁸ These notice disclosure requirements are similar to those applying to admitted carriers under section 627.701(4)(a). However, it is significant that section 626.9374 specifically refers to "hurricane or wind losses" and section 627.701(4)(a) only refers to "hurricane losses."²⁹ Section 626.9374's reference to "wind losses" implies that any surplus lines policies insuring against any wind loss, including one not associated with a hurricane, would be required to have the 14-point boldface type disclosure. This interpretation is reasonable given: 1) the Legislature's amendments to section 627.701 to transition personal residential and commercial residential property insurance policies providing windstorm deductibles and coinsurance based on wind losses to higher hurricane deductibles and coinsurance based on hurricane losses;³⁰ and, 2) the Florida Office of Insurance Regulation's distinction between windstorm events associated with hurricanes and windstorm events not associated with hurricanes as evidenced by its directive to residential property to use the "all other perils" or "other than hurricane" deductibles following Tropical Storm Fay in 2008.³¹

III. Conclusion

Surplus lines insurers should carefully examine Chapter 627, Florida Statutes to determine which, if any provisions specifically refer to surplus lines insurers or surplus lines insurance to determine the specific statutes within Chapter 627 that are applicable and the extent of such application in light of CS for HB 853's exemption language. Moreover, the new disclosure requirements are different from those required under Chapter 627 and should be carefully examined.

Endnotes

1. §§626.913 - 626.937, Fla. Stat. constitute and are referred to as the "Surplus Lines Law." See §626.913, Fla. Stat.
2. See also "Florida State and Federal Courts Impose Policy Form Review and Approval Requirements on Surplus Lines Insurers," FORC Journal: Volume 20, Edition 1, Spring 2009.
3. The certified question answered by the Florida Supreme Court in *Zota* was "[w]hether Fla. Stat. § 626.922 or § 627.421, or both, require delivery of evidence of insurance directly to the insured, so that delivery to the insured's agent is insufficient."
4. "[T]his Court has previously held that-under a full statutory analysis-section 627.021(2) applies exclusively to part I of chapter 627. *Essex*, 985 So. 2d at 1042 citing *Nat'l Corporacion Venezolana, S.A. v. M/V Manauere V*, 511 So. 2d 968, 970-71 (Fla.1987); §§ 627.011-627.381, Fla. Stat. (2003) (Part I of Chapter 627).
5. *Essex*, 985 So. 2d at 1043.
6. 291 Fed. Appx. at 225.
7. The 2009 Florida Legislature convened on March 3, 2009. See Article III, §3(b), Fla. Const.
8. See *Lowry v. Parole and Probation Comm'n*, 473 So. 2d 1248, 1250 (Fla.1985) (where "an amendment to a statute is enacted soon after controversies as to the interpretation of the original act arise, a court may

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consider that amendment as a legislative interpretation of the original law and not as a substantive change thereof."

9. Fla. H.R. Government Policy Counsel, CS for HB 853 (2009), Staff Analysis (April 21, 2009) at 8.
10. See *Underwriters at Lloyd's London v. Osting-Schwinn*, 545 F.Supp 2d 1261 (M.D. Fla. 2008) (applying section 627.4137, Fla. Stat. to surplus lines); *All Underwriters v. Weisberg*, F.3d 1309 (11th Cir. (Fla.) 2000) (applying section 627.428 to a marine insurance dispute on a surplus lines marine insurance policy); *Essex*, 985 So. 2d at 1050 (indicating that the federal courts remain free to impose an award of attorney's fees under section 627.428 in favor of defendants should they ultimately prevail against Essex); *Chacin v. Generali Assicurazioni Generali SPA*, 655 So. 2d 1162 (Fla. 3d DCA 1995).
11. See §11.07, Fla. Stat. requiring that all bills and joint resolutions passed by the Senate and House of Representatives must be enrolled on paper by the Secretary of the Senate or the Clerk of the House of Representatives, accordingly as the bills or joint resolutions may have originated in the Senate or House of Representatives, before they are presented to the Governor or filed in the Department of State.
12. See Article III, §8, Fla. Const.
13. §1, CS for HB 853, Eng. 1 (2009).
14. §7, CS for HB 853, Eng. 1 (2009).
15. Fla. H.R. Government Policy Counsel, CS for HB 853 (2009), Staff Analysis (April 21, 2009) at 4.
16. §7, CS for HB 853, Eng. 1 (2009).
17. See *Hassen v. State Farm Mut. Auto. Ins. Co.*, 674 So. 2d 106, 108 (Fla.1996). When a law affects substantive rights, liabilities, rights and duties, the law is presumed to apply prospectively. *Metro. Dade County v. Chase Fed. Hous. Corp.*, 737 So. 2d 494, 499 (Fla.1999). The policy rationale underlying this presumption is that "the retroactive operation of statutes can be harsh and implicate due process concerns." *Id.* For this reason, if a statute operates retrospectively, the courts will not apply it to pending cases absent clear legislative intent. *Id.*
18. §8 CS for HB 853, Eng. 1 (2009).
19. See *Lawnwood Medical Center, Inc. v. Seeger*, 990 So. 2d 503 (Fla.2008); *Ray v. Mortham*, 742 So.2d 1276 (Fla.1999).
20. §2, CS for HB 853, Eng. 1 (2009).
21. §627.4035(1), Fla. Stat. states in pertinent part: "(1) The premiums for insurance contracts issued in this state or covering risk located in this state shall be paid in cash consisting of coins, currency, checks, or money orders or by using a debit card, credit card, automatic electronic funds transfer, or payroll deduction plan. **By July 1, 2007, insurers issuing personal lines residential and commercial property policies shall provide a premium payment plan option to their policyholders which allows for a minimum of quarterly and semiannual payment of premiums. Insurers may, but are not required to, offer monthly payment plans. Insurers issuing such policies must submit their premium payment plan option to the office for approval before use.**" (Emphasis added).
22. §4,CS for HB 853, Eng. 1 (2009).

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23. Section 627.4137(1), Fla. Stat. imposes a 30 day deadline for insurers to provide disclosure statements regarding liability coverage. Amendments to disclosure statements must be provided to claimants immediately upon discovery of facts warranting amendment. *See* §627.4137(2), Fla. Stat.
24. *Id.*
25. §627.428, Fla. Stat. states in pertinent part: "(1) Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had. (2) As to suits based on claims arising under life insurance policies or annuity contracts, no such attorney's fee shall be allowed if such suit was commenced prior to expiration of 60 days after proof of the claim was duly filed with the insurer. (3) When so awarded, compensation or fees of the attorney shall be included in the judgment or decree rendered in the case."
26. Unlike section 627.428(2), Fla. Stat., newly created section 626.9373, Fla. Stat. does not refer to suits based on life insurance or annuity contract claims. Sections 626.9201(1), 626.927(1), and 626.929(2), Fla. Stats., refer only to property, casualty or marine insurance. Furthermore, section 626.939, Fla. Stat. regarding records produced upon order by the Office of Insurance Regulation does not apply to life insurers.
27. §6, CS for HB 853, Eng. 1 (2009).
28. §626.9374, Fla. Stat. requires the following disclosure language bolded in at least 14 point size font when applicable: THIS POLICY CONTAINS A SEPARATE DEDUCTIBLE FOR HURRICANE OR WIND LOSSES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU.***THIS POLICY CONTAINS A CO-PAY PROVISION THAT MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU.
29. §627.701(4)(a), Fla. Stat. states in pertinent part: "(4)(a) Any policy that contains a separate hurricane deductible must on its face include in boldfaced type no smaller than 18 points the following statement: 'THIS POLICY CONTAINS A SEPARATE DEDUCTIBLE FOR HURRICANE LOSSES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU.'" A policy containing a coinsurance provision applicable to hurricane losses must on its face include in boldfaced type no smaller than 18 points the following statement: 'THIS POLICY CONTAINS A CO-PAY PROVISION THAT MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU.'
30. In 1993, section 627.701, Fla. Stat. referred only to "windstorm deductibles" and "wind losses." *See* §13, Chapter 93-410, Laws of Florida. Over time, references to "hurricane" were added and "wind" and "windstorm" deleted. *See* §12, Chapter 96-194; §11, Chapter 97-55; §12, Chapter 2005-111, Laws of Florida. Furthermore, language concerning transition from wind deductibles to higher hurricane deductibles was deleted by §12, Chapter 2005-111, Laws of Florida.
31. Office of Insurance Regulation, Informational Memorandum, OIR 08-08M (August 21, 2008), states in pertinent part: "**To Residential Property Insurers in the State of Florida Deductible Applicable to Tropical Storm Fay Claims.**" The purpose of this informational memorandum is to remind property insurers that Tropical Storm Fay has not been declared a hurricane by the National Hurricane Center of the National Weather Service. Tropical Storm Fay is currently classified as a windstorm event that is unrelated to a hurricane. Section 627.4025(2)(a), Florida Statutes, specifically defines "hurricane coverage" as coverage for loss or damage caused by the peril of windstorm during a hurricane. Insurers are hereby notified that hurricane deductibles shall not apply to property losses associated with a Tropical Storm Fay claim. All insurers must

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apply the deductible that is unrelated to hurricane, generally referred to as the "all other perils deductible" or "other than hurricane deductible." An insurer that fails to apply the appropriate deductible is subject to administrative action.

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