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APPLYING INSURANCE CONCEPTS

Continuing Education
For Illinois Insurance Professionals

APPLYING INSURANCE CONCEPTS

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ABOUT THIS COURSE

"Applying Insurance Concepts" provides a review of essential topics for licensed producers and then explores the ways in which those topics have been applied in the sale of major insurance products. Seemingly abstract ideas related to risk, liability and other issues will be explained in great detail and will then be followed by extensive chapters about real-world coverage options:

- Chapter 1 reminds readers of the importance of insurance as a risk management tool and the various legal and professional concepts that impact the industry.
- Chapter 2 gives producers an understanding of their own risks, particularly in regard to consumer interactions and carrier relationships.
- Chapter 3 explains the history of insurance regulation and identifies the various entities that have been tasked with promoting market fairness and consumer protection.
- Chapter 4 guides students through various claims-related scenarios and highlights certain practices that might create disharmony between insurers and policyholders.
- Chapter 5 provides an overview of group life insurance and reinforces some of the fundamental life insurance concepts mentioned in previous chapters.
- Chapter 6 offers information about personal auto insurance and reemphasizes some of the major property and casualty insurance concepts found in earlier chapters.

As always, we hope this course helps you recognize how each corner of the insurance business plays a valuable role in protecting the public. By continuing in your insurance career and completing high-quality continuing education programs, you can help your clients become more informed and put them in a position to make smart decisions.

CHAPTER 1: REVIEWING INSURANCE FUNDAMENTALS

Introduction

There are many ways to manage risk in our lives. If we are concerned about the risk of a fire destroying our property, we might attempt to reduce the risk by installing smoke detectors in our homes and offices. If we worry about the risk of dying in a plane crash, we might attempt to avoid the risk entirely by refusing to travel on airplanes.

However, some risks are either too important or too complex for us to handle on our own. Sometimes, the best way to manage a risk is to transfer it to someone else by virtue of insurance.

What Is Insurance?

In general, insurance is a contractual arrangement whereby one party agrees to absorb a risk in exchange for compensation. Typically, the party absorbing the risk is an insurance company, and the compensation given to the company is a set dollar amount known as a "premium." Insurance technically can't prevent death, property damage, lawsuits or other bad events from happening, but it can help us recover from those unpleasant circumstances without suffering significant financial loss.

Pure Risks and Speculative Risks

Insurance is meant to help people and businesses manage "pure risks." A pure risk is a matter of chance in which the only potential outcomes are a negative outcome or a neutral outcome. For example, in the case of auto insurance, the pure risk is that a driver will either experience the negative outcome of being in an accident or will have the neutral outcome of arriving safely at a destination, no better and no worse than when the driver got into the car.

In all but a few rare and highly controversial cases, insurance cannot be purchased to directly manage "speculative risks." A speculative risk is a matter of chance in which a clearly positive outcome is possible. For example, gambling at a casino involves speculative risk because a player has a chance of winning as well as losing. Similarly, investing in the stock market involves speculative risk because an investment can lead to a profit as well as a loss.

A few insurance products blur the line between pure risk and speculative risk because they are tied to performance of the financial markets. Some of these products are actually a combination of insurance and securities and can only be sold by people who hold the appropriate securities license.

Perils

A peril is the basic cause of a loss. Examples of perils include the following:

- Fire (for property insurance).
- Death (for life insurance).
- Illness or injury (for accident and health insurance).
- Collision (for auto insurance).
- Theft (for many forms of personal and commercial property insurance).
- Flood (for flood insurance).

Insurance policies will list or define the perils that will trigger coverage (and thereby result in compensation) for the consumer. The same policies might contain a list of perils that will not trigger coverage and thereby won't result in insurance-provided compensation for the consumer. Perils that won't trigger coverage under an insurance contract are commonly listed as "exclusions."

Hazards

A hazard is something that increases the likelihood of a loss or at least has the potential to increase the size of the loss. In general, hazards fit into one of three groups:

- Physical hazards.
- Moral hazards.
- Morale hazards.

Physical Hazards

A physical hazard is an environmental factor that could increase either the likelihood or severity of a loss. Examples of physical hazards are as follows:

- Frayed wiring, which could eventually lead to a fire or electric shock.
- A wet floor or icy sidewalk, which could eventually lead to an injury and/or a lawsuit.
- A broken window, which could eventually lead to theft.
- A pollution-heavy workplace, which could eventually lead to illness, death and/or a lawsuit.

Moral Hazards

A moral hazard is an incentive or opportunity for someone to commit unethical or even illegal activity. Within the context of insurance, moral hazards provide a temptation to use insurance for personal gain rather than for the transfer and management of risks. If an insurance product is not structured to eliminate or at least minimize moral hazard, the resulting negative outcomes might include:

- A life insurance beneficiary murdering the insured in order to collect death benefits.
- A property owner committing arson on his or her own property in order to collect insurance money.
- An antique dealer staging a robbery of his or her collectibles in order to receive insurance benefits.
- An employee faking an injury in order to receive workers compensation payments.

Although not all instances of moral hazard can be eliminated, insurance products have been structured to reduce them in reasonable ways. For example, you usually cannot buy life insurance on someone else's life unless you have a close, positive relationship with the person. (This concept is known as "insurable interest.") You typically cannot collect more than a damaged item's actual cash value (as opposed to its "replacement cost") and can't receive compensation that puts you in a better financial position than before the loss. (This concept is known as the "principle of indemnity.") Even the injured employee who receives workers compensation will be unable to receive as much money while on disability than when he or she was actually working.

You'll learn more about insurable interest, the principle of indemnity and other important concepts later in this chapter.

Morale Hazards

A morale hazard exists when a person becomes overly reliant on insurance and therefore lacks the motivation to prevent or reduce losses in other ways. For example, a tenant who purchases renters insurance for her personal property might say to herself, "Since I have insurance, I'm not so worried about locking my door anymore." A person receiving disability benefits might conclude, "I could probably try going back to work now. But since my insurance is still paying my bills, I think I'll wait another week and see if I continue to feel well." A doctor's patient might say, "I could probably beat this flu by staying home and resting. But since my insurance will cover my medical visit, I might as well make an appointment to see my physician."

Insurers use several techniques to reduce morale hazards. To encourage home security, property insurers might offer lower prices to people who purchase alarm systems or who install deadbolt locks. To discourage overuse of medical care, health insurers might require patients to pay coinsurance fees, deductibles and copayments for most health care services.

Although moral hazards and morale hazards might seem very similar, they involve very different thought processes. People who take advantage of moral hazards do so intentionally and consciously, and they are often willing to deceive an insurance company in exchange for personal gain. People who take advantage of morale hazards often do so on an entirely subconscious level and aren't actively trying to harm the insurance company.

Evaluating and Calculating Risk

Providing insurance to the public requires careful attention to mathematical and actuarial principles. If an insurance company does not follow certain principles, it is likely to accept more risk than expected and could ultimately put itself in financial jeopardy.

Law of Large Numbers

In order to remain financially strong, insurance companies cannot agree to accept the transfer of a risk until they have a firm understanding of that risk. In order to offer life insurance, a carrier must have a firm understanding of life expectancies among potential customers. In order to offer fire insurance, a company must have a general idea of how often fires occur within certain geographic areas and the amounts of damage they usually cause.

A mathematical concept called the "law of large numbers" essentially states that the probability of an occurrence (such as a loss) becomes clearer as it is tested against an increasingly larger sample of data. Consider, for example, a coin flip and the likelihood of the coin landing "heads" or "tails." If we flip a coin only twice, it's possible that it will land on "heads" both times. Based only on those two flips, we might incorrectly assume that the probability of a coin landing on "heads" is 100 percent and that the probability of it landing on "tails" is 0 percent. However, if we flip the coin 100 times, 1,000 times or even more, we are likely to see that the coin will land on each side on a fairly even basis and that the real probability is 50 percent for "heads" and 50 percent for "tails."

Insurers use the law of large numbers by pooling together a high quantity of similar risks and using historical data to determine the amount of losses that will likely occur during a given timeframe. Rather than insure just two homes in a city against fire losses and hoping for the best, they will insure hundreds of homes in that city and (due to the larger sample size) be able to more accurately predict the amount of customers who will suffer a fire-related loss.

Based on this prediction from a large sample size, the insurer is in a better position to anticipate the cost of doing business and can price its products accordingly. If the law of large numbers is applied correctly, only an unforeseeable surge in losses (and not any single loss) should have the power to disrupt the insurance market.

Adverse Selection

Adverse selection occurs when insurance is purchased disproportionately by people who are at the highest risk of suffering a loss. Unless an insurer can balance its portfolio by attracting low and moderate-risk customers, it will be unable to offer affordable products to the public and might even be unable to serve certain markets at all.

For an example of adverse selection, consider the buying habits that have typified the market for individual health insurance. The people who tend to be most interested in purchasing health insurance are those who already have health problems, whereas the people who tend to be least interested in health insurance are young people with no health problems. If a health insurance company is too good at attracting sick customers and unsuccessful at attracting healthy customers, too much adverse selection will exist, and insurance will become unaffordable or unavailable.

One way to combat adverse selection is to carefully evaluate each insurance customer's level of risk and then charge high-risk

customers more than low-risk customers. In theory, lower prices should attract low-risk applicants, while higher prices will make high-risk applicants less likely to pursue insurance. Similarly, an insurance company might establish underwriting guidelines that clarify who is eligible for an insurance product (regardless of price) and who will not be issued a policy under any circumstances. However, these guidelines and pricing decisions must be based on an applicant's risk and must be supported by solid actuarial data. Decisions based on non-risk factors (such as race, ethnicity and—in some cases—gender) have the potential to violate state and federal antidiscrimination laws.

Adverse selection can also be reduced by requiring people to purchase insurance regardless of their risk. This method diversifies an insurer's pool of risks by bringing more low and moderate-risk customers into the market. Theoretically, those added low and moderate-risk customers can make it easier for an insurer to absorb high-risk customers. This approach to addressing adverse selection was implemented in much of the U.S. health insurance market in 2010 via the Affordable Care Act.

Insurance Contracts

Insurance policies are contracts between the company issuing the policy and the consumer who is purchasing it. Although you certainly don't need a law degree in order to successfully sell insurance, a basic understanding of contract law and contractual provisions can make insurance fundamentals easier to grasp.

We will summarize some important legal concepts in the rest of this chapter, but please be aware that the presented information is intended to be general in nature. The intricacies and enforceability of specific insurance contracts are topics that should be addressed by attorneys with a background in insurance law.

Unilateral vs. Bilateral Contracts

A unilateral contract is a contract in which only one of the parties makes a legally enforceable promise. In an insurance transaction, the insurance company promises to compensate a consumer for a loss, and the consumer agrees to pay premiums to the insurer. If a loss occurs and the insurer does not deliver on its promise to provide compensation, the consumer can take the insurer to court in order to obtain a financial settlement. However, if a consumer fails to pay premiums, the insurance company generally cannot take the consumer to court and demand payment. Instead, the insurer might respond to nonpayment by cancelling the person's insurance. Since the consumer can enforce the contract in a court of law but the insurer cannot, insurance policies are usually considered to be unilateral contracts.

The opposite of a unilateral contract is a "bilateral" contract. In a bilateral contractual arrangement, both sides promise to do something, and both sides can use the courts to enforce the contract if a promise is not kept.

Aleatory Contracts

In order to insure a person or thing, the individual wanting the insurance must have an "insurable interest" in that person or thing. In essence, this means the person buying the insurance must have a reasonable desire for the person or thing to remain unharmed. The existence of insurable interest is one of the important elements that differentiate insurance from pure gambling.

Although insurance is not gambling, it does involve matters of chance. In general, although an insurance company promises to provide financial compensation after a loss, there is a chance that no loss will ever occur. Even life insurance can involve the chance of a loss not occurring, since many forms of life insurance are only in effect for a set number of years and then cannot be renewed.

Since compensation from an insurance company is contingent on a loss actually occurring, there is a chance that one party to the insurance contract will benefit significantly more than the other. For example, there is a chance that no loss will occur, in which case the insurer would benefit much more than the consumer. Conversely, there is also the chance that a loss will occur very early in the policy period and that the insurer will need to pay significantly more to the consumer than it collects from that person in the form of premiums.

A contract that incorporates elements of chance (as is the case with most insurance contracts) is known as an "aleatory contract."

Contracts of Adhesion

A "contract of adhesion" is a written agreement in which one party chooses the language of the contract and the other party merely has the option of either accepting the contract as written or rejecting it. A contract of adhesion involves little or no back and forth regarding the specific wording of the agreement.

Most insurance contracts are contracts of adhesion. Insurance carriers either write their own policy forms or use standard forms that are common in their line of business. For example, many property and casualty insurers use policy forms with wording from a company called the "Insurance Services Office" (ISO).

On occasion, a consumer will request that something be added or deleted from a proposed insurance contract, but even the wording that adds or deletes sections of the contract will usually be written by the insurance company or some other insurance entity.

Other than in rare cases involving insurance for very high-profile businesses, the consumer and his or her representatives won't be involved in the drafting of the contractual language. When a consumer or the consumer's representative plays an active role in the writing of an insurance contract, the contract is sometimes referred to as a "manuscript" policy and might not be considered a contract of adhesion by the courts.

Since contracts of adhesion are written by only one of the parties, disputes regarding ambiguities in their wording will usually be resolved in the other party's favor. Within the context of insurance, this means that if an insurer and a consumer are arguing about the meaning of an unclear word or an ambiguous phrase in an insurance policy, a court is likely to rule for the consumer. The general assumption is that the insurance company has more specialized knowledge than the consumer and, as the writer of the contract, already had an adequate chance to protect itself. Thus, when there is more than one way to reasonably interpret the policy, the consumer should generally get the benefit of the doubt.

Warranties and Representations

When entering into an insurance contract, consumers are expected to act in good faith. Fulfilling this obligation requires honesty and a willingness to disclose information about the risk being insured. If information provided by a consumer to an insurance company turns out to be incorrect, the options available to the insurance company will depend on whether the

incorrect information relates to either a "warranty" or a "representation."

In regard to insurance contracts, a warranty is a statement that must be literally true in order for the insured to keep the policy in force. Alternatively, you can think of a warranty as a promise (such as a promise that a particular fact is 100 percent correct) that the consumer agrees to never break. If information related to a warranty is discovered to be incorrect, the insurer might have the ability to void the contract even if the incorrect information seems fairly irrelevant.

For example, consider a disability insurance application that asks the consumer to disclose any pre-existing health conditions. Now imagine that the applicant suffers from acne but does not think to disclose this condition because it doesn't seem serious and is unlikely to result in a disability. If the failure to disclose the acne is considered part of a warranty, the insurance company might be able to cancel the person's disability coverage on this basis even if the acne never results in a claim for disability benefits.

By contrast, if incorrect information from a consumer is considered part of a representation (and not a warranty), the insurer cannot void the insurance contract unless the information is "material." In general, something is material if it is likely to influence the insurance company's decision to issue a policy in the first place.

An insurer's ability to act in response to incorrect information from the consumer is often determined by court precedents and state laws. For example, depending on the state and the type of insurance product, information from a consumer might be considered a warranty for a limited amount of time (such as one or two years after the date of application) and then become a representation. States and courts might also determine the specific types of information that can be considered warranties and the types that must be treated as representations.

Concealment

Concealment occurs when, instead of directly providing false information, a consumer merely fails to disclose something to the insurance company. In order for concealment to jeopardize a consumer's insurance coverage, the nondisclosure usually must have been intentional and related to a material fact. However, this general rule might not apply in certain jurisdictions or in certain lines of insurance.

Principle of Indemnity

Particularly in property and casualty insurance, benefits paid by the insurer to the consumer are commonly based on the "principle of indemnity." The principle of indemnity calls on the insurance company to compensate policyholders to the degree that they are neither worse off nor better off after an insured loss. Rather, within the confines of the contract, the insurer should attempt to make a policyholder "whole" again.

Most property insurance policies apply the principle of indemnity by only insuring items up to their "actual cash value." An item's actual cash value is the amount it would cost to replace the item minus depreciation. Coverage that does not subtract for depreciation is known as "replacement-cost coverage" and is sometimes available to consumers for an additional premium.

For an example of how actual cash value coverage works, imagine a scenario in which you have property insurance on your 10-year-old computer. If your computer is stolen, the insurance company is unlikely to reimburse you for the cost of a brand-new machine. Instead, you are likely to receive an amount equal to the value of a computer that is already 10 years old.

Valued Policies

The principle of indemnity has served as an important safeguard against fraud and other forms of moral hazard, but it is not applied in all lines of insurance. For example, life insurance and insurance for antiques tend to be issued as "valued policies." A valued policy compensates a consumer in an amount that was already agreed to in advance of a loss.

Valued policies are used in cases where either an insured item would be difficult to replace or (in the case of life insurance) the financial consequences of a loss cannot be calculated with certainty. But even though these policies don't directly incorporate the principle of indemnity, the carriers that issue them take other steps in order to address moral hazard. In property insurance, valued polices usually require an appraisal before coverage can be issued. In life insurance, a carrier might address moral hazard by putting a cap on the amount of death benefits that an applicant can purchase in proportion to the insured person's income, net worth or some other factor.

Concurrent Causation

"Concurrent causation" occurs when a loss is created by more than one peril. It becomes an important issue in insurance when one of the perils is covered by the policy but another is not. For example, concurrent causation is a common concern after hurricanes because hurricanes typically produce wind damage and flood damage at the same time. Although wind damage is covered by practically all forms of homeowners insurance, flood damage is not. (Flood insurance is provided by insurers as a separate product.)

Some insurance contracts contain specific instructions as to how the carrier will respond to losses involving concurrent causation. However, absent contractual language to the contrary, many courts have ruled that a loss that is caused by both a covered peril and a non-covered peril should be covered by the insurance company.

Insurable Interest

In order to insure a person or a piece of property, the party who is purchasing the insurance must have an "insurable interest" in that person or property. In general, an insurable interest involves a desire for the insured person or piece of property to remain unharmed.

Insurance companies require insurable interest in order to prevent moral hazard. Without it, unethical people could purchase insurance on the lives of complete strangers and on a stranger's belongings. Then, an unethical person would be tempted to harm the insured person or damage the insured property.

Originally, insurable interest was also made mandatory in order to prevent insurance from being used as a form of gambling and to make it clear that insurance was intended to manage pure risks rather than speculative risks. (For a review of pure risks and speculative risks, refer to an earlier portion of this chapter.)

Specifics regarding what qualifies as an insurable interest can differ among the various states. However, life insurance can usually be purchased on someone's life if the purchaser is the same person or if the purchaser is the insured person's close family member, business partner or creditor. (If the purchaser and the insured person are not the same, the insured person

might need to provide written consent.) Similarly, property insurance can usually be purchased on someone's property if the purchaser is the owner of the property or if the purchaser has accepted the property as collateral in exchange for a loan.

In property insurance, insurable interest must exist at the time of loss. So, for example, if someone insures his or her home but then sells the home, that former owner will not be able to collect money from the insurance company if the house burns down. This follows the principle of indemnity (as discussed earlier in this chapter) and ensures that a policyholder is made "whole" after a loss rather than any better or worse.

In life insurance, insurable interest must exist at the time the policy is issued but not necessarily at the time of loss. This can be an important point when spouses own life insurance on each other but eventually get divorced. In this scenario, the former spouses might be able to continue to own insurance on each other even though they might not depend on each other for any type of support.

Note that insurable interest in life insurance is generally required of the policy's owner but not the policy's beneficiary. This allows the owner of life insurance to name practically any person or entity as the policy's beneficiary, including any friend, family member, charity or business partner.

Presumably, the non-requirement of insurable interest for beneficiaries exists because most life insurance beneficiaries are revocable. If the policy's owner no longer wishes someone to collect a death benefit as a result of the insurance, the owner can often simply contact the insurer and change the beneficiary. However, this flexibility also means that people who own insurance on their own lives need to be proactive if their relationship with the policy's beneficiary deteriorates. For example, if a husband buys life insurance on his own life, names his wife as the beneficiary, gets a divorce and marries someone else, he must contact his insurance company if he wants his new spouse added as a beneficiary and his ex-wife removed from it. If he dies without taking action, his ex-wife would collect the policy's death benefit and wouldn't need to share any of it with the new spouse.

Damages

Damages that are paid on behalf of others by an insurance company are particularly relevant to liability insurance. Though there are several different types of damages that might be awarded by a court or included as part of a settlement, not all of them can be managed with the help of insurance.

Let's review two basic types of damages and whether each type can be covered by insurance.

Compensatory Damages

Casualty insurance can be purchased to manage potential liability for "compensatory damages." When one party is deemed responsible for another party's loss, compensatory damages are paid by the responsible party in order to make the wronged party "whole" again. These damages adhere to the principle of indemnity and are intended to make the wronged party no better and no worse than before the loss occurred.

Compensatory damages can be categorized as either "special damages" or "general damages." Special damages are damages that are easily quantifiable, such as those awarded to replace damaged property or damages awarded to reimburse an injured person for medical bills that have already been paid out of the injured person's pocket. General damages, on the other hand, aren't easily quantifiable. General damages might be awarded when someone else is held liable for a death, a long-term disability, a reduced quality of life or a harmed reputation.

Punitive Damages

In addition to having to pay compensatory damages, a liable party might be ordered to pay "punitive damages" to the harmed party or to a government entity. Punitive damages are sometimes called "exemplary damages" because they are imposed in order to make an example of the liable party and to discourage society from engaging in the kind of activity that caused the loss. Whereas compensatory damages are intended to make the wronged party "whole" again, punitive damages are intended to punish the liable party for instances of fraud, major negligence, abusive practices and other negative behaviors.

In order to ensure that punitive damages serve their intended purpose, they usually cannot be covered by liability insurance. Punitive damages might need to be excluded from insurance as a matter of law or might be excluded voluntarily by an insurance company in order to reduce moral hazard.

Parts of Insurance Contracts

Now that you have a better understanding of some important insurance concepts, let's explore some of the most common parts of an insurance policy.

Declarations Page

The declarations page is one of the first—if not the very first—pages of an insurance policy. Although insurance policies are generally considered to be contracts of adhesion (and are written by the insurance company with almost no negotiation with the consumer), the declarations page is likely to list those aspects of coverage that the consumer had the ability to choose or that are unique to that person. For example, the declarations page might contain the following information:

- The name of the insured party.
- The overall dollar limit (or face amount) of the coverage.
- The deductible, if any.
- The duration of the policy.
- Whether property is covered up to its actual cash value or its replacement cost.
- The policy number.

Many insurance policies make several references to the "named insured." With a few exceptions, the named insured is usually the only person or entity who will be covered by the insurance. The exact identity of the named insured will usually be the person or entity specifically named on the declarations page.

The identity of the named insured should be reviewed carefully by the consumer so that the insurance applies to all intended parties at all times. For example, if a business has several names or several subsidiaries or undergoes a change in its name, the declarations page should take those issues into account and list all of the appropriate names. Listing the wrong names can result in the consumer paying for too much coverage by accident or (more likely) not having coverage when it is expected.

Insuring Agreement

An insurance policy's "insuring agreement" is the insurance company's basic promise to the consumer. For example, the insuring agreement might say something like, "We will pay for an occurrence of property damage or bodily injury during the policy period." Though this might seem like a fairly straightforward

promise, it is impacted (and usually made more complicated) by other parts of the policy, such as definitions and exclusions. In the example referenced here, for instance, the basic promise of the insuring agreement will be dependent on what is actually meant by the terms "occurrence," "property damage," bodily injury" and "policy period." In order to fully understand the scope and limits of the insuring agreement, the entire policy must be read in context.

Note that some insurance policies will contain multiple insuring agreements, particularly in the case of a "package policy" that is designed to cover multiple types of risk via the same contract. This is commonly done in homeowners insurance, in which one insuring agreement will pertain to property damage while a second insuring agreement will pertain to personal liability.

Endorsements

An endorsement is an amendment to an insurance company's standard policy. It can either add benefits for the consumer (often in exchange for a higher premium) or subtract benefits in order to make the insurance more affordable.

Depending on the specific type of insurance being sold, an endorsement might be referred to as a "rider." The word "rider" is fairly common in life and health insurance.

Entire Contract

In life and health insurance policies, an "entire contract" clause is typically included to clarify that both the insurance policy (including any endorsements) and the information on the consumer's application are the entire contract between the carrier and the policyholder. The clause protects insurers by allowing them to potentially cancel coverage if information on an application turns out to be false. It also protects the consumer by not allowing the insurer to cancel coverage after it has been issued as long as the application was completed fully and honestly. If the insurance company wants to amend the policy or charge a higher amount after it has been issued, the carrier generally must wait until the policy period ends and the coverage is up for renewal.

Guaranteed Renewable vs. Non-Cancellable

Despite seeming very similar, the terms "guaranteed renewable" and "non-cancellable" mean importantly different things. This is particularly true in accident and health insurance, which might be purchased by people who are healthy when their policy is issued but who later experience significant medical issues.

Within the context of accident and health insurance, a guaranteed-renewable policy cannot be canceled by the insurance company unless the insured person fails to pay premiums or has committed some kind of fraud. The insurance company must offer to renew the policy at the end of the policy period and cannot force the policyholder to pay more for the renewed coverage just because his or her health has deteriorated. However, the insurer might be allowed to raise prices on entire classes of customers at renewal time (such as an increase for all policyholders of a certain age who live in a specific geographic area).

By contrast, non-cancellable coverage must be offered for renewal at the end of the policy period and cannot cost any more than what has already been agreed to by the carrier and the consumer. Since this type of insurance leaves very little room for an insurer to guard against people's deteriorating health, non-cancellable coverage is usually expensive or unavailable for most shoppers.

In some markets, such as the individual market for major medical insurance, the consumer protections involved with guaranteed-renewable or non-cancellable coverage might be limited to a certain number of years (such as until the insured turns 65 and becomes eligible for the federal Medicare program).

The Role of Insurance Producers

Licensed insurance producers act as intermediaries between consumers and insurance companies. Although there are many different ways in which producers can do business, common tasks performed by nearly all active producers include:

- Selling insurance products to the public.
- Analyzing insurance-related needs of consumers.
- Collecting and/or facilitating the payment of premiums for insurance.
- Providing important insurance-related documents to applicants and policyholders.

Be aware that the title "insurance producer" is a relatively broad term that can apply to many different kinds of insurance professionals. For example, the term includes someone who acts as an "insurance broker" as well as someone who acts as an "insurance agent."

Insurance Brokers

An insurance broker (unlike an insurance agent) legally represents the interests of consumers in insurance transactions. Brokers help their clients shop in some of the more complex parts of the insurance market and attempt to secure the best coverage at the best price. Unlike insurance agents, brokers aren't contractually obligated to place business with a specific insurance carrier, and they do not have the authority to accept a risk on behalf of an insurance company. (The ability to accept a risk on an insurer's behalf is known as "binding." Binding will be addressed later in this chapter.)

Insurance brokers don't often specialize in personal property and casualty insurance for individuals and families and are, therefore, not always utilized by the average consumer. However, brokers commonly play a major part in selling the following types of insurance:

- Property and casualty insurance for businesses.
- Supplemental (and sometimes primary) health insurance for individuals and families.
- Group health and other employee-benefit plans.
- Coverage for special items that isn't sold by typical personal lines insurance carriers (such as insurance for classic cars, art collections or antiques).

Insurance Agents

An insurance agent (unlike an insurance broker) legally represents the interests of insurance companies in an insurance transaction. Although agents might have ethical obligations to analyze a consumer's needs and help the buyer secure the best coverage at the best price, the agent usually has a contractual duty to only place business with specific insurance companies rather than with any carrier that is willing to accept a risk.

Agents are typically required to engage in good "field underwriting" by not overburdening an insurance company with high risks. They also owe a heightened level of disclosure to the companies they represent.

Under the common rules of agency, information that is made known to the agent is generally considered by law to be known by the insurance company. In addition, some agents have the authority to issue coverage (known as "binding") on the insurance company's behalf.

Captive Agents

An insurance agent might represent a single insurance company or might have contractual relationships with multiple carriers.

A "captive agent" tends to work as an independent contractor for a single insurance company. That company might provide significant assistance to new agents in order to help them build their business. However, a captive agent is prohibited from helping consumers secure insurance from any other company. Assuming the captive agent works for a carrier that is willing to accept a risk, the agent must recommend that company's products and cannot help the consumer get a potentially better deal elsewhere. If a captive agent's customers decide to switch their insurance to a different carrier, the captive agent will not be able to collect any more commissions on that business.

Independent Agents

Independent agents can represent multiple insurance companies at the same time. As a result, if they have contractual relationships with multiple companies that are willing to accept a risk, they are free to help the consumer choose the best coverage at the best price among those companies. Similarly, if a consumer becomes unhappy with his or her insurance carrier, the independent agent can shop the risk again among several companies and still continue to collect commissions if the risk is placed elsewhere. Compared to captive agents, independent agents receive considerably less help from insurers with their training and startup costs.

The distinctions among brokers, captive agents and independent agents can be important to a producer's relationship with the public. However, please be aware that the summaries provided here are meant to be general in nature. In reality, the practical day-to-day differences between brokers and the different types of agents can seem very blurry, and they might differ significantly from one line of insurance to the next. For example, the positives and negatives of being an independent life insurance agent might not be exactly the same as the positives and negatives of being an independent property and casualty insurance agent.

In addition to paying attention to who they technically represent in an insurance transaction, new producers should carefully weigh their options and choose a role (broker, captive agent, independent agent, etc.) that best suits their career goals.

Binders

Some agents have the contractual authority to issue "binders." Through a binder, an agent accepts a risk on a carrier's behalf and gives temporary coverage to a consumer while an insurance policy is still in the process of being issued. If a loss occurs during the period in which the binder is in force (typically no more than 30 days), the insurer generally must cover the loss. If an agent has issued a binder but the carrier ultimately decides not to issue a policy, the binder will remain in effect until its expiration date or until the insurer cancels it in writing.

Although some binders might be provided orally, even an oral binder should be immediately followed by a written version delivered to the consumer. If there are conflicts between an oral binder and a written binder, the written version typically takes precedence.

Since binders impose contractual obligations onto insurance companies, agents must be very careful when issuing them and must understand the limits of their binding authority. If a binder is issued inappropriately and a loss occurs, the insurance carrier might take punitive actions against the agent.

In practice, binding authority tends to be more common among property and casualty agents than among life and health agents. In place of a binder, some agents might only be capable of providing a "conditional receipt," which can help cover losses between the time it is received and the time a policy is issued. However, in order for the conditional receipt to provide any coverage after a loss, the insurer's underwriting department must believe that the applicant would've ultimately been approved for a policy. If a loss occurs but the underwriting department discovers a serious problem with the consumer's application (such as an undisclosed medical issue), the conditional receipt might be meaningless.

Certificates of Insurance

A "certificate of insurance" is proof of insurance that is provided by the insured to a third party. Certificates of insurance are commonly requested in commercial lines when a business is attempting to secure work on a project as an independent contractor. For example, before a land developer hires a construction firm to build something on a vacant lot, it might request a certificate of insurance from the construction firm in order to verify that the firm has its own liability protection. For issues related to convenience and privacy, it is often simpler for an insured to give a third party a certificate of insurance than to provide a copy of the insured's entire insurance policy.

Although intended as evidence of insurance, a certificate will contain much less information than a full policy and won't always provide a clear picture regarding what kinds of losses would be covered by insurance and what types of losses are excluded.

Unlike a binder, a certificate is not a contract and does not alter any of an insurer's obligations under an insurance policy. If the party who requests or provides a certificate wants coverage to be altered or clarified in some way (such as by adding a customer to a business's liability insurance for the duration of a project), changes must first be made to the policy itself. Changes made only to the certificate (and not to the policy) are generally not enforceable.

In the event that an agent alters a certificate in a way that contradicts the policy, the insured party or the party requesting the certificate is likely to get a false impression of the applicable coverage. Such false impressions could lead to charges of misrepresentation against the agent.

Post-Loss Issues

The importance of some insurance issues might not seem relevant until the insured suffers a loss. We'll conclude this chapter by summarizing a few contractual provisions that can become critical at that time.

Proof of Loss

Especially in property insurance, an insured who suffers a loss is usually required to provide "proof of loss" to the insurance company. This is often done on special forms provided by the carrier and can involve itemizing various types of damage.

In order to manage its finances and keep enough money in reserve to handle future claims, insurance companies will require proof of loss within a certain amount of time, such as 60 to 90 days after a loss occurs. Deadlines for providing proof of loss might be extended in certain cases, such as following a major catastrophe that prevents owners from accessing their damaged property.

Despite the limited timeframe for providing proof of loss, insurance companies are discouraged from placing unreasonable burdens on customers as part of the claims-paying process. In fact, requiring excessive amounts of proof (and the filing of excessive paperwork) is often considered an illegal "unfair claims settlement practice" that can result in significant regulatory fines for carriers. Specifics about prohibited claims practices differ by state.

Arbitration and Mediation

If a consumer and an insurance company can't come to an agreement about the size or insured nature of a loss, going to court doesn't need to be the next step. Instead, the parties can agree to try some type of "alternative dispute resolution," such as arbitration or mediation.

In mediation, attorneys, retired judges or other third-party participants attempt to get both sides of a dispute talking to each other in order to come to a resolution. However, recommendations or proposals that are made by those third parties aren't binding on the insurer or the consumer, so they don't guarantee an end to the dispute.

Conversely, if a dispute goes through arbitration, the parties generally must abide by what the impartial attorneys, judges or other third parties decide and cannot take the argument any further by filing a lawsuit.

Subrogation

Many insurance policies contain a "subrogation clause" that takes the consumer's right to sue someone for an insured loss and transfers it to the insurance company.

To understand subrogation, imagine a scenario in which you are the victim of an auto accident. If your own insurance provides coverage for your own losses, your insurance company might compensate you and then attempt to be reimbursed for that amount by either the at-fault driver or the at-fault driver's insurance company. However, in accordance with the principle of indemnity, you would not be able to sue the at-fault driver for the amount you already received from your own insurer. Your ability to sue was transferred by you to your insurance company via subrogation.

Subrogation saves harmed consumers from having to take expensive legal action in order to collect money from liable parties. It also helps keep the cost of insurance down by providing a way for insurance companies to collect money from people who are truly at fault. But because subrogation can still require time and effort from an insurance company, a carrier will only exercise its right of subrogation when it is cost-effective to do so.

Conclusion

Practically since its beginning, insurance has operated under several fundamental principles that protect carriers and consumers. By following these principles and enforcing common contractual provisions, the insurance community has played an immensely important role in risk management. Your commitment to being a knowledgeable insurance producer can help continue the mutually beneficial relationship between insurance entities and the public.

CHAPTER 2: ERRORS, OMISSIONS AND LIABILITY FOR INSURANCE PRODUCERS

Introduction

Despite devoting countless hours to educating their clients about risk, some agents and brokers forget to look in the mirror every once in a while and acknowledge the ways in which insurance can help producers protect themselves. Just as they would encourage the general public to evaluate the various options for auto coverage, property coverage and liability coverage on a regular basis, insurance professionals should find time to review the appropriateness of their own errors and omissions (E & O) insurance.

Believe it or not, until the early 1990s or so, many insurance agencies believed they and their individual producers didn't necessarily need errors and omissions insurance in order to run their business. They often operated under the misconception that this important type of liability protection was mainly important for those in the industry who were less ethical, less careful, less knowledgeable or less experienced.

But as news of producers being threatened with lawsuits became more common, opinions about errors and omissions insurance underwent a significant shift. While admirable traits like professionalism, honesty and competence continue to be viewed as the main deterrent to disputes with consumers, today's insurance producers generally understand that avoiding the threat of lawsuits is also a matter of luck.

Even the best of us will occasionally make a mistake as part of our work, and even our best efforts to correct an error won't guarantee that a client, customer or carrier will forgive us. We might be confident that we have done everything right, but there's always at least a small chance that the people with whom we interact will react negatively and forcefully when they don't get exactly what they want.

For these reasons and more, the right errors and omissions insurance is a critical component of a successful, long-term insurance career.

The Professional Liability Market

Before going into detail about the specifics of errors and omissions insurance, let's briefly address some key definitions.

Be aware that some people use the terms "professional liability insurance," "malpractice insurance" and "errors and omissions insurance" interchangeably. Others make the following distinctions among those three terms:

- Professional liability insurance is a broad category of liability insurance that includes malpractice insurance, errors and omissions insurance, directors and officers (D & O) insurance and more.
- Errors and omissions insurance is a type of liability insurance that covers various professionals when their services don't meet clients' or customers' expectations.
- Malpractice insurance is another name for errors and omissions insurance that is specific to doctors, lawyers and a few other professions with a long tradition of needing professional liability insurance.

Some experts have been even more specific with their language and have suggested that the interchangeability of these three terms creates the potential for confusion and unexpected coverage gaps. For example, the late Rough Notes magazine contributor Donald S. Malecki interestingly raised the issue of errors and omissions insurance and its applicability (or lack thereof) in cases where liability stems not from a professional service (which is typically only offered by people with a license or special credentials) but from a clerical task (which might indeed be performed by a licensed or specially credentialed person but can also be done by relatively unskilled office workers). Should errors and omissions insurance be reserved for cases involving those clerical-type tasks? And should terms like "professional liability insurance" and "malpractice insurance" be reserved for cases involving activities that can only be performed by a specially licensed or specially credentialed person?

Though those questions might seem, at first, like parts of a merely semantic argument, they relate to a broader and very important point that will be emphasized throughout this chapter: Whether they are helping consumers with an E & O transaction or are buying an E & O product for themselves, insurance professionals must read coverage forms very carefully and confirm that they and the insurance carrier are in agreement about the types of scenarios that will be covered by a given policy.

Who Needs E & O?

Errors and omissions insurance is intended to help professionals when they are accused of negligence or incompetence in their work. This type of accusation might arise whenever a professional either provides services that do not meet a client's or customer's expectations or fails to provide an expected service at all. In general, for most types of errors and omissions coverage to apply (assuming we are putting medical malpractice insurance in a separate category), the harm to the client or customer must be financial in nature rather than a case of property damage or bodily injury.

Basic examples of scenarios that might ultimately result in an errors and omissions claim include the following:

- Giving bad professional advice.
- Failing to complete an important task before an important deadline.
- Committing a seemingly minor but ultimately costly clerical error.
- Performing an inadequate analysis of a client's needs.

In 2006, the popular trade publication National Underwriter reported that there were more than 150 classes of business within the errors and omissions insurance market. That number has undoubtedly risen since then, along with the aforementioned fear of lawsuits. An abbreviated list of professionals who tend to be good candidates for E & O (or, in some cases, malpractice) insurance appears below:

- Medical professionals.
- Legal professionals.
- Accountants.
- Architects.
- Engineers.
- Funeral directors.
- Real estate agents.
- Stockbrokers.
- Insurance agents and brokers.
- Web and software designers.
- Various types of "consultants," who are typically hired for advisory roles because of their alleged expertise.

Mandatory E & O Insurance

Many of today's professionals will have an interest in errors and omissions insurance because they sincerely wish to reduce their own level of risk. Others might not particularly want this type of insurance protection but will ultimately need to secure a policy because of state laws, a mandate from their employer or a demand from an important client.

In cases where insurance is mandated by a state, the government's intentions are usually to ensure that harmed consumers have a way of being compensated for an alleged professional's negligence and also to stabilize the E & O market so that carriers have a healthy mix of low, medium and high-risk policyholders in their portfolios. Be aware, however, that the mandatory purchase of errors and omissions insurance might only apply to specific types of professions in specific states.

Common E & O Scenarios for Insurance Producers

Having addressed some of the many different types of professionals who might have an interest in errors and omissions (or malpractice) insurance, we will spend the rest of this chapter exploring the ways in which errors and omissions products can or cannot provide risk protection for you and other licensed insurance producers.

We've already mentioned some broad examples of customer dissatisfaction that might lead to an errors and omissions claim. Now let's narrow our focus and review some examples that are specific to insurance agents and insurance brokers.

Here are some hypothetical but fairly common cases in which good errors and omissions insurance might come in handy for you:

- A policyholder's claim is denied in whole or in part, and the policyholder accuses you of failing to secure adequate coverage based on his or her specific situation.
- You place a client's insurance with a carrier that ultimately becomes financially incapable of meeting its claims-paying obligations.
- You forget to process a renewal before a policy's expiration date and allow coverage to unintentionally expire.
- You sell property insurance to someone who fails to purchase flood or earthquake insurance and who later accuses you of not explaining that losses from those natural disasters are generally not covered by standard property insurance.
- You are asked to cancel coverage that applies to more than one person but fail to receive authorization from the appropriate party (such as the "first named insured").
- You are helping a client find special coverage from an E & S (excess and surplus) carrier and forget to consider the seemingly subtle but potentially significant differences among the products sold in this non-standard market.

E & O Risks With Carriers

Concerns for producers pertaining to errors and omissions tend to center on perceived or actual mistakes that impact consumers. However, producers shouldn't forget their ethical and legal obligations to the insurance carriers that they represent or

otherwise work with. In fact, according to statistics from Swiss Re and the Independent Insurance Agents and Brokers of America (as published in Best's Review), roughly 8 percent of errors and omissions claims against insurance producers are prompted by angry or otherwise dissatisfied insurance companies.

In general, allegations of unprofessional conduct from carriers against agents or brokers tend to involve the following issues:

- Failing to disclose risk-related information about an applicant or policyholder to the insurance company.
- Overstepping authority in regard to binding (or not binding) coverage for an applicant before an application has been fully reviewed and processed by the insurance company.

Problems With Other Types of Liability Insurance

Much like the uninsured prospects who they attempt to educate, insurance licensees might make the incorrect assumption that they are already covered for professional liability—including for errors and omissions—by other policies. Let's go through some common types of insurance and address why they are hardly ever the best option for producers who are concerned about E & O risks:

- **Homeowners insurance:** Although homeowners insurance typically includes coverage for personal liability, it tends to exclude liability arising from business activities (with the possible exception of a minor who is operating his or her own business on a part-time basis). Furthermore, liability coverage in homeowners insurance only applies to cases in which the insured is deemed responsible for bodily injury or property damage. It doesn't help an insured who is accused of harming someone in purely financial ways.
- **Personal umbrella coverage:** Personal umbrella coverage can help consumers who want even more personal liability protection than a homeowners insurance policy can provide. But since its focus is on personal rather than professional liability, negligence related to the insured's job duties is unlikely to be covered by this type of product.
- **Directors and officers (D & O) insurance:** This insurance can be beneficial to people who are on boards of directors or who are otherwise responsible for a business's major financial decisions. But even if an insurance professional has D & O coverage through his or her high-ranking involvement at a company or corporation, this insurance generally won't extend to the person's insurance-related dealings with applicants or policyholders. Whereas D & O is intended to protect business leaders when their decisions harm their own company, E & O is largely intended to protect professionals when their decisions harm their clients or customers.
- **Commercial general liability (CGL) insurance:** This form of insurance is fairly standard among a broad range of businesses and is intended to help business entities when they are held liable for bodily injury or property damage. (A classic example of a CGL-related claim would be a case in which a customer slips and falls at the insured's place of business and demands financial compensation.) However, since CGL coverage is generally geared toward bodily injury and property damage, it is widely considered to be insufficient for professionals who offer advice or who can be held liable for someone's financial losses. Admittedly, an unaltered CGL coverage form usually doesn't exclude liability stemming from "professional services" and therefore might seem perfect for medical professionals (who might be sued for bodily injury) or various types of engineers or architects (who might be sued for faulty services that result in property damage). But the vast majority of carriers selling CGL insurance amend the standard coverage forms in order to specifically exclude "professional services." In other words, for most professionals, even a good CGL policy won't be enough.

Clearly, while the insurance products mentioned in this section might play an important role in an insurance producer's personal and professional life, they have significant gaps that can make errors and omissions insurance a near necessity.

Problems With "Going Bare"

The importance of E & O coverage has risen to a point where not having the insurance has earned its own term. If you are an insurance professional without errors and omissions insurance, you are said to be "going bare."

The term "going bare" suggests that not having errors and omissions insurance leaves someone exposed and vulnerable. To be fair, it is nearly impossible to say that every single person is a good candidate for a particular kind of insurance. But before an insurance agent or broker dismisses the idea of purchasing an E & O product, that person should seriously consider the following questions:

- Even if I follow all the rules and treat people as well as I possibly can, am I likely to ever have a particularly demanding and litigious client?
- Even if I win every lawsuit filed against me, how will I pay for an effective defense team?
- Even if I never have a litigious client or get sued, am I likely to ever work for an agency or insurance carrier that might require me to have my own errors and omissions insurance?

Assuming you believe errors and omissions insurance is important to your professional life, let's spend the next several pages going through the ways to obtain such coverage and many of the important policy features you might want to evaluate.

Obtaining E & O Insurance Through an Employer

Insurance producers who are interested in obtaining and maintaining adequate errors and omissions coverage might want to examine their options with their current or prospective employer.

An insurance company or agency that has already bought errors and omissions insurance for itself might already have options in place for its employees or its captive agents. However, many insurance businesses require employees and captive agents to pay a portion of premiums in order to be covered under the business's policy or at least make them responsible for all or a significant portion of the policy's deductible.

Regardless of any required cost-sharing, producers who are offered errors and omissions insurance through their employer might want to consider the following questions before accepting it:

- How will the coverage respond if I'm accused of an error or omission by my employer rather than by a customer?

- If a complaint is made against me and my employer, am I comfortable with my employer having full authority to choose and direct our legal defense team?
- Am I engaged in any insurance-related activities (such as teaching or consulting) that aren't done on behalf of my employer and, therefore, might not be covered by my employer's insurance?

Obtaining E & O Insurance on Your Own

If an insurance business does not offer errors and omissions coverage to its employees (or if the producer is self-employed), a risk-sensitive agent or broker will need to shop the market on his or her own. Although insurance businesses have the option of adding independent contractors (such as independent insurance agents) to their own E & O coverage, a business might only agree to do so for very valuable producers. Even then, coverage under one business's E & O plan wouldn't protect that producer in transactions for other insurance businesses.

If you need errors and omissions insurance and already have commercial general liability coverage in place for your own business, you may want to consider contacting the same carrier that issued the CGL policy. Ideally, having your E & O and CGL insurance from the same carrier (and serviced, presumably, by the same agent) will help reduce coverage gaps or at least make you more aware of risks that neither policy adequately addresses. In rare cases, you might even be able to add an E & O endorsement to your existing CGL policy instead of having to purchase an entirely separate product.

Decent errors and omissions coverage might also be offered through insurance trade associations. In fact, the ability to buy into a producer-centered E & O plan at a relatively affordable price is often a major reason why agents and brokers join such organizations in the first place. Even if the coverage offered by a trade organization isn't the best fit for your needs, your membership might help you save some money when applying elsewhere for your own insurance. After all, active members in these organizations tend to take their careers very seriously and are therefore viewed by some E & O underwriters as good risks.

No matter the route you take to find your own errors and omissions coverage, consider following the same kinds of advice that you would give to your own clients when evaluating their options from various insurance companies:

- Read all materials received from carriers (including marketing materials and policy forms).
- Don't be afraid to ask questions if something seems unclear or if an exclusion or policy limit seems unreasonable.
- Recognize that each product has its own benefits and drawbacks that can make all the difference when a loss occurs. Since there is no standard form of errors and omissions insurance, don't automatically assume that the cheapest policy is the best policy.

Underwriting for E & O

When applying for errors and omissions insurance, you will be asked to provide various pieces of information to the E & O insurance carrier. The following are some questions that a carrier might ask you. Depending on the carrier, your answers might have a significant impact on your eligibility for suitable insurance and the price you'll need to pay for it:

- How much business—based on premium volume—do you do every year in each line of insurance? (More business might mean more risk. Also, some lines of insurance are viewed as riskier than others. For example, someone who specializes in interest-sensitive variable life insurance might be viewed as a bigger risk than someone who sells term life insurance.)
- Do you plan on branching out and selling any new types of insurance in the near future?
- Which words do you use to advertise yourself and your credentials? (The higher the amount of expertise and trust associated with those words, the greater the potential risk. For example, producers who merely refer to themselves as "insurance agents" might be viewed as a lower risks than producers who refer to themselves as "insurance advisers.")
- Which specific services do you perform on behalf of clients, customers or insurance carriers? (Examples might include policy issuance, risk management advice, claims handling, underwriting and third-party administration services.)
- What sorts of procedures do you already follow in order to minimize your E & O risk? (For example, you might run an agency and require all of your producers to take courses about E & O issues on an annual basis. You might have systems in place that document all important communications with customers and clients.)
- Do you have any history of errors and omissions claims (or of being sued in a professional capacity)?
- Are there any recent events that have not yet resulted in legal action against you but might result in such action in the future?
- Have you ever done business under another name?
- Which insurance carriers do you represent or regularly do business with? (The E & O carrier will want to ensure that you are placing business with financially strong companies.)
- Do you have the authority to "bind" coverage for insurance companies, or are you only authorized to accept applications?
- If you are involved in commercial lines of insurance, which industries do you specialize in?
- If you are self-employed, how many people do you employ? (Some carriers will cover your employees unless you opt to exclude them.)
- If you are self-employed and hire independent contractors, do you require them to have their own errors and omissions insurance?
- Are you a member of any insurance-related professional organizations?
- How much errors and omissions insurance are you requesting?
- How high of a deductible are you requesting?
- Is this coverage intended to be your primary E & O coverage, or will it only be used when other insurance has reached its limit? (In general, excess coverage tends to be less expensive than primary coverage because it is less likely to be utilized.)

Common Policy Issues

At this point, we will look into some of the most important policy provisions, exclusions and features found in errors and omissions insurance. As you read through the next several sections, keep in mind that the information is intended to be general in nature. Since there is no standard coverage form for errors and omissions insurance, any E & O product that you

encounter might differ in important ways from other products in the market.

Who Is the Insured?

Whether you are buying errors and omissions insurance for yourself or expect to be covered through your employer, it is critical that you understand who is actually considered an "insured" within the policy. Failing to understand the specifics of this issue can lead to significantly negative consequences at the worst time.

The broadest forms of errors and omissions insurance will cover the insurance business (or person) specifically named on the policy's declarations page, as well as all past, present and future owners, employees and independent contractors when conducting business on the named entity's behalf. However, agreeing to insure so many people under the same policy can raise the amount of risk to the carrier and, consequently, can require the named insured to pay relatively high premiums.

In order to reduce costs, insurance entities that purchase E & O coverage will commonly exclude independent contractors or might choose to only cover a few contractors who are especially important to the business. It is also possible for the insured entity to cover its owners but not any employees. As was mentioned earlier in this chapter, some businesses walk a middle ground in this regard by extending coverage to their workers, but only if a worker is willing to pay part of the premiums and/or the deductible.

If a person or business already has E & O coverage, the definition of "the insured" should be reviewed again following an entity's change in ownership or name and at the end of someone's employment. A business will probably want to ensure that the new owners or the new business name are clearly included within the definition. A departing employee (or even a departing owner) will want to review the definition (as well as other important policy provisions) so that there is clarity regarding when the person will no longer be covered by the employer's insurance and whether the person will retain a limited amount of protection against claims arising from past activities.

Covered Professional Services

Once you confirm that you are an insured party under an errors and omissions policy, your attention should turn toward the types of activities to which the policy applies. In general, errors and omissions insurance is only applicable in cases in which the insured is performing "professional services" or "professional acts." If an error or omission arises from an activity that is beyond the scope of professional acts or professional services, the insured will need to find another way to deal with any resulting damages.

Note that an E & O policy's definition of professional services is likely to be specific to a particular profession. For example, the definition might apply to various activities that are associated with selling insurance but not to the various activities that are instead commonly associated with accounting, selling real estate or providing legal advice. In the event that you work in multiple professions, you might need a separate errors and omissions policy for each one. At the very least, you might need to contact an agent and have your existing insurance adjusted to address your multiple jobs.

Today's insurance producers attempt to offer many different services in order to attract and keep good clients. Therefore, it is important for an insurance professional to analyze an E & O policy's definition of professional services very carefully. Ideally, the right E & O product will include a clear definition that addresses all of a producer's activities and all of the roles that the producer could potentially play in his or her dealings with the public. For example, a carrier's definition of professional services might include those activities that are performed by an insured while serving in the following capacities but not in any others:

- Insurance agent.
- Insurance broker.
- Insurance consultant.
- Insurance teacher.
- Insurance claims adjuster.
- Risk manager.
- Notary public.

Coverage Limits

Even a well-worded errors and omissions policy won't help the insured if the policy's dollar limits are too low. Those dollar limits might be imposed on a per-occurrence basis (with coverage for a single error or omission capped at a particular amount) or an aggregate basis (with coverage for multiple errors and omissions in the same coverage period capped at a different amount).

For a simple example, let's assume an insurance agent has E & O coverage with a $50,000 per occurrence limit and a $100,000 aggregate limit. Now pretend the agent has already settled two lawsuits against him for $50,000 each. However, the agent is in the process of settling a third suit for $25,000. In this case, even though the third settlement amount ($25,000) is less than the policy's per-occurrence limit ($50,000), the agent won't have coverage for the third settlement because his insurer has already paid a combined $100,000 as a result of the two earlier settlements. In other words, the policy's aggregate limit has already been reached, so the agent will need to pay out of pocket for the third settlement.

There are seemingly few rules regarding how to calculate appropriate coverage limits for your errors and omissions insurance. Some agencies and producers choose their limits largely on the basis of their business's estimated worth. Others consider the highest face amount of all the policies they have sold and choose limits that are comparable to that number. However, experts sometimes question the logic behind those strategies and suggest that policy limits be determined with assistance from an experienced E & O insurance specialist.

Due to risk management concerns from carriers, it is sometimes impossible to obtain all of the errors and omissions coverage you want from just one company. If a careful analysis makes you believe that you should have an especially high coverage limit, your most practical option might be to obtain insurance up to a certain amount from one carrier (for use as your primary insurance) and apply for coverage up to an additional amount from a second carrier (for use as "excess" coverage if your primary insurance's limits are reached). Excess coverage tends to be easier (and cheaper) to obtain than primary coverage because it won't be utilized as often and, therefore, puts the excess insurer in a reduced state of risk. Primary insurance, on the other hand, will be utilized for practically every E & O claim involving the insured until the policy's limits are exhausted.

Defense Costs

Errors and omissions insurance isn't just for cases in which a professional is officially deemed to be at fault for a loss. It can also be extremely helpful when an ethical, competent and law-abiding producer becomes ensnared in a frivolous suit with an

overly combative customer. In fact, regardless of whether a producer wins a lawsuit, loses a lawsuit or agrees to an out-of-court settlement, errors and omissions insurance will usually help pay for the producer's defense and related legal fees.

Most forms of errors and omissions insurance include a duty to defend the insured. Note that this duty to defend is different (and significantly more beneficial to the insured) than a mere "right" to defend. Unless a scenario is obviously unrelated to professional services or the performance of professional acts, the duty to defend makes the insurer obligated to provide competent legal counsel. In exchange, the insured is obligated to cooperate with the insurance company in regard to his or her defense, which might include providing evidence to attorneys, appearing at legal proceedings and answering attorneys' questions.

The issue of defense costs should be a factor in evaluating and choosing an errors and omissions product's coverage limits. Though E & O insurance is purchased mainly to deflect the cost of judgments and settlements against the insured, significant legal fees might be incurred while a case or complaint is still being disputed. Whereas many other types of liability insurance will cover such interim expenses without impacting a policy's dollar limits, these costs might reduce the amounts available for judgments and settlements under an E & O insurance contract. If a carrier is willing to cover these costs in ways that won't reduce the amounts available for judgments and settlements, it will typically do so in exchange for a higher premium from the insured.

Deductibles

A deductible is the amount, in dollars, that an insured must pay after a loss in order for the insurer to start paying benefits. If an insurance product has no deductible, the insured has what is known as "first-dollar coverage."

Deductibles help reduce the cost of insurance for some consumers and make it less likely that an insurance company will need to process and pay so many small claims. In the errors and omissions market, they also are used as an incentive for the insured to do his or her work as carefully as possible. Since E & O deductibles are typically higher than deductibles for other common types of insurance (often amounting to thousands of dollars), even an otherwise well-insured producer is likely to suffer financial consequences if poor service leads to a claim.

Your errors and omissions insurance might have a single deductible for the policy period or might have a per-claim deducible that essentially must be paid in connection with every single loss. Similarly, the deductible might only apply to settlements and judgments against the insured or might also need to be paid before the carrier will cover any defense costs.

Regardless of the specifics, the more the insured is willing to absorb in the form of a deductible, the lower the cost of insurance is likely to be.

Exclusions

Reviewing the exclusions in your errors and omissions policy can help clarify your expectations in case of an eventual claim and can also alert you to instances in which you might need to take additional action in order to eliminate coverage gaps.

Several common exclusions that might apply to E & O insurance for producers are listed below:

- Libel or slander.
- Theft.
- Embezzlement, commingling or misappropriation of funds (including any premiums collected from consumers).
- Property damage and bodily injury. (Insurers generally prefer that liability for property damage or bodily injury be addressed via different types of coverage, such as commercial general liability insurance.)
- Fraud or dishonesty.
- Cyber liability (such as the loss or disclosure of personal data).
- Placing coverage with a carrier that ultimately becomes insolvent. (Many insurers will cover producers in this scenario if the insolvent insurer's financial rating was strong when the producer placed the coverage.)
- Intentional acts.
- Employment liability.
- Violations of antidiscrimination laws.
- Regulatory fines and punitive damages. (Depending on the state, insurance companies might be prohibited by law from covering these fines or damages.)
- Violations of securities laws.
- ERISA violations (if the producer is helping to administer employee benefit programs for businesses).
- Claims by the insured against another insured (assuming the policy covers more than one person).
- Any allegations that don't relate to professional services or professional acts (as defined elsewhere in the policy).

Policy Periods

Errors and omissions insurance contracts are usually in effect for one year and are then eligible to be renewed on an annual basis.

As you will see in the next few sections, the effective dates and policy periods of your E & O insurance are very important. Depending on the specifics of the policy language, both a claim and the alleged error or omission that led to it might need to have occurred during the policy period.

Claims-Made Policies vs. Occurrence Policies

Until the 1970s or so, E & O and other types of professional liability insurance were commonly issued as "occurrence policies." Under an occurrence policy, the insured is covered for liability as long as the alleged error or omission occurred while the policy was in force. As an example, consider a professional who was insured under an occurrence policy and provided bad advice to a client a year ago. Since then, the professional has allowed his or her insurance to lapse. If the client who received the bad advice suddenly decides to sue the professional tomorrow, the lapsed occurrence policy could still be relied upon to help pay for any judgments or settlements stemming from the advice.

Casualty insurers eventually determined that occurrence policies exposed them to too much liability and have stopped making these types of insurance products widely available. Instead of offering occurrence policies to interested applicants, insurance companies typically provide what are called "claims-made policies."

Under a claims-made policy, the insured is covered for liability if the claim that resulted from an error or omission occurred while the policy was in place. (In general, within the context of E & O insurance, a "claim" is a written demand for money as compensation for the insured's allegedly negligent actions.) In most cases, the alleged error and omission must occur during that timeframe as well.

Consider our previous example of a professional who gave bad advice a year ago, gets sued tomorrow and allowed his or her E & O coverage to lapse in the meantime. If the lapsed coverage involved a claims-made policy and not an occurrence policy, the insurer would generally be under no obligation to help the professional pay for defense costs, judgments or settlements stemming from the allegedly bad advice.

Admittedly, the mechanics of a claims-made policy are a bit more complex than our presented examples might suggest. Additional important information about claims-made policies can be found in the next few sections.

Retroactive Dates and Prior Acts

A claims-made policy's "retroactive date" is the earliest date on which an error or omission can occur in order for the insurer to cover any resulting claim. In most instances, this date will be identical to the date on which the policy was first issued to the insured. If the policy is renewed on time, the retroactive date will remain unchanged and will continue to be identical to the date on which the policy was first issued to the insured.

If someone allows his or her errors and omissions insurance to lapse (or cancels the coverage in the middle of a policy period) and then decides to purchase a policy again at a later date, the retroactive date will be moved up and will usually be identical to the date on which the new policy (not the old one) is issued. A potential exception to this rule about having a new retroactive date after a lapse or cancellation might exist if the professional is merely having one carrier's policy replaced with another carrier's policy and is not going a single day without being covered by one policy or the other.

On rare occasions, a claims-made policy might have a retroactive date that is earlier than the policy's original issue date. For instance, pretend you have just purchased an insurance agency from a retiring producer. You have done a reasonable amount of due diligence and aren't aware of any errors or omissions by the retiring producer that could create trouble for you. However, you'd like an extra layer of protection just in case one of the retiring producer's mistakes has evaded detection. In this case, it might be possible to pay a higher premium for an earlier retroactive date that would protect you from the retiring producer's earlier activities.

Note, however, that E & O insurers typically won't pay any claims for errors or omissions that the policyholder was already aware of (or should have been aware of) on or before the policy's issue date. In other words, a currently uninsured producer should be able to obtain coverage for future errors and omissions but not for past ones.

Tail Coverage and Extended Reporting Periods

Professionals who are retiring or who have another legitimate reason to cancel or not renew their E & O insurance might still want a limited amount of coverage in case an earlier error or omission comes back to haunt them. In these cases, it might be appropriate for the professional to purchase what is sometimes referred to as either "tail coverage" or an "extended reporting period."

Some errors and omissions products include a very small amount of tail coverage free of charge. For instance, if the insured voluntarily cancels or decides not to renew an E & O policy, the insurer might still respond to claims that are reported within 30 to 60 days after the policy's expiration or cancellation date.

Then, for an additional charge, the insurer might agree to respond to claims that are reported over a much lengthier period, such one year or even 10 years after the policy's expiration date. The insured will usually need to purchase this extra coverage within a limited time after the cancellation or non-renewal. The cost will depend on the length of the extended reporting period and will often be based on a percentage of the insured's most recent annual premium.

Regardless of the length of an extended reporting period, be aware that tail coverage is only applicable when a future claim relates to an error or omission that happened before the policy was canceled or non-renewed. Therefore, if a retired professional decides to return to business and wants liability protection from future errors or omissions, a new policy must be purchased. The professional's tail coverage won't be enough.

Reporting a Claim

Within the context of errors and omissions insurance, a "claim" is generally defined as a written demand for money in response to an insured's alleged incompetence. A claim might come from a producer's client or customer or even from an insurance company that the producer has worked with. Unless an extended reporting period applies, errors and omissions insurance will only cover claims that are reported to the insurer during the policy period.

Policy language will specify the deadline for reporting claims to the insurer. For example, a policy might say a claim must be reported within 30 days after the insured becomes aware of it. Ideally, claims should be reported as soon as possible so that the insurance company's legal team can evaluate the situation and begin collecting any relevant evidence. The sooner the defense team can speak with witnesses (especially the insured), the clearer those witnesses' recollections are likely to be.

If an insured is planning on cancelling or not renewing his or her errors and omissions policy and is aware of a situation that has the potential to produce a later claim, it is generally unwise to ignore the situation until a written demand for money actually materializes. Instead, the insured should inform the insurance company as soon as possible and provide all known specifics (including what happened and to whom) to the carrier. Depending on the policy, this preemptive notice to the insurer might be treated as a claim and can make the insured eligible for insurance protection even if a written demand for money isn't made until after the policy period. In other words, such preemptive notice might, in and of itself, trigger a form of tail coverage.

E & O Settlements

When someone accuses us of wrongdoing, we naturally tend to become very emotional. We might feel anger toward our accuser and want to prove the person wrong at practically any cost, or we might even believe that there's truth to the accusation and want to fix the problem on our own. But with so much money at stake, the carrier behind our E & O insurance will want us to put our personal feelings aside and to keep our situation within the proper perspective.

If the insured is accused of wrongdoing and receives a demand for money, the insured's response should be communicated with great care. If the insured admits fault, proposes a settlement or agrees to mediation, the E & O carrier might refuse to cover any claims resulting from the situation.

After the E & O carrier becomes aware of a claim, it will attempt to determine the strength of the insured's case and whether it

makes sense to settle the matter. Be aware that the carrier's job is to help limit liability-related costs for itself and its policyholders. So even if the insured has a good chance of prevailing in a court of law, the E & O carrier might determine that a quick settlement is the least expensive and best option.

Hammer Clauses

An E & O policy's "hammer clause" is meant to address situations in which the insured disagrees with an insurer's recommendation to settle a claim. In general, the insured won't be forced to settle a claim against his or her wishes but will be held responsible for any eventual settlement or judgment beyond the carrier's originally proposed settlement amount.

For example, suppose an insurance company believes the insured should settle a dispute for $75,000. If the insured refuses to settle, loses his or her case and is ultimately ordered to pay $100,000 to the plaintiff, the insurance company would contribute no more than $75,000. The insured would need to pay for the rest out of his or her own pocket.

Conclusion

Considering all the liability risks that exist for agents and brokers, a nervous observer may wonder why anyone would dare to pursue an insurance career in the first place. But a combination of care, competence and the right errors and omissions coverage can ease fears regarding professional risks. By being mindful of the kind of insurance you are buying for yourself, you can ultimately spend less time stressing about your own level of risk and devote more attention to helping consumers.

CHAPTER 3: REGULATING THE INSURANCE INDUSTRY

Introduction

"Regulation" has become a loaded word, especially among financial professionals. Get just a few insurance executives, producers and policyholders in a room, and you could probably get them to argue for hours about government involvement in the industry. Are insurers regulated too much? Too little? And assuming they can all agree that at least some regulation is necessary, should the power to regulate insurance belong to the federal government, each state or a combination of national and local authorities?

Despite our personal opinions regarding the specifics or degree of regulation in our business, we should never forget that the core goal of laws, rules and other restrictions is to protect the public. In insurance, the public includes not only the people who purchase insurance but also the people who sell it. The public might need protection from the following dangers:

- Deceptive sales practices that take advantage of uninformed consumers.
- Unethical marketing techniques that unfairly restrict competition among producers and carriers.
- Unreasonably high prices that prevent insurance from being purchased by buyers who really need it.
- Unreasonably low prices that jeopardize an insurer's claims-paying ability and the economy at large.

To better understand the current state of insurance regulation, consider these statistics from the National Association of Insurance Commissioners:

- Insurance companies collected nearly $3 trillion in premiums in 2021.
- Roughly 11,000 people worked for insurance regulatory bodies in 2021.
- There were approximately 6,000 U.S. insurers in 2021.
- There were more than 2 million insurance producers in 2021 (with roughly 3,000 of them having their license revoked or suspended that year).
- State insurance departments received more than 250,000 formal complaints from consumers in 2021.
- States collected approximately $20 million as a result of fines against producers in 2021. Those fines were imposed cumulatively on roughly 19,000 individual producers.

With so many jobs and so much money tied to our field, the debate regarding the best way to regulate insurance should be on all of our minds. This course material will help you engage in that important debate by explaining where we are today in terms of regulation, how we got there and where we might be headed.

Federal vs. State Regulation

From as far back as the 19th century, the question of whether insurance should be regulated at the national level or the state level (or perhaps both) has prompted strong responses from a variety of interested parties.

People who support federal regulation of insurance (as opposed to state regulation) typically make the following arguments:

- Federal regulation would allow for a uniform set of rules for insurers and producers, which might simplify compliance for licensees who conduct business in multiple states.
- Federal regulation would provide a baseline of protection for consumers, regardless of where they live, and wouldn't create an incentive for insurers to operate only in states where regulation is relatively modest.

Supporters of state regulation (as opposed to federal regulation) tend to emphasize at least the following points:

- State regulation helps lawmakers and businesses focus on the needs of local communities, which might have different insurance-related concerns than the rest of the country.
- State regulation allows lawmakers and regulators to make experimental changes to the insurance market without impacting markets in other states. Presumably, experiments that work well in one state will be copied by other states, and experiments that fail can be discontinued and ignored by the rest of the country.

Traditionally, the insurance community and local regulators have favored state regulation instead of federal regulation. In fact, it is not uncommon for state regulators and trade groups to reform their rules and requirements in order to preserve the state-based system. Following federal investigations of alleged misconduct in insurance, a collection of state insurance directors (known as the National Association of Insurance Commissioners) often creates model laws or rules that each state is encouraged to adopt. Meanwhile, producer groups will often revise their codes of ethics and insist that members comply with consumer protections that go beyond the requirements of state laws. These steps commonly quiet the debate over federal regulation, but the break in the argument rarely lasts long.

The traditional preference for state regulation has undergone at least a modest shift in recent years. Particularly in regard to licensing, carriers and producers who do business in multiple states have expressed support for a streamlined and more

uniform set of requirements from either the federal government or a non-governmental national organization. You'll read more about national licensing later in this chapter.

Before exploring some of the modern issues related to insurance regulation, let's step back into the past and review some of the regulatory history behind our business.

Early Insurance Regulation

According to the Federal Insurance Office, U.S. insurers have been regulated by state laws from as far back as the late 1700s. New Hampshire, in particular, noted the expansion of the insurance industry within its borders and, in 1851, appointed the first insurance commissioner in the country. Within another 20 years, all states had their own insurance department with their own insurance commissioner at the helm. Arguably the most famous of these commissioners was Massachusetts' Elizur Wright, who instituted solvency requirements for life insurance companies and developed actuarial tables that influenced the life insurance underwriting practices of today.

Paul v. Virginia

One of the first major U.S. court cases involving insurance is a good example of how much views on regulation have evolved. The 1869 case Paul v. Virginia centered on the ability of an insurance company to sell its products in multiple states. Virginia law, at the time, required all insurance companies selling insurance to Virginia residents to be licensed with the state and for all agents of out-of-state insurers to have a Virginia license. A Virginia man (Paul) was appointed to transact business in the state on behalf of a New York insurance company, which hadn't satisfied the state's financial requirements for licensure. Despite living in Virginia and meeting the licensing requirements for individuals, Paul was denied a license on the basis of the New York insurer's lack of compliance. Paul sold insurance in Virginia for the company anyway and was fined $50 by the state.

Contrary to insurers' general belief today, Paul and his supporters argued that the individual states couldn't fine him because his selling of insurance was a form of interstate commerce and, therefore, an activity that should only be regulated by the federal government. Regardless of the specific facts of the Paul case, many of the era's insurers supported federal regulation of insurance because they believed it would exempt them from having to pay various state-level taxes.

The case went all the way up to the U.S. Supreme Court, where a majority of the justices disagreed with Paul's argument. To them, the selling of insurance was essentially a contractual transaction rather than commerce and was, therefore, subject to state laws. Virginia's fine was ruled constitutional, and the case set a precedent for the next several decades. However, although the court determined that state regulation was permissible under some circumstances, it did not specify which aspects of insurance could and could not be regulated at the national level.

The Armstrong Commission

By the early 20th century, problems at U.S. life insurance companies had earned national attention. Several carriers had gone out of business since the Paul case, and those that remained were accused of financial irresponsibility by the popular press. The rivaling newspaper empires of Joseph Pulitzer and William Randolph Hearst targeted companies that had failed to increase policyholder dividends in spite of increased profits. Readers of those publications were made to believe that much of a life insurance company's earnings were going to playboy executives and crooked politicians instead of to "widows and orphans."

Those concerns and others led President Theodore Roosevelt to endorse greater federal regulation of insurance as part of his 1904 State of the Union speech. According to the Federal Insurance Office, Roosevelt's ideas were incorporated into a failed Congressional bill that would have created a federal Bureau of Insurance, including a presidentially appointed Comptroller of Insurance.

The pushes for more regulation culminated in the three-month investigation conducted by New York's Armstrong Commission. Following 57 high-profile hearings on life insurance practices, the state implemented several new restrictions on life insurance companies. Under the new laws and rules, insurers were prohibited from engaging in certain kinds of high-risk business, making certain political contributions and selling certain products (including those that provided unfair dividends to policyholders and beneficiaries). Within a few years, the rebating of premiums and the twisting of life insurance policies were prohibited, too. The state also began mandating regular audits of insurers' finances.

The Armstrong Commission's efforts brought changes beyond the New York market. Since companies that were licensed to sell insurance in New York were also required to abide by the state's standards when doing business in other parts of the country, many of the state's reforms become the norm in the industry. Meanwhile, the commission's main prosecutor against the insurance companies, Charles Evans Hughes, became a revered public figure, eventually obtaining the position of Chief Justice of the Supreme Court and launching a failed presidential bid as the Republican Party's candidate against Woodrow Wilson in 1916.

United States v. South-Eastern Underwriters Association

The issue of state vs. federal regulation, originally addressed in the Paul case, was revisited in the Supreme Court's 1944 ruling in United States v. South-Eastern Underwriters Association.

In the years leading up to the case, some states had allowed insurance companies to share loss-related data and set property insurance rates together. This collaborative work generally helped strengthen smaller and newer carriers that lacked enough of a history to predict their future liabilities, but it wasn't permitted in all parts of the country and, even where permissible, sometimes had legal limits.

By 1944, a rating bureau known as the "South-Eastern Underwriters Association" had roughly 200 member insurers, which, in total, comprised approximately 90 percent of the property insurance market within a six-state territory. Carriers that didn't join the bureau and set their prices in accordance with its standards were allegedly prohibited from receiving industry-wide loss data and were subjected to boycotts by reinsurance companies. (Reinsurance, in essence, is insurance for insurance companies.) When bribes were allegedly made by the bureau to state regulators in order to maintain existing rates, the U.S. government stepped in and accused the association of violating federal antitrust laws.

South-Eastern didn't strongly deny the accusations regarding monopolies, price fixing and boycotts. Instead, it leaned on the aforementioned Paul v. Virginia ruling and claimed that, regardless of the conduct in question, insurance transactions across state lines weren't commerce and, therefore, weren't required to follow federal interstate commerce laws (including antitrust laws).

The Supreme Court's ruling in United States v. South-Eastern Underwriters Association effectively reversed the earlier precedent set by Paul v. Virginia by concluding that insurance sales across state lines weren't merely contractual arrangements. Instead, they were a form of interstate commerce and, as a result, had to comply with federal antitrust laws.

Despite a dissenting opinion by Justice Harlan Stone, the Court also clarified its stance on the separate regulatory powers of states and the federal government. In general, the mere fact that something was deemed interstate commerce didn't automatically make it an entirely federal issue, and the mere fact that something wasn't deemed interstate commerce didn't automatically make it a state issue. Furthermore, subjecting insurers to federal antitrust laws didn't impose on the states' regulatory authority since none of the states explicitly permitted monopolies, price-fixing and other activities prohibited by federal laws. Instead of federal regulation being a contradictory substitute for state regulation and vice versa, the two regulatory systems were intended, in the court's view, to complement each other.

The McCarran-Ferguson Act

In response to the insurance community's negative reaction to the South-Eastern ruling, Congress quickly passed the McCarran-Ferguson Act. Through this 1945 law, the federal government emphasized the public benefit of having insurance regulated primarily by each state rather than by national authorities.

The McCarran-Ferguson Act specifically exempted insurance companies from federal antitrust laws. However, in order for this federal exemption to apply, states must proactively regulate the activities addressed in the federal Sherman Act, Clayton Act and Federal Trade Commission Act. In general, this means each state must enact its own measures that prohibit boycotts, coercion or intimidation in the insurance market. If a state fails to create these barriers to fair markets, the federal antitrust laws mentioned earlier in this paragraph can be applied to insurance companies. By setting such standards on their own, the individual states have limited the federal government's ability to stop insurers from sharing loss-related data and using industry-wide standard policy forms, such as those property and casualty forms written by the third-party, non-governmental entity known as the "Insurance Services Office" (ISO).

Besides providing antitrust exemptions, McCarran-Ferguson clarified the extent to which other federal laws would be applied to the business of insurance. Specifically, according to the act, "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance (…) unless such act specifically relates to the business of insurance."

The McCarran-Ferguson Act pushed most aspects of insurance regulation away from the federal government and toward the individual states. However, consumer discontent with the industry tends to rekindle conversations about whether the law should remain in place. After Hurricane Katrina, for example, some prominent federal legislators openly questioned whether the antitrust exemption was being abused and resulting in widespread price fixing and unfair claims practices.

One criticism of McCarran-Ferguson has been its alleged inability to create strong competition in all states. Insurers generally claim that their federal antitrust exemption facilitates the sharing of important loss-related data, which is supposed to help new or smaller carriers make responsible underwriting decisions. Yet detractors point out that some insurance markets are dominated by only a small handful of carriers and aren't inviting to small insurers in the first place.

The occasional movement to amend McCarran-Ferguson is typically also accompanied by some admittedly confusing arguments about the effectiveness of repeal. Some proponents of ending the law focus on the antitrust exemption and believe that repeal would prevent misdeeds such as price fixing. But as supporters of the law point out, the federal antitrust exemption only applies if the states already prohibit this kind of conduct. Since states have already made it illegal for insurers to engage in price fixing, coercion, intimidation and other kinds of market misconduct, the real question to ask isn't "Should insurers need to comply with antitrust laws?" Instead, observers who are considering the effectiveness of McCarran-Ferguson must ask themselves, "Are the states enforcing their own antitrust laws effectively without extra enforcement from the federal government?"

This course material won't take a stand on either side regarding the usefulness of McCarran-Ferguson. But since this law has been so instrumental in shaping today's regulatory environment, it is important for you to understand the core pieces of the debate.

The Gramm-Leach-Bliley Act

For centuries, legislation in the United States kept banks out of what were believed to be risky businesses so that depositors' funds were not put in danger. In effect, this meant there were relatively few chances for banks to become involved in the underwriting of insurance or securities.

All the way back in 1864, for example, banks were given the power to carry out tasks directly necessary and incidental to their business. At the time, however, selling insurance was not considered an incidental activity and was therefore prohibited within banking circles. Later, in an attempt to boost faith in banks after the stock market crash of 1929, Congress passed the Glass-Steagall Act, which prevented commercial banks (generally those that take deposits and make loans) from affiliating with any entity that was principally engaged in the sale of securities.

Yet at other important moments, the walls separating the various sections of the financial world crumbled bit by bit. By 1916, state banks in some parts of the country were being allowed to sell insurance. Meanwhile, the Office of the Comptroller of the Currency (OCC) had determined that too many national banks were failing in small towns and decided that federal depository institutions needed to become more competitive. With these economic conditions in mind, the federal government ruled that a national bank could enter into the insurance business if it was located in a town with 5,000 residents or less.

Restrictions have lessened at a swifter pace over the past 30 years. In 1986, the OCC started letting national banks sell insurance products in larger towns and cities if the transaction was conducted through a subsidiary in a town of under 5,000 people. A decade later, the U.S. Supreme Court's ruling in NationsBank of North Carolina v. Variable Annuity Life Insurance Co. upheld the right of commercial banks to sell annuities. All the while, local laws were sometimes allowing state banks into the insurance game, and loopholes in federal laws were often big enough for the occasional bank-sponsored insurance product to slip its way through the market. The insurance industry

challenged many of these developments in court, but the challenges were ultimately ineffective.

During the 1980s and early 1990s, Congress debated the deregulation of financial industries on a number of occasions. These legislative attempts at regulating the entry of banks into the investment and insurance businesses generally did not amount to any real change, but two significant events near the end of the 20th century helped force the government's hand.

The first of the two events was the Supreme Court's ruling in Barnett v. Nelson, a Florida case centering on conflicts between federal insurance laws and state insurance laws. In 1974, Florida had enacted a statute that made it illegal for agents to sell insurance in any part of the state if they were affiliated with a "bank holding company," which can be defined as an entity with a controlling interest in one or more banks. Some 20 years later, plaintiffs argued the state statute was unlawfully ignoring the provisions of the 1916 federal statute regarding permissible insurance activities in small towns.

The state responded with a two-part argument that touched on the federal statute as well the McCarran-Ferguson Act, which generally says that a state insurance statute can be pre-empted by a federal law only if the federal law relates specifically to insurance.

In Florida's eyes, the 1916 statute related specifically to banks but not to insurance. The Supreme Court interpreted the matter differently, reasoning that the federal statute related specifically to insurance and that the intent of the 1916 Congress had been for the statute to reign over conflicting state laws. In short, the McCarran-Ferguson Act, which had kept federal regulators out of insurers' hair for years, proved to be more penetrable than expected.

The second significant event occurred on April 6, 1998, when the world was alerted to a merger between Citicorp (a bank holding company) and Travelers Group (a multifaceted entity that, among other things, was engaged in the underwriting of insurance). Although this merger that gave us Citigroup was technically in violation of the Glass-Steagall Act, provisions in the Bank Holding Act of 1956 gave the newly formed financial organization at least two years to divest itself of its insurance business and avoid criminal charges.

Rather than pushing Citigroup to make a few extra deals and comply with federal law, the two-year grace period was treated as a chance to rally lawmakers behind the idea of making major changes to federal financial regulations. On November 12, 1999, President Bill Clinton signed the Financial Services Modernization Act of 1999 into law, effectively repealing the restrictions within Glass-Steagall and allowing entities like Citigroup to exist concurrently as a bank, insurance company and securities broker. In time, Citigroup spun off its insurance wing into another company, but it was able to do so on its own terms.

Purposes and Expectations Regarding the GLBA

For all the attention it received in the business press and elsewhere, the Financial Services Modernization Act of 1999 (more commonly known as the Gramm-Leach-Bliley Act, in honor of its Congressional sponsors) wasn't exactly shocking or revolutionary in scope. As stated earlier, financial institutions that really wanted to dip their toes simultaneously into commercial banking, investment banking and insurance could often find a way to do it by relying carefully on technicalities in federal and state laws. So it wasn't as if, at long last, a law had finally come along and made the impossible possible.

But what Gramm-Leach-Bliley did do was give banks, insurers and investment firms a clearer path toward unification. If a bank had always wanted to purchase or partner up with an insurer but had not done so for fear of being in noncompliance with U.S. regulations, that bank could finally turn to the GLBA, follow its specifics and feel reasonably confident that it was obeying federal law.

The GLBA and Privacy

By allowing banks, insurers and securities firms to become more tightly intertwined, the GLBA also made it more likely that people's personal information would be shared among businesses. To protect against the possibility that these businesses would infringe upon individual privacy rights, the GLBA includes provisions to protect consumers' personal financial information.

There are three principal parts to the GLBA's privacy requirements:

- The Financial Privacy Rule.
- The Safeguards Rule.
- The pretexting provisions.

The Financial Privacy Rule governs the collection and disclosure of customers' personal financial information by financial institutions. It also applies to companies that are not financial institutions but still receive such information.

The Safeguards Rule requires all financial institutions to design, implement and maintain safeguards to protect customer information.

The pretexting provisions of the GLBA protect consumers from individuals and companies that obtain personal financial information under false pretenses, a practice known as "pretexting." An example of pretexting would be a phone survey that claims to be gathering information to help insurance companies create new products but, in truth, will be using the acquired information to either sell insurance to the consumer or steal the person's identity.

In response to the GLBA's privacy-related provisions, the individual states updated their rules for insurance companies' handling of consumer information. Although we won't go any further into the specific requirements of the GLBA, you should be aware of the privacy and safeguard requirements in your state. These state-level requirements can be (and often are) more extensive than the Privacy Rule, Safeguards Rule and pre-texting provisions mentioned earlier in this section.

Insurance Regulators and Other Rule-Setting Entities

Now that you have an understanding of insurance's past, let's go into detail about our current regulatory system. In the next several sections, you'll read about where requirements for insurance come from and the various organizations that set the minimum standards for your business.

Laws, Rules and Rulings

In order to comply with the insurance requirements in your state, you have at least three sources that must be considered:

- Laws.
- Rules.
- Rulings.

Laws

Insurance laws are passed by legislators, such as state senators and members of the state's house of representatives. Although it is likely that at least a few legislators in your state have an insurance background, experience in the industry is not a pre-requisite for voting on these laws. Since they usually lack this practical experience, legislators may intentionally (or unintentionally) write laws by using broad or non-specific language that might be open to different interpretation. For example, a law might require that insurance producers complete 24 hours of continuing education, but it might not state exactly what qualifies as an "hour" (60 minutes of live instruction? 50 minutes with a break? 10 pages of reading?).

For the purpose of organization, the contents of most insurance laws will appear within a state's "insurance code." However, important laws that impact insurance professionals are also likely to appear elsewhere within a state's long list of statutes.

Rules

Many laws include language that requires the executive branch to establish rules about how a given law should be enforced. This is particularly common when a law is very complex or relates to a specialized field (such as insurance).

Unlike the laws that they help to implement, rules from a state's executive branch are supposed to be formulated and approved by people who have some expertise in the subject matter. Expertise is important at this stage because the rules are intended to clarify the non-specific language or other generalities found in the law. Without clear and careful rules, individuals won't necessarily know how to comply with the requirements, and law enforcement officials might have a hard time prosecuting people for alleged violations.

The rules for implementing insurance laws are usually drafted and approved by the state's department of insurance. States without an insurance department might give rulemaking authority to a department of financial institutions or some similar government agency.

Rulings

Individuals or business entities that believe they have been unfairly harmed by a law or rule may have the opportunity to pursue legal action through the court system. Lawsuits against legislators and regulators typically ask a court to answer at least one of the following questions:

- Did legislators have the constitutional right to pass the law in the first place?
- Do the rules written by the executive branch appropriately reflect the intent of the law?
- Did the executive branch follow its set of rules when penalizing the individual or business entity?

As an alternative to filing a lawsuit, parties who are disciplined as a result of alleged rule violations might have the right to a disciplinary hearing, in which the particulars of the situation can be presented to various members of the insurance department.

Insurance Departments and Insurance Commissioners

State insurance departments are generally intended to protect the public by monitoring market conduct and enforcing the state's various insurance requirements. More specifically, the insurance department is likely to concern itself with the following issues:

- Solvency of local insurance companies.
- Licensing of insurance producers and insurance companies.
- Consumer education regarding insurance topics.
- Fair sales and claims practices in the local insurance market.

The insurance department in most states is headed by an "insurance commissioner." In some parts of the country, this person might instead have the title of "director" or "superintendent." The commissioner is responsible for managing the insurance department, setting its priorities and enforcing the state's insurance rules and laws. He or she might also have the power to hold hearings and either approve or reject insurance rates and insurance products.

Depending on the state, the insurance commissioner will either be appointed by the state's governor or voted into office by the general public for a fixed number of years. Industry observers who prefer the concept of appointment tend to believe that an appointed commissioner will be more inclined to focus on the overall long-term health of the insurance market and less likely to make decisions based on short-term political motives. On the other hand, an elected commissioner might be very sensitive to consumer complaints and would risk being removed from office if his or her agenda isn't perceivably beneficial to a majority of local citizens. Commissioners who are elected to office often have a legislative background, whereas appointed commissioners usually already have some experience as an insurance regulator.

The National Association of Insurance Commissioners

The state insurance commissioners, as well as their counterparts in Washington D.C. and the various U.S. territories, are members of a non-governmental non-profit organization called the "National Association of Insurance Commissioners" (NAIC). The NAIC does not have the power to regulate any aspect of insurance. But because it is comprised of individuals who each have that power, its activities can have a widespread impact on insurance laws and rules in each state.

The original and continued purpose of the NAIC is to promote uniformity in insurance regulation without sacrificing the states' regulatory authority to the federal government. In fact, according to a U.S. Treasury report, a participant at the group's first meeting in 1871 claimed that attendees were "fully prepared to go before their various legislative committees with recommendations for a system of insurance law which shall be the same in all states—not reciprocal, but identical; not retaliatory, but uniform."

In order to achieve its goal of greater uniformity, the NAIC periodically drafts and updates model laws and model rules. The models are written and amended by one of the group's many committees and then presented to the entire membership. If a model is supported by at least two-thirds of the commissioners, it is officially approved and released to the states.

The NAIC models provide a guide to legislators and commissioners who would like to address a particular insurance issue in their state. However, each state legislature (and each state insurance commissioner) retains its own authority and is not required to change its laws or rules in response to the NAIC's recommendations. Depending on the issue at hand, a state might choose to adopt an NAIC model law or model rule in its entirety, only to a certain extent or not at all. Most states, for example, have adopted the portion of the NAIC's model licensing law that calls for 24 hours of continuing education every two years for producers. But some states continue to require fewer or more hours, and even those that have adopted the NAIC's number of

hours have almost always established their own licensing requirements that aren't found in NAIC model documents.

The NAIC holds considerable power in national legislative circles. When Congress or other federal officials threaten to take away some regulatory authority from the states, it is very common for the NAIC to revise its models and push its members to adopt them. In the past, this approach either stalled or defeated efforts to establish a federal producer licensing system, significant oversight of insurance by the Federal Trade Commission and other threats to state powers.

National Council of Insurance Legislators

The National Council of Insurance Legislators (NCOIL) receives less recognition than the NAIC but serves a similar purpose. Like the NAIC, the NCOIL creates model laws with the intent of having them adopted by the individual states. The main difference between the two organizations relates to their membership. Whereas the NAIC is a group for state insurance commissioners, the NCOIL is a group for state senators and state house members.

The Securities and Exchange Commission

The Securities and Exchange Commission (SEC) is a federal agency that regulates many kinds of variable products. In general, a variable product is a financial product that does not guarantee a return of the amount investors put into it. Common types of variable insurance products include variable life insurance and variable annuities.

On occasion, the SEC has claimed that it should have regulatory authority over sales of indexed annuities as well. Indexed annuities generally guarantee a return of the owner's principal investment plus interest, but the amount of interest is based in large part on the performance of the financial markets. Even though most of these products have escaped SEC regulation and continue to be considered insurance products, many financial professionals who sell them have obtained securities licenses just to be safe. Common securities licenses include Series 6 (for mutual funds and variable products) and Series 7 (for stocks).

FINRA

An individual who sells variable products on behalf of an independent broker-dealer (essentially a brokerage firm) is generally known as a "registered rep." Independent broker-dealers and their representatives must comply with state securities and insurance rules as well as requirements mandated by the Financial Industry Regulatory Authority (FINRA).

Formerly known as the National Association of Securities Dealers (NASD), FINRA is a private, non-profit self-regulator for the securities industry. It is heavily involved in securities licensing and enforcement actions. It also enforces continuing education requirements for individuals who sell variable products.

According to its website, FINRA brought more than 800 disciplinary actions against individuals and brokerage firms and levied fines of more than $57 million in 2020. During the same year, FINRA referred more than 970 suspected instances of fraud and insider trading to the SEC and other law enforcement agencies.

Producers who sell any kind of variable product should be very careful to research their obligations under state law, SEC regulations and FINRA rules. The combinations of requirements for a particular financial professional might differ depending on the specific kinds of products being sold, the kind of entity employing the producer and whether the producer or employing firm claims it is offering financial advice or not.

The Federal Insurance Office

The massive Dodd-Frank Wall Street Reform and Consumer Protection Act did many things that have impacted various aspects of the financial industry. We will focus here on the law's creation of a new segment within the U.S. Department of the Treasury known as the "Federal Insurance Office" (FIO).

Contrary to popular belief, the Federal Insurance Office is not a regulator. Nor does it have anything to do with the implementation of the Affordable Care Act or the Medicare program. Perhaps most importantly, the FIO was not created in order to shift insurance regulatory power away from the individual states. Instead, the FIO is charged with the following tasks, among others:

- Representing the United States at international insurance forums.
- Administering the federal government's terrorism-risk insurance program.
- Monitoring access to insurance in underserved communities.
- Identifying insurance entities that might merit additional regulation.
- Making recommendations to Congress and other branches of the federal government in order to modernize insurance markets.

Recommendations from the FIO come from the Federal Advisory Committee on Insurance, an appointed group that is supposed to include consumer advocates, academics, insurance professionals and insurance regulators.

At the time this course material was being written, the federal government was in the process of reevaluating its stance regarding the Dodd-Frank law, including the need for the FIO.

The International Association of Insurance Supervisors

The International Association of Insurance Supervisors (IAIS) is a Switzerland-based organization of insurance representatives from over 140 countries. The IAIS tends to have little direct impact on the average producer because it doesn't concern itself with issues like licensing or market conduct. However, it does play a major role in establishing global financial standards that are important to the overall health of the world's insurance community.

Assorted Federal Offices and Departments

In the relatively rare instances in which a federal law relates directly to the business of insurance, regulation can be the responsibility of a U.S. Cabinet department or some subsidiary agency. The department or agency with regulatory authority will generally depend on the kind of insurance addressed in the law. Federal health insurance laws are usually enforced by the Department of Health and Human Services. The National Flood Insurance Program is administered by a segment of the Department of Homeland Security. And as was alluded to in our explanation of the FIO, the federal terrorism-risk insurance program is overseen by the U.S. Treasury.

Common Regulatory Issues and Responsibilities

Now that we know who our regulators are, let's turn our focus toward what these various departments and other entities actually do.

Above all else, the purpose of insurance regulation is to protect the public. The next several sections explain some of the most common tasks that are meant to fulfill this important purpose.

Solvency Regulation

When an insurer's assets are enough to honor its liabilities, the company is considered to be "solvent." Solvency is an immeasurably important issue because financially mismanaged carriers might not have enough assets to make good on their promises to pay legitimate claims. An insolvent insurer harms consumers, of course, who might not receive fair compensation for insured losses, but it also has a negative impact on the other insurers in the market. When one carrier fails, other companies might be required to contribute to a state fund in order to pay for the insolvent insurer's liabilities or, at least, might be required to absorb some of the insolvent insurer's customers.

Insurers aim to prove their solvency by submitting annual reports to state regulators. Additional audits might be conducted by the state insurance department every few years for each company or might be done on a more frequent basis if a particular carrier seems financially unhealthy.

In general, states want to know that an insurer has enough "admitted assets" in order to withstand mistakes in underwriting and potential economic downturns. Common admitted assets include the values of stocks, bonds, cash and real estate. But depending on the state and the type of insurance, a carrier might be prohibited from using too much of a particular type of asset in order to prove solvency. For example, most life insurance companies aren't allowed to own significant amounts of stock, although this limit tends to be less stringent for property and casualty companies. An insurer's personal property (such as office furniture and supplies) generally won't qualify as an "admitted asset."

Guaranty Funds

State guaranty funds are used to compensate claimants whose insurance is from an insolvent company. These funds might be financed through periodic fees paid by all insurers in the state, or they might require financial contributions from all carriers once an insolvency actually occurs.

Regardless of how they are structured, guaranty funds are not ideal for consumers or insurers. They often limit a harmed consumer's compensation to a certain amount (such as $100,000) and involve long waiting periods (usually including a liquidation process) before any benefits become available. They also risk penalizing responsible insurers by making them pay for the mistakes of irresponsible carriers. For these reasons and more, regulators and insurance professionals should take solvency requirements very seriously.

Approval of Forms

Before they can market an insurance policy to the public, insurers generally must have the policy's language (or "form") approved by the state insurance department. The approval of forms is meant to ensure that the products in the market contain the consumer protections required by law (or by rule).

Though not necessarily a roadblock to a form being approved, the policy's readability will sometimes be evaluated, too. Regulators have long believed that insurance policy language is too complex for the average purchaser and have encouraged carriers to revise their forms in ways that increase comprehension. The Insurance Services Office, in particular, has revised its many property and casualty forms over the past several decades in an attempt to make them more understandable. (Many property and casualty carriers utilize these ISO forms as a model for their own forms.)

Approval of Insurance Rates

Rate regulation has multiple goals and, therefore, can be a tricky balancing act. On one hand, regulating the amount insurers can charge for coverage can be a valuable tool that makes insurance more affordable for those who need it. But because of fears about insolvency and other kinds of market disruption, state regulators need to avoid making rates so low that an insurer's ability to cover its liabilities is jeopardized.

There are many types of insurance rate regulation in the United States. The type utilized will depend in large part on the state doing the regulating and the type of insurance in question. States have been active in the regulation of health insurance, property insurance and auto liability insurance but have often been more flexible when dealing with life insurance rates or the price of annuities.

Some of the most common rate-filing methods are summarized below:

- **Open rating:** Rates are generally assumed to be appropriate and will not be reversed by the insurance department unless there is an extreme case.
- **State-made or mandatory bureau rating:** Rates are established by the insurance department or a state-approved panel of experts but not by insurers.
- **File and use rating:** The insurance department receives an insurer's proposed rates but only has a limited amount of time to reject them. If the department does nothing, the rates remain in effect.
- **Prior approval rating:** Rates cannot be used by an insurer until they have been officially approved by the insurance department.
- **Flex rating:** Rates generally don't need to be pre-approved unless they are beyond a particular threshold (such as a rate increase of 15 percent or more).

Assorted Market Regulation

States typically prohibit a number of activities in order to keep the insurance market fair and transparent. When done properly, this helps consumers (who might otherwise be taken advantage of by slick sales gimmicks) and the good-hearted insurance professionals who would otherwise lose business to unethical competitors.

Commonly prohibited activities include (but are not limited to) the following actions:

- "Twisting," in which consumers are encouraged to change insurers for no good reason.
- "Churning," in which consumers are encouraged to change their policies for no good reason.
- "Commingling of funds," in which collected premiums are held in the same account as an agency's general operating funds.
- "Conversion," in which collected premiums are stolen.
- "Baiting and switching," in which false advertising is used to lure new customers into the door, after which they are encouraged to purchase a completely different product.
- "Fraud," in which material facts are misrepresented in order to steal money from the insurance company.

- "Unfair discrimination," in which people pay more for insurance (or aren't offered insurance) for reasons other than their data-supported risk profile.
- "Unfair claims practices," in which insurers wrongfully refuse to give insurance claimants the contractual amount owed to them.
- "Libel," in which false and defamatory statements about competitors or other people are made in writing.
- "Slander," in which false and defamatory statements about competitors or other people are said out loud.

Company Licensing

Insurance companies that want to do business in a particular state generally must have the appropriate license. Among other things, the licensing process might involve auditing the company's finances and investigating the financial and personal histories of its top-level personnel. Unless the insurance department becomes aware of misconduct and initiates more frequent investigations, licensed carriers can generally expect to be subjected to a thorough state audit every three to five years.

Specific licensing requirements might depend on whether the company is a "domestic insurer," "foreign insurer" or "alien insurer." These terms relate to where an insurer has its home office, but their definitions aren't as simple as they might seem.

In regard to licensing, a licensed insurance company is considered a domestic insurer in its home state but is a foreign insurer in any other state where it also has a license. An alien insurer is an insurance company from another country. Since they are all licensed entities, domestic, foreign and alien insurers are collectively known as "admitted carriers."

When insurance cannot be easily obtained in a given state, a consumer might be able to purchase coverage from a "non-admitted carrier." Although they might be licensed elsewhere, non-admitted carriers are not licensed to sell insurance in the buyer's state. In order to provide some consumer protections against an unlicensed carrier, insurance from a non-admitted carrier can only be purchased with the help of specially licensed professionals and only under special circumstances. In general, the producer selling the insurance must be licensed as a "surplus-lines broker" in the buyer's state and must be able to show that adequate coverage from an admitted carrier was not reasonably available.

Producer Licensing

Insurance producers, including agents and brokers, must be licensed in order to sell insurance. However, many states allow someone with an expired license to receive a commission when a consumer renews a policy, as long as the initial sale occurred while the license was in effect. Despite a push for greater uniformity and reciprocity in the licensing process, each state is responsible for enforcing its own licensing requirements.

According to the National Association of Insurance Commissioners, more than 2 million individuals are licensed to sell insurance. Those 2 million people hold over 10 million licenses. The difference in those numbers is the result of many individuals having licenses in multiple states. A license from a producer's home state is the person's "resident license," and any licenses from other states are known as "non-resident licenses."

In order to become licensed as a producer, a person must complete pre-licensing education, pass a state exam, pay various fees and undergo some kind of background check. A few states also require a licensee to already be affiliated with a particular insurance company. This relationship is sometimes called an "appointment." Even if an appointment isn't a mandatory part of the licensing process, each insurance company might have its own requirements and procedures before a licensee can sell the company's products.

Individuals who are interested in obtaining a producer license must choose one or more "lines of authority." The line of authority is the kind of insurance that a license allows someone to sell. At the very least, a state will have a life/health line of authority and a property/casualty line of authority. Many states don't combine life and health or property and casualty and also have additional lines of authority (such as personal lines and limited lines automobile). The chosen line of authority will dictate the kinds of pre-license coursework that must be completed and the type of state exam that must be passed.

Upon the conclusion of a license term, a producer can usually renew his or her license by submitting documentation to the department of insurance, paying required fees and completing continuing education. Many states have followed the NAIC's continuing education standard, which requires a producer to complete at least 24 hours of continuing education (including three hours of ethics training) every two years. Individuals selling annuities or long-term care insurance are likely to have additional continuing education requirements. And of course, as in most things related to insurance regulation, each state is likely to have its own rules regarding hours, course content and course delivery.

Multi-State Regulation

Despite their generally strong belief that insurance should be regulated at the state level, many producers and carriers have softened their stance in recent years due to the challenges of multi-state requirements. If an insurer wants to offer the same product across the country, it might have 50 different approval processes to complete (one for each state), including the payment of fees and the tedious completion of paperwork. Similarly, if an insurer or a producer wants to become licensed in more than one state, obtaining the additional licenses might be a long, strenuous process with different requirements across different jurisdictions.

At least in regard to licensing, the federal government and the NAIC have supported greater reciprocity among the states so that producers doing business in different places don't need to jump through so many bureaucratic hoops. In fact, the aforementioned Gramm-Leach-Bliley Act addressed this very issue by suggesting the creation of a national licensing entity.

The National Association of Agents and Brokers

In response to complaints from insurance trade groups whose members wanted to become licensed in multiple states, Congress inserted producer licensing language into the Gramm-Leach-Bliley Act. Under the law, the states were given an ultimatum: Either enact reciprocity laws that would allow out-of-state producers to easily obtain a non-resident license, or risk the formation of the National Association of Agents and Brokers (NARAB).

NARAB was initially viewed not only as a clearinghouse where producers could easily apply for licenses from multiple states but also as a threat to each state's licensing powers. Fears over federal oversight prompted nearly every state to adopt reciprocity agreements among themselves, as well as many standard licensing rules proposed by the NAIC. For example, the NARAB threat contained in the Gramm-Leach-Bliley Act was at least

partially responsible for the implementation by many states of a three-hour ethics training requirement as part of a producer's continuing education.

The response to the original version of NARAB resulted in greater licensing reciprocity across the United States, but producers have since realized the difference between reciprocity and uniformity. While reciprocity allows a licensee in one state to become licensed in another state without having to complete all of the same steps as an unlicensed person, the steps that can be skipped often still differ across state lines. Furthermore, even if a producer is only required to complete a few forms and submit fees in order to obtain a non-resident license, someone applying in multiple states hasn't been able to send all the forms and all the fees to one central location. So, a non-resident's application in one state might be approved quickly, while the same person's application in another state might remain unapproved until certain items are delivered or other requirements are satisfied.

The drive for more uniformity was strong enough for NARAB to be reconsidered and supported by both houses of Congress in 2014. This new version of NARAB (sometimes referred to as "NARAB II") would create a licensing clearinghouse and an online portal through which producers would be able to submit all non-resident licensing applications and fees at the same time. Membership would be contingent on having met various requirements established by a board of directors (such as completion of continuing education and a background check) and would be entirely voluntary. A producer who is only licensed in one state or in only a few states might opt against joining NARAB, but producers who want to sell in several states might choose to join.

Since NARAB II does not call for states to lose any of their regulatory authority (and is meant to be more of a facilitator in the licensing process than anything else), the NAIC and several producer organizations supported its creation. However, even though the basics of NARAB II were signed into law in 2015, this attempt at greater licensing reciprocity had not yet been implemented at the time this course was written.

Conclusion

By now, it should be obvious to you that insurance regulation is both an important and dynamic issue. Theories about how to best protect consumers can change just as often as the products being offered to the masses. But no matter what changes ultimately occur, insurance professionals must always be aware of the many regulators who set rules for conduct.

CHAPTER 4: HANDLING INSURANCE CLAIMS

Introduction

Insurance producers are taught to analyze people's needs, explain important policy provisions and engage in other ethical sales practices. But the well-intentioned efforts of an agent or broker at the front-end of an insurance transaction won't matter much if a policyholder ends up having a negative claims experience. Consumers who have just suffered a loss are unlikely to care how little they may have paid for coverage or how friendly an agent acted toward them when they purchased their policy. All they will want at that moment will be a quick, fair settlement from their insurance company.

Claimants who don't receive the kind of compensation they expect from their insurer are likely to take their business elsewhere. A survey released in 2016 by J.D. Power and Associates found that auto insurance claimants who reported low satisfaction with their insurer's claims process were seven times as likely to switch carriers than claimants who reported a high amount of satisfaction. The same survey also said lowly satisfied claimants were roughly 11 times less likely to recommend their insurer to someone else. Even if a dissatisfied policyholder decides not to look for other coverage or switch insurers, that person may even harm the company's reputation through bad word of mouth.

As long as we assume a claimant is not engaging in fraud, it shouldn't be difficult to understand why a denied or held-up request for insurance money can provoke so much anger. An insurance policy is, after all, a contract between the entity paying for coverage and the company issuing it. The entity paying for coverage agrees to pay premiums on time and to not misrepresent material facts. In return, the company issuing the policy agrees to provide money after a loss in accordance with the policy's language. Rightly or wrongly, an insurer that denies a claim or waits a long time before paying it might appear to be breaching its contractual obligations to the consumer.

Courts and regulators who believe an insurer has acted in bad faith toward claimants might have the power to impose serious sanctions on the company. Arguments over a small amount of money can result in tremendous penalties. For example, a dispute in California regarding nonpayment of just $192 ended in a $30,000 fine being imposed by the state's insurance commissioner.

The Producer's Role in Claims

Although producers are paid mainly to market and sell insurance products, they may be called upon to assist with the handling of claims. In some cases, the producer might have direct involvement with a claim, including the ability to authorize small payments. At other times, the producer will have no authority to provide compensation but will be asked by a consumer to intervene in a claims dispute.

Producers who receive questions from claimants don't need to provide an opinion regarding whether a loss should be covered, but they should at least be able to provide a general explanation of what the claims process will entail. Once a claimant has been informed of what to expect, the producer can contact the adjuster assigned to the case and try to obtain some answers.

Producers who are hesitant to engage in the claims process might want to think about how their behavior could jeopardize renewals. Surveys have found that a claimant's level of satisfaction increased with greater involvement from agents. Greater satisfaction with the outcome of a claim makes it more likely that a policyholder will remain with his or her current insurance company.

Meanwhile, independent agents who resist involvement with claims shouldn't assume that an angry claimant who switches insurers will still want to work with them. An insured may decide that an agent who doesn't help with claims isn't an agent worth having.

Producers should also keep in mind that the people who purchase insurance have invested some trust in them. Because they lack much insurance-related experience, typical consumers are likely to believe an agent or broker who oversells a positive policy feature and fails to mention contingencies or exclusions. For example, a first-time homeowner who is told she has replacement-cost coverage might not be aware that this kind of coverage, in and of itself, does not guarantee there will be

enough money to completely rebuild a building. Similarly, she might not understand how losses from hurricanes might be exempted from coverage on the basis of a flood exclusion. Unless she takes the time to carefully examine her policy (something consumers are not likely to do), she will only learn about these things if the person selling the insurance mentions them or if she actually experiences these kinds of losses.

Providing thorough and compassionate service during the claims process might not be enough to fully satisfy a confused policyholder, but it might reduce the producer's chances of being verbally attacked for allegedly poor disclosure.

The Claims Process

Because the claims process is designed to help policyholders receive the benefits they've been paying for, producers may find it helpful to explain ahead of time how the process works. At the very least, when an insurance policy is delivered to an insured, a producer can explain where information about claims can be found. Mentioning the process at that time might make it more likely that the insured will review those sections of the policy carefully and be more prepared if a loss ever arises.

Duties of the Insured

Consumers who experience a loss should report the situation to their insurance company as soon as possible. In most cases, this is accomplished by calling a toll-free number that is being staffed by customer service representatives. However, a policyholder who has a good relationship with an insurance agent or broker might turn to that particular producer first. An increasing number of companies are also letting their customers report claims online.

Once the loss is reported to the insurance company, the policyholder should receive a reference number for the claim and contact information for the insurer's claims department. Regardless of whether a loss is first reported to an agent, customer service representative or claims adjuster, the claimant should receive clear instructions regarding what to do next and what to expect. Providing detailed instructions to claimants as soon as possible is important because there are usually deadlines for submitting proof of a loss to the insurer.

The duties of the insured will depend in part on the nature of the insurance claim. A claim for a life insurance settlement might not be approved until the claimant has given the insurer a death certificate or other evidence of death. If the claim in question relates to casualty insurance, the insured might need to submit copies of any formal demands for money by third parties. For some health-related claims, including those for disability or workers compensation, a sick or injured person might need to consent to having his or her medical records examined by insurance representatives. Property insurance claimants will need to grant the insurer access to the damaged property and must take reasonable steps to keep the damage under control. These steps might include putting boards over broken windows or moving personal property away from a leaky ceiling.

The more information provided to the insurer at claim time, the faster the process will be. With this in mind, policyholders should be encouraged to keep good records long before they ever experience a loss.

Detailed home inventories—whether written down or comprised of photographs—make it less likely that an insurance company will dispute ownership of damaged items. Meticulous accounting by business owners can minimize problems if a company ever needs to close due to a natural catastrophe and files a business interruption claim.

Careful recordkeeping should continue after the main loss has occurred and should include documentation of any loss-related expenses. For example, homeowners should keep receipts for hotel and restaurant bills if they have been displaced by a weather-related disaster. Extra expenses that businesses incur in order to begin operating soon after an interruption should be documented, too. Unless the homeowner or business is severely uninsured, reimbursement for at least some of these expenses is available.

The insurance policy itself will, of course, be another very important record during the claims process. In today's business world of comprehensive databases, a claimant who loses the policy or doesn't have the policy number readily available shouldn't experience major problems when reporting a loss. Still, the document can be an immeasurably helpful reference for someone who keeps it in a safe place. It may serve as a refresher to the claimant regarding his or her duties after a loss. And perhaps more importantly, it can help the claimant anticipate how a particular claim is likely to be treated by the insurance company.

Insurance Adjusters

After a claimant notifies the insurance company of a loss, the person's case will often be passed along to a specially trained "claims adjuster." A claims adjuster evaluates whether the loss should be covered at all and, if so, for how much. Good claims adjusters must have extensive knowledge of policy language, an up-to-date understanding of how value is measured, and an ability to make fair decisions in a reasonably quick amount of time. Adjusters can be involved in seemingly any kind of insurance, but they tend to be most commonly associated with property and casualty losses.

Adjusters can be classified by the kind of relationship they have with insurance companies. For instance, some adjusters are employees of a single insurance company. These adjusters may or may not need to be licensed, depending on the particulars of state law.

Adjusters known as "independent insurance adjusters" work on behalf of an independent "adjustment bureau" and are called into action when an insurance company either doesn't have enough of its own adjusters in an area or needs someone with special expertise. Many states require these adjusters to be licensed, but licensing rules are sometimes relaxed temporarily after a natural disaster.

Individuals known as "public adjusters" represent claimants during the claims process and do not work for or on behalf of an insurance company. Public adjusters typically must be licensed in their state of business and will earn a percentage of whatever settlement a claimant receives from the insurer.

Communicating With Claimants

Insurance company representatives must communicate with claimants in a timely manner during various stages of the claims process. This duty, of course, includes paying valid claims soon after liability has been made clear to the insurer. It also exists in regard to returning messages left by claimants and making sure they receive the necessary paperwork to properly report a loss. Even if the insurer's liability for a claim is uncertain, the claimant should be made aware of what's happening and the reason for it.

Many deadlines and other requirements for communicating with claimants are set by state law. Most states base the deadlines on model regulations created by the National Association of Insurance Commissioners (NAIC). The NAIC's Unfair Claims Settlement Practices Model Regulation is intended to apply to practically every insurance company and mentions the following deadlines and responsibilities:

- Within 10 days of receiving an inquiry from a claimant, the insurance company must respond.
- Within 10 days of being notified of a loss, the insurance company must provide necessary claim forms to the claimant.
- Within 30 days of being notified of a loss, the insurance company must complete its claim investigation.
- Within 15 days of receiving proof of loss forms from a first-party claimant (a claimant seeking coverage through his or her own policy), the insurance company must inform the claimant whether the claim has been approved or denied.

The model regulations provide some leeway when an insurer legitimately needs more time to make a claims decision. An insurer that can't easily determine its liability for a first-party claim can send the claimant an explanation within 15 days of receiving proof of loss forms instead of having to make a hasty decision. However, if the delay lasts another 45 days, a second notice with an explanation must be sent to the claimant.

Keep in mind, though, that the requirements mentioned here are merely model regulations. Each state has the authority to reject the NAIC's recommendations in their entirety or in part. Deadlines and other requirements tend to differ slightly from state to state.

Despite the importance of laws, obeying them right down to the letter won't guarantee a good relationship between an insurer and the public. Consider a situation in which a claimant has suffered a major loss and has contacted a claims adjuster or an insurance agent. If the adjuster or the agent assures the claimant that insurance money will be provided by a specific deadline, the claimant will treat this news like a promise. Even if there is a legally legitimate issue that delays payment beyond the provided deadline, the claimant may have a right to be angry and may complain. This sort of problem can easily be managed by not making promises that can't be guaranteed or by informing the claimant as soon as possible when promises need to be broken.

In cases where claims need to be delayed or denied, providing as much communication as possible is usually the best policy. In fact, claims rules in the United States typically say a notice of denial must include detailed information about the reason for the rejection. The required information for this type of notice includes references to the portion of the claimant's insurance policy on which the denial is based. First-party claimants who receive this notice and have kept a copy of their policy can then refer back to the whole document and determine whether their insurer is reading the contractual language fairly. Third-party claimants (such as an injured person making a claim against another driver's insurance) usually don't have the right to receive this specific information about other people's insurance policies.

Settling Disputes With Consumers

When consumers believe a claims decision is unfair or inappropriate, they often have the ability to appeal the decision through some kind of internal review board. A written explanation and other documents might need to be provided to the entity conducting the review. In many situations, this or another internal process is enough to settle the claim. In some cases, for example, the insurer might conclude that all or part of a claim was inappropriately handled because of a clerical error or an honest misunderstanding.

If disputes with an insurer can't be resolved internally, arbitration is another possibility. In arbitration, the carrier and the consumer both pay to have the matter settled by a third party. By engaging in arbitration, both sides agree to abide by whatever arrangement the arbitrator produces. In other cases, a similar process known as "mediation" will be followed, in which a third party will attempt to bring the two parties together but without the ability to force a resolution.

When disputes aren't settled through arbitration, mediation or internal reviews, consumers can file a complaint with their state's insurance department. A claimant might also take legal action in order to make sure that the contractual provisions of the insurance policy are enforced. In some jurisdictions, claimants can sue for bad faith and receive judgments beyond the amount of their insured losses. We'll go over this issue in greater detail later in this chapter.

Claims Issues in Specific Lines of Insurance

Many types of claims issues touch professionals in all areas of insurance, but others are specific to certain lines. Some concerns that are mainly relevant to particular corners of the business are addressed in the next several sections.

Property Insurance Claims

Small property insurance claims might be settled entirely through the sending and receiving of paperwork, but larger ones will require an onsite inspection by an adjuster. During an inspection, the adjuster might snap several photos and scribble several notes. Unless they are absolutely necessary, no repairs should be done until the inspector has viewed the damage.

Access to damaged property will be granted to the insurance company as part of the owner's policy. Consumers who deny access after a loss are in danger of not receiving the insurance money they might otherwise deserve. Still, the access required by the contract might not need to be unlimited. In fact, according to NAIC model regulations, insurers who deny claims because of a claimant's failure to provide access must prove the claimant was being unreasonable. Presumably, this could protect a claimant who denies access at a particular time for personal reasons but is very willing to reschedule.

Catastrophic Claims

A hurricane, tornado, terrorist attack or similarly major event can produce thousands of claims. Even if an insurance company pays a large percentage of them, the sheer volume of claims makes it inevitable that a large number will be denied. Insurers who aren't proactive during the rebuilding of hard-hit communities will expose themselves to potentially unshakable public relations problems. Companies taking unreasonable positions toward claimants after a catastrophe are also at great risk of being named in a class-action lawsuit.

The importance of dealing with claims in as timely a manner as possible is at its greatest following a major or total loss. Dissatisfaction with an insurance company is certain to increase if a delay in the claims process means that a business can't re-open its doors or that a family needs to remain in temporary housing. In some cases, claims from major disasters have gone unresolved for several years.

Although insurers have the right and the obligation to ensure that money isn't provided to perpetrators of fraud, they should recognize that delays in providing legitimate compensation can ultimately lead to more losses. The sooner a family can start rebuilding their home, the less the insurer will have to pay for additional living expenses like hotel and restaurant bills. The quicker a business is able to get up and running with the help of insurance money, the smaller its business interruption claims will be.

One of the simplest yet most effective actions an insurer can take after a catastrophe is to be noticeably present in the affected area. These days, it's customary for companies to set up several mobile offices in damaged communities and bring in additional adjusters by the busload. In order to expedite claims processing, states will often loosen licensing requirements so that out-of-state adjusters can give quick service to residents.

Some ethics-based decisions might need to be made before adjusters arrive at a disaster area. Questions for managers and top-level insurance professionals to answer include the following:

- Should claims be processed on a first-come, first-served basis, or should a major loss take precedence over a comparatively minor one?
- Should grace periods be extended for disaster victims who are late in paying their premiums?
- How aggressively should the insurer enforce controversial exclusions, such as an anti-concurrent causation clause? (An anti-concurrent causation clause prevents a claim from being paid if it is linked to both a covered peril and an excluded peril.)

The answers to those questions will need to be found very carefully, with attention paid to the concepts of fairness, goodwill and the insurer's financial stability.

Auto Insurance Claims

Disputes regarding auto insurance claims often involve replacement parts or the insurer's relationship with auto-related businesses. Arguments over replacement parts arise when an insurer initially offers to pay for parts that are inferior to what was originally in the vehicle. For example, the insurer might offer to pay for the poor-fitting part instead of the more appropriate part available through the vehicle's manufacturer. Some companies might not be totally opposed to replacing a part with a true replacement, but they might make the process difficult for the repair shop by requiring multiple approvals and inspections. The use of cheaper parts may save the insurer money in the short term, but it can lead to future losses if the cheaper part is truly inferior and breaks down.

Insurers may be accused of unethical behavior if they engage in a practice known as "steering" during the claims process. In the context of auto insurance, steering occurs when an insurance company refers claimants to other businesses with which it has a financial relationship. Examples of steering include cases where drivers are referred to body shops that will accept lower payments from the insurance company. A similar situation might occur in a rental scenario in which a claimant needing a replacement vehicle is referred to a rental company willing to take less money.

For many consumers, the ethical issues involved with steering come down to a matter of choice. Most claimants probably understand that an auto insurance company has well-established relationships with body shops and rental-car providers. As long as they receive good service at minimal or no cost, many claimants won't be opposed to working with an insurer's favored businesses. However, drivers who have a preference for a particular body shop or rental company shouldn't be misled into thinking they don't have other options.

In many states, it is illegal for an auto insurer to only cover repairs when they are completed at a favored shop. Even when insurers give the consumer the choice of going elsewhere, they shouldn't influence the claimant's decision by making potentially false statements. For example, it may be unethical (or even illegal) for the insurer to stress that repairs done by a different shop are unlikely to be completed properly or quickly.

Casualty Insurance Claims

Casualty insurance often calls on the insurer to cover the cost of defending the insured. The insurer's duty to provide a defense is generally considered to be broader than its duty to pay for a settlement or court-awarded damages. In other words, unless it is already clear that the situation surrounding the claim is excluded from coverage, the insurance company is expected to pay for a defense. The insurer generally cannot refuse to defend an insured in a situation in which its liability is still uncertain.

Conflict often arises in casualty situations when the party taking legal action against the insured has proposed a settlement but the insured and the insurer can't agree about whether to provide it. In most of those cases, it is the insured who is hesitant and the insurer who wants to offer the settlement. A doctor being sued for malpractice, for instance, might not want to settle a case because a settlement is sometimes seen as an indirect admission of guilt.

But there have been instances in which the insurer has been the reluctant party and been convinced that a judge or jury will rule in the policyholder's favor. This stance must be analyzed with tremendous care. Again, suppose a doctor has been sued for malpractice. The plaintiff has offered a $500,000 settlement, but the doctor's insurer has rejected the offer because the case against the doctor seems frivolous. If the insurer misjudges the case and loses in court, the awarded damages are likely to be higher than the rejected $500,000 settlement and could even be greater than the doctor's insurance limits. In some cases like this one, courts have ordered casualty insurers to pay the entire amount of any judgments, including amounts beyond a policy's limit.

Third-Party Claimants

Casualty insurance claims might be made by the insured or by a "third-party claimant." A third-party claimant is a person or entity making a claim against somebody else's insurance. For example, a driver who is involved in an accident in which another driver was at fault might make a claim against the at-fault driver's insurance.

Situations involving third-party claimants can create ethics-related difficulties for insurers. If fault regarding an accident is in dispute, the insurance company might have to deal with a third party who wants his or her claim to be covered and a policyholder who wants the same claim to be denied. In auto insurance, for example, a third-party claimant who doesn't have collision insurance on his own vehicle might demand that another driver compensate him for property damage. At the same time, the other driver might not believe she caused the accident and might worry that a successful claim against her insurance will boost her premiums.

Disputes with third-party claimants often cause insurers to think about contractual relationships. The contractual relationship

established through an insurance policy is generally between the insurance company and the policyholder. Since a third-party claimant lacks a contractual relationship with the policyholder's insurer, the third party might not be obligated to receive the same level of cooperation with the carrier. For example, although insurance companies often need to disclose which portion of a policy was used to deny a claim, this requirement typically doesn't apply to third-party claimants. In certain situations, the details of a policyholder's coverage might be privileged and private information and won't be disclosed to others without consent.

Still, the lack of a contractual relationship with a third-party claimant doesn't entirely excuse the insurer from certain requirements. In states where the NAIC's Unfair Claims Settlement Practices Model Regulation has been adopted, insurers might not be allowed to advise third-party claimants to make claims against their own insurance when the insurance company's customer is clearly the one at fault. So, if it is reasonably clear that a homeowner suffered damage due to a neighbor's negligence, the neighbor's insurer might not be allowed to tell the homeowner to make a claim against his own insurance.

Options for dissatisfied third-party claimants differ from state to state. At the very least, a third-party claimant who is receiving unsatisfactory service from someone else's insurer can file a complaint with the state's insurance department. A minority of states let third-party claimants sue insurance companies for unfair claims practices.

Unclaimed Life Insurance

Life insurance claims tend to be significantly easier to settle than property or casualty insurance claims. Presumably, a lot of the relative ease involved with life insurance claims exists because the policies contain simple face values. Proof of death, such as a death certificate, makes it nearly certain that the insurance company will need to compensate a beneficiary, and the clearly defined face amount makes it obvious how much the compensation should be. Unless there is a dispute regarding a double indemnity provision (in which the beneficiary may be entitled to double the death benefit in the event of a fatal accident) there is usually little or no argument over the size of the settlement.

This assumes, of course, that the beneficiary is aware of the life insurance policy in the first place. Life insurers face an ethics issue when a policyholder has died but no one has stepped forward to make a claim. Beneficiaries may be unaware of their right to life insurance benefits if they weren't closely involved in the deceased's finances or if the policy in question was purchased several years ago.

Traditionally, unclaimed life insurance benefits remained with the insurance company for at least a few years after a death. During that time, the insurance company was able to invest the money within reason and keep the resulting interest. At the end of this period, the money would usually be transferred to a state fund, and the state would earn interest on the death benefit until a beneficiary claimed it.

Critics of the life insurance industry sometimes wondered if the potential to earn interest on unclaimed death benefits discouraged companies from confirming deaths and contacting beneficiaries. Among other evidence, they cited cases in which insurers have searched through death records from Social Security in order to cut off annuity payments but not to determine whether someone covered by life insurance had died. In their defense, insurers pointed out that policy language only required payment of death benefits when a beneficiary had filed a claim. They also sometimes suggested that the states' increased monitoring of unclaimed death benefits was motivated by government's own desire to hold onto unclaimed money and receive interest from it.

Upon being alerted to someone's death, a state's insurance department might be able to help surviving family members identify the existence of unclaimed life insurance in the deceased's name. Also, be aware that some states, including Illinois, have taken legislative action in order to ensure that companies actively alert beneficiaries to the existence of unclaimed life insurance.

Regulation of Claims Practices

The options for consumers who believe an insurer hasn't handled claims fairly will depend on state law and related court decisions. However, the ability to file a complaint with a state insurance department exists across the country.

In accordance with the NAIC's Unfair Claims Settlement Model Regulation, insurance companies are expected to maintain detailed records. These records are meant to help the insurance department determine how a claim was handled and for what reasons. The model regulations also call for insurers to respond to inquiries from regulators as fully as possible and within 15 days of a request.

Some state insurance departments will only take disciplinary actions against an insurer for poor claims handling if they have received multiple complaints about the same carrier. If the department determines that an insurer's unfair response to a claim is a general business practice rather than an isolated incident, it may impose fines amounting to several thousands of dollars. Not all complaints will lead to fines, but even the threat of a state-conducted audit is sometimes enough to get a disputed claim paid.

The ability to take action against an insurer in a manner other than complaining to the insurance department can differ significantly by state. In general, policyholders have the right to sue the insurer for breach of contract, but this route has a few potential roadblocks to consider.

One major drawback to suing for contractual liability is that the amount awarded to the policyholder might be limited to the amount of the disputed claim. The party filing the lawsuit might not be allowed to receive compensation for punitive damages or pain and suffering.

In cases where this kind of cap exists, a claimant might not be willing to take an insurer to court over a relatively small loss. Furthermore, third-party claimants—such as an accident victim making a claim against another driver's liability insurance—might not have the option of suing for breach of contract. After all, the contractual relationship established through an insurance policy is between the insurance company and the policyholder. In general, the contractual relationship isn't between the insurance company and someone who sues the policyholder.

Realizing how much a delayed or unpaid claim can impact consumers, several states have either written or interpreted claims-related laws in a manner that lets policyholders seek damages beyond the contractually owed amount. Still, states don't always agree on the rights of third-party claimants in these situations. They also differ on whether a consumer needs to

prove that the insurer acted unfairly as part of a general business practice.

The removal of barriers to suing an insurance company is often encouraged by consumer advocacy groups, but insurers often argue that allowing more legal action against them could result in negative consequences. Mainly, if insurers are constantly worried about being taken to court over claims, they might become less inclined to investigate fraudulent losses. Then, if the insurer provides more money to perpetrators of fraud, the cost of coverage for honest consumers could go up. You'll read more about the fine line between fair claims practices and fraud prevention later in this chapter.

Unfair Claims Settlement Practices

Claims-related penalties are more likely to be above and beyond the amount actually being disputed if the insurer is accused of an "unfair claims settlement practice." This kind of accusation can be made if an insurer unfairly denies a claim or in situations where the insurer makes a claimant wait an unreasonable amount of time before finally providing payment.

Many of the specific actions that rise to the level of an unfair claims settlement practice are set by state law or state rules. Several of the more commonly prohibited practices are mentioned in this section. Each mentioned practice is followed by a basic example:

- **Denying a claim without conducting an appropriate investigation:** Following a combination of an earthquake and a fire at his home, Joe files a property insurance claim. Joe has coverage for fire losses but not earthquake losses. Instead of sending an adjuster to determine how much each peril contributed to the damage, his insurance company denies his entire claim outright.
- **Failing to settle a claim when the insurer's liability is reasonably clear:** Wayne and Mary are involved in a car accident in separate vehicles. Although Wayne freely admits the accident was his fault, his insurance company delays compensating Mary for her losses and instructs its legal team to find a loophole in the policy so it can deny all claims.
- **Intentionally offering to settle for an amount below what the claimant actually deserves:** Laurie's home was broken into by robbers, who stole most of her personal possessions. She has kept good records of what she owned and was sure to purchase coverage that was in line with what her belongings were actually worth. However, her insurance company views the settlement process as a negotiation and decides to offer her a much smaller amount. (This practice is often referred to as "lowballing.")
- **Withholding money for a covered portion of a claim while disputing the rest of a claim:** Sarah's home was damaged by a hurricane. She and her insurer agree that at least a portion of her losses are covered. Coverage of her other losses are in dispute and depend on the wording of a flood exclusion. Rather than at least give her the money for the uncontested portion of her losses, her insurer decides to give her nothing until the flood-related dispute has been settled.
- **Requiring a deadline for providing proof of loss that isn't stated within the insurance policy:** Ben was listed as a beneficiary on his father's life insurance policy. The policy wasn't discovered until nine months after the father's death. Although the policy lists no deadline for providing proof of a death, the insurance company denies Ben's claim and says he should've provided a death certificate within six months of his father's passing.
- **Refusing to pay a claim because other sources of compensation may be possible:** George slips on a neighbor's steps and hurts his back. His health insurance company refuses to pay his medical bills because it holds the neighbor responsible for the accident. George's insurance policy makes no mention of this kind of situation, yet his insurer tells him he has no choice but to sue his neighbor.
- **Failing to make claimants aware of statutes of limitations:** Roberta has been fighting with her health insurance company over unpaid doctor bills for nearly two years. After those two years, she will not be allowed to take legal action against the insurer. The insurance company knows her deadline is approaching but doesn't disclose it in a timely manner. The deadline passes, and Roberta is left without the ability to have the matter settled in court.
- **Reducing or eliminating policy benefits in order to facilitate a quicker settlement:** Jean's home requires major repairs after a fire. The amount offered by the insurer won't be enough to restore the home to its prior condition. In order to convince Jean to accept this amount, the insurance company stops paying for the apartment where she and her family are temporarily residing.

Conclusion

Some insurers believe an increasingly strict interpretation of claims laws might discourage adjusters from fighting fraud. If the cost of being sued is higher than the amount of a suspicious claim, it might make short-term economic sense to pay the claim and move on. The risk of an expensive lawsuit, along with the desire to avoid public relations disasters, creates an awkward situation for insurers. No matter what decision they make in regard to a claim that shouldn't be covered, the insurer's financial outlook may be damaged.

Whether they realize it or not, producers may have a few chances to reduce the stress felt by fraud-conscious adjusters. Since the producer is often the insurance representative who has had the most personal interactions with a consumer, the producer may be able to vouch for the person's character. Although a producer's positive opinion about a claimant might not be a good enough reason to abandon a fraud investigation, it may be one of many tools that can lead to a fair decision.

While meeting with applicants and noting their character, producers can also explain and debunk many insurance myths. By reminding property insurance applicants that their policy won't cover losses from floods or earthquakes, producers reduce the chances of a flood-related or quake-related claim causing dissatisfaction. You can't force a consumer to read an insurance policy, but you can take time to judge the person's comprehension of the important points.

Finally, be aware that some states have passed laws to eliminate a producer's potential liability for reporting potential fraud in good faith. If you suspect fraud but are concerned about your legal liability in the event of being wrong, consult your carrier and/or a compliance expert in your community.

CHAPTER 5: GROUP LIFE INSURANCE OPTIONS

Introduction

Although discussions of employee benefits tend to focus on health coverage and retirement plans, employer-paid group life insurance actually came first. Even in the first few decades of the twentieth century, businesses understood that providing life insurance could be an inexpensive way to attract and keep good workers. When a job applicant has to choose between two similar employment opportunities, an offer of free life insurance might put one suitor over the top. When an employer can't afford to give dedicated staff members a raise, implementing a group life insurance plan can boost company morale.

In some cases, having a group life insurance plan might simply seem like the decent thing to do. Workers are likely to mention their spouses, children or other family members to their bosses at some point and may even invite members of their household to company functions. If management gets to know these family members, the employer may develop deep sympathy for them after an employee's death. The feeling can be even more intense if the company knows that the family was living paycheck to paycheck and relied on the deceased to pay the bills.

The money made possible through group life insurance is rarely enough to eliminate anyone's long-term financial concerns, but it's usually capable of covering immediate expenses while survivors take a deep breath. It's a great way to express appreciation for the employee's loyalty.

The right plan can even create tangible financial benefits for the affiliated employer. Dollars spent on life insurance for employees can be deducted from an employer's taxable income within certain limits. More complicated plans might let the employer recoup paid premiums after a death or receive a large lump sum when an especially important employee passes away.

Group Life in the Modern Market

Regardless of their purpose, group life insurance plans are fairly common in today's business world. Still, they aren't as common as in previous decades. Changes to the tax code have effectively discouraged businesses from implementing some of the more complex setups. On occasion, high unemployment has also resulted in fewer people being covered by the simpler, more popular plans.

The challenge today for insurance producers in the group life market is two-fold. Companies without a group plan obviously need to be told about the possible benefits and drawbacks. However, education regarding how a plan works should also extend to employees who already have access to one. Since more plans these days are calling for supplemental contributions from workers, eligible enrollees may need help determining whether purchasing group coverage is a good idea. Meanwhile, those who get group life for free might benefit from knowing what their options would be upon leaving their employer.

Our summary of group life insurance will help you meet that challenge by focusing on consumers' needs as well as on plan administration. Topics will include the size of death benefits, the typical tax treatment of premiums and the conversion rights for former employees. Wherever possible, we'll also point out distinctions between life insurance for groups and life insurance for individuals.

Group Plan Basics

Group life insurance involves the use of a single insurance policy to insure the lives of several people. The specifics of the policy are negotiated and agreed to by the insurance company and the policyholder. In most cases, the policyholder is an employer that wishes to provide insurance to its employees. Alternatively, the policyholder can be an association, a union or a creditor. For the sake of simplicity, the examples and terminology used in our explanation of group life insurance will be based on plans from employers.

While playing the role of policyholder and plan sponsor, the employer often chooses a death benefit to serve as a base amount for all of the plan's participants. The base amount is typically either a flat dollar amount (such as $50,000) or a multiple of the participant's annual salary. Many employers go a step further and give enrollees the chance to purchase additional coverage beyond the base amount with their own money. We'll go into further detail about the size of death benefits a little later in this chapter.

The person or entity who will ultimately receive death benefits through the group plan is typically decided by the employee. This party, known as the "beneficiary," is usually a close family member, but it isn't uncommon for employees to designate a charitable organization to receive the money instead.

The manner in which the beneficiary receives death benefits can be left up to the beneficiary or can be chosen in advance by the employee. The method of receiving life insurance money from the insurer is known as a "settlement option" and may involve one lump sum or several smaller payments over a number of years.

Group Underwriting and Premiums

Premiums for group life insurance are typically paid monthly to the insurer by the employer. When the cost of the insurance is paid in whole or in part by an employee, the employee's share will come out of a payroll deduction and be delivered to the insurer on the employee's behalf. A common policy provision known as a "waiver of premium" can excuse an employee from having to pay his or her portion of premiums while the person is too disabled to work.

The cost of group life insurance will depend on several characteristics of the group's members. Companies underwriting group life insurance might be interested in a group's average age, its average salary and the number of male employees versus female employees. The insurer might also be concerned about the kind of business being covered, the number of employees who have recently died and the cumulative health history of group members.

Plans requiring premium contributions from participants sometimes charge employees more as they age, but the individual's personal health history will either be irrelevant or a minimal factor. The minimal or lack of emphasis on a participant's own medical history is made possible by the concept of "pooling." In pooling, risks are shared among all group members in a way that is meant to keep premiums relatively stable for everyone. The bigger the pool of participants, the less likely it will be that a particular employee's health status will impact everyone else's costs.

At large employers, covered employees might represent the entire pool that will be used to set premiums. Smaller companies, on the other hand, are often added to a pool of several similarly sized businesses and charged an amount based on the

characteristics of the larger pool. Depending on the insurer's preference and state law, a group might be subjected to only one or a combination of these pooling methods. For example, a small employer might be pooled together with similar businesses for the purpose of determining an initial price and then have the price lowered or increased based on the particular employer's loss history.

Terms and Renewals

The most traditional form of group life insurance covers enrollees for guaranteed-renewable, one-year terms. As long as the employer satisfies certain enrollment requirements (such as having at least a minimum number of enrolled employees), the policy can be renewed each year at the employer's option. The insurance company can't refuse to renew coverage simply because the group has become riskier to insure, but an increase in risk can be reflected in higher premiums for the new term.

Even if an insurer keeps premiums stable, there is always the risk that an employer will cut back on its share of costs and require higher contributions from employees. Workers who want to lock in their premiums over several years (or think they might benefit from not being part of a pool) may want to consider individual life insurance rather than group coverage.

Picking an Insurer

Employers interested in a group life plan should research a carrier's financial standing and the speed with which it pays claims. The value of group life insurance will usually be low enough to be covered by a state's guaranty fund if a carrier runs out of money, but any complications or delays in the claims process can harm beneficiaries who lack adequate savings. As the plan's sponsor, the employer probably won't enjoy playing the role of intermediary between an angry claimant and an uncooperative insurance company.

In order to stand out from the competition, an increasing number of insurers are trying to attract employers by offering more than just good coverage at a good price. Along with promising a death benefit, some newer plans pay for free consultations with estate planners and funeral directors. These modern-day add-ons are designed not only to simplify end-of-life planning but also to get employees thinking about whether their existing assets will be enough to fulfill their last wishes.

Eligibility and Enrollment

For an employer to have its own group life insurance plan, it may need to satisfy various participation requirements. Most insurers prefer to only sell plans to businesses with at least 10 employees. Businesses with fewer workers will often work around this requirement by banding together and becoming part of a "multiple employer trust."

Additional participation rules are likely to apply depending on how premiums are paid. If premiums are paid entirely by the employer, participation usually needs to be automatic for all employees within a particular class. For example, depending on how the plan is structured, participation might need to be automatic for all full-time employees or for all workers who have been with the employer for a particular number of years. If premiums are paid totally or in part by employees, participation must be voluntary and might need to be exercised by a certain number of eligible workers. For instance, a group plan involving employee contributions might be discontinued if fewer than 75 percent of eligible employees opt into it. Regardless of whether these requirements are imposed by the insurance company or by law, they are intended to ensure that risks are spread across an adequately sized pool of people.

The pooling of risks makes group life insurance accessible to practically all of a business's employees, but there are a few important exceptions to this rule. Before employees can join their plan, they must be "actively at work." In general, being actively at work means working 30 hours per week for the employer. Although this requirement creates an obvious coverage exclusion for many part-time workers, its main purpose is to excuse the insurer from having to cover people with serious disabilities. The exclusion doesn't apply if the disability occurs after the person's enrollment in the plan, but it can be a problem if the company switches plans or is implementing one for the first time. Beyond this exclusion, group life insurance is almost always available to eligible members regardless of their individual health histories.

Benefits provided under a group life plan will occasionally be different for employees beyond a certain age or for high-ranking executives. For instance, death benefits might decrease once a participant turns 65, or they might have a higher dollar limit or other more favorable characteristics if the insured holds an especially important position. However, any aspects of a plan that favor some employees over others need to be analyzed with care. When it is poorly executed, age discrimination can easily violate state or federal labor laws like the Age Discrimination in Employment Act. And even when they're legal, plans that discriminate against employees on the basis of salary can produce unfavorable tax consequences. Some tax-related rules for discriminatory plans will be summarized later in this chapter.

In a voluntary or contributory group plan (with the employee paying any part of the premium), eligible employees will have a chance to enroll when they're hired (following any applicable probationary period) or during an annual open enrollment period. If employees want to enroll at some other point, they might need to undergo a medical exam or have their health records analyzed by the insurance company.

The limit on enrollment periods exists to prevent a problem known as "adverse selection," in which insurance is purchased disproportionately by people who put the carrier at greater risk. Similar enrollment rules are typically enforced to minimize adverse selection in the market for group health insurance. In fact, the enrollment periods for group life and group health insurance are often identical.

Common Death Benefits

Death benefits from group life insurance will equal a flat dollar amount, a multiple of an employee's salary or a combination of the two. For instance, a policy might provide that a beneficiary will be given one year's worth of the deceased salary or $50,000, whichever is less. Amounts might vary on the basis of age, hours worked or years of service. Again, differences in benefits among workers need to be constructed carefully in order to avoid illegal discriminatory conduct.

Coverage purchased entirely by an employer is often capped at $50,000 in order to simplify compliance with the federal tax code. Unfortunately, this amount of money is rarely enough to satisfy a beneficiary's needs for long. Enrollees who believe the death benefit is inadequate can often raise it at their own expense.

Employers or employees commonly have the option of purchasing "accidental death and dismemberment coverage" as a rider to the group policy. Dismemberment coverage gives employees an amount equal to a portion of the death benefit

when they lose their sight or have one of their limbs severed in an accident. Accidental death coverage increases the death benefit for beneficiaries if an employee dies in an accident rather than from an illness or natural causes. The most well-known types of accidental death coverage include a "double indemnity" provision, which multiplies the policy's death benefit by two.

Some insurance companies will offer "accelerated death benefits" to enrollees. Accelerated death benefits are essentially an advance of death benefits for employees who are terminally ill, have been diagnosed with a debilitating disease or are in need of long-term care. Money received in the form of accelerated death benefits is generally tax-free to people who use it for long-term care or who have a life expectancy under two years. The portion of death benefits not advanced to the employee will be paid to the beneficiary after the insured's death.

Analyzing Needs

Employees who can sign up for even a small amount of entirely employer-paid life insurance are practically being offered free money. But even if decisions regarding whether to take free coverage are obvious, plan participants still have an important question to ask themselves: "Is this the right amount of life insurance for me?"

The death benefits provided through group life insurance don't take each individual employee's financial needs into account. Instead, the death benefits made possible by the plan are, in a sense, a compromise designed to satisfy several criteria. As the policyholder, the employer may want to offer free or inexpensive coverage as a sign of generosity, while at the same time keeping costs low and maximizing tax advantages for itself. Meanwhile, the insurance company may want to structure death benefits in a way that simplifies the administration of the plan while also shielding itself from overly large risks within a large and diverse pool of participants. These desires inevitably create scenarios in which group members don't have enough insurance to match their situation.

To estimate an appropriate amount of life insurance, employees should ask themselves the following questions:

- How much money will my dependents need in order to maintain their current standard of living and keep up with inflation?
- How much money will my children need for school tuition and basic necessities?
- How long will my dependents need financial assistance?
- How much money should beneficiaries receive—regardless of need—as a gift from me?
- How much money should beneficiaries receive in order to offset debts (such as a mortgage loan) that I would normally pay for?
- How much should beneficiaries receive in order to pay estate taxes?
- How much money should beneficiaries receive in order to pay funeral costs, burial costs and other expenses related to my death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?

Believe it or not, there are cases in which the answers to those questions suggest that someone's current level of life insurance is already appropriate or unnecessary. Several financial advisers believe someone who is single and has no debts or dependents doesn't need life insurance. Many people who fit this description might not have a good enough reason to join a voluntary group life plan or to purchase more coverage than what's provided for free.

For the majority of workers, though, the amount calculated by answering those questions will be greater than $50,000 or a year's worth of salary. Upon coming to that conclusion, employees need to think about how to make up the difference. The most common options for them will be to either voluntarily purchase more coverage through their group plan or shop around for their own policy.

Is Group Coverage the Best Deal?

Again, there ought to be little or no debate regarding whether free life insurance from an employer is a good thing. But if employees are required to pay for even a portion of their coverage, they shouldn't automatically assume that buying through their group is their best option.

The cost differential between group life insurance and life insurance for one person will depend greatly on the individual's health. Unhealthier people tend to save money with group life insurance because it puts little or no emphasis on their personal medical history. In fact, when employees have serious medical conditions, group life insurance might be the only form of life insurance available to them. Healthier people, on the other hand, tend to benefit less from group life insurance because their higher life expectancy is used against them in order to make coverage available to high-risk participants. They might end up paying less if they opt for an individual policy outside of the group.

Despite the general rule about group life not favoring healthy employees, health shouldn't be the only factor used to compare costs in the group and individual markets. Group plans can still be cheaper for healthy employees if the employer is paying a significant portion of the premiums. Costs might also be lower in a group plan because the employer and the insurer share administrative tasks.

Portability and Conversion

Some employees may prefer to buy insurance outside of their group because they want portable coverage. When employees leave or lose their jobs, federal and state law usually lets them keep their group health insurance for several months if they're willing to pay for it. This portability usually doesn't extend to group life insurance unless the employer opts to include it as part of the plan. In general, group life insurance is considered "convertible" but not portable.

The main distinction between portable coverage and convertible coverage is that portable coverage essentially lets former employees keep what they already have. If an employee worked at a company that offered portable term life insurance with premiums that could change every year, that's basically the kind of insurance the former employee can opt to keep. The former employee with portable coverage will be able to keep the insurance regardless of his or her health.

A former employee with convertible coverage can still be covered regardless of health, but the person's group insurance will often be replaced by a very different kind of life insurance. Instead of being entitled to essentially the same kind of coverage as the group, a former employee with convertible term insurance will only have the right to obtain "permanent life insurance."

Unlike term life insurance, permanent life insurance is designed to keep somebody insured for the rest of his or her lifetime. It also has an investment feature that gives the policy a "cash value." A

policy's cash value grows over time and can be used in a number of ways. The policyholder can borrow money against it, use it to offset future premiums or even receive a portion of it in a lump sum if coverage is ever canceled. In many cases, term life insurance that's converted to permanent coverage will have level premiums that are based on the person's age at the point of conversion.

The longevity and versatility of permanent life insurance can be very attractive, but they help explain why these policies are often significantly more expensive than term insurance. Healthy people who were satisfied with term insurance through a former employer should be able to qualify for term insurance of their own instead of converting to a permanent policy. Even people with health problems might opt against converting to a permanent policy because of the extra cost.

Interested workers generally have the right to convert their group coverage dollar-for–dollar to an individual permanent policy within a month of leaving their employer. Benefit managers need to be aware of specific deadlines and options in their state so that they can inform personnel who are leaving the company. If a former employee dies without having known about conversion rights, survivors might take legal action against the business.

Tax Issues for Group Life Insurance

Life insurance can produce positive tax-related outcomes for businesses, beneficiaries and covered employees. Death benefits are often exempt from income taxes, and money spent on insurance within a group plan can sometimes be exempted or deducted from federal tax bills. Still, as is usually the case with rules from the Internal Revenue Service, the eligibility requirements for tax benefits can be very complex.

Many of the general tax rules for group life insurance will be summarized in the next few paragraphs, but specific tax advice should only be provided by a qualified tax professional. Tax rules change frequently, and competent tax planning can only be done after considering the specifics of a situation.

Taxation of Death Benefits

Life insurance death benefits are usually not taxable as income to beneficiaries. A rare exception to this rule might be a case in which the beneficiary became entitled to death benefits after paying money to the policy's previous owner. In this scenario, the amount beyond what was paid to the policy's previous owner might be taxed as income. The selling of life insurance from one owner to another is known as either a "viatical settlement" or a "life settlement." These settlements occur in the individual market for life insurance but not in the group market.

Life insurance beneficiaries may also need to pay some income taxes depending on how they receive death benefits. The most popular life insurance settlement option delivers death benefits in a lump sum, but some beneficiaries prefer to receive their money in installments. One positive of choosing the installment option is that money can be kept with the insurance company and earn interest. Interest earned on death benefits will be taxed in a way that impacts a portion of all the received installments. IRS formulas determine how much of each installment will count as income.

On occasion, businesses purchase life insurance on their employees and name themselves as beneficiaries. This kind of insurance, known as "corporate-owned life insurance," is commonly intended to help a company cope with the financial fallout of losing a key executive or owner. Companies usually can't deduct the premiums they pay for corporate-owned life insurance from their taxes, but they can still receive the policy's death benefits on a tax-free basis. For death benefits to be tax-free to the business, the following conditions must have been met:

- The covered person consented in writing to the corporate-owned life insurance before it was issued.
- The covered person was either an employee of the business within a year prior to death OR was considered a director or highly compensated employee of the business.

If those two requirements aren't satisfied, the business will have to pay income taxes on the difference between the death benefit it receives and the premiums paid to the insurance company.

Estate Taxes

Although death benefits are generally exempt from income taxation, the value of a life insurance policy can sometimes be included as part of the deceased's estate. This is important to some families because estates valued at more than an amount set by law will be subjected to federal estate taxes within nine months of the person's death.

Life insurance will be considered part of the deceased's estate for tax purposes if the estate was listed as a beneficiary or if the deceased had any ownership rights in regard to the policy. Ownership rights include the right to transfer the policy to someone else, the right to use the policy as collateral for a loan and the right to choose the beneficiary. As long as the estate is not listed as the beneficiary, the owner can avoid having the insurance included as part of his or her estate by transferring all ownership rights at least three years before dying.

Since they usually can pick their own beneficiaries, people who die with group life insurance will have the insurance's death benefits included as part of their estate. Most estates aren't worth enough for the federal estate tax to apply to them. For example, in 2023, the federal version of the estate tax didn't apply to estates worth less than approximately $13 million. (However, some states apply their own estate taxes to lower amounts.)

IRS Rules for Group Term Life Plans

In general, businesses that don't list themselves as beneficiaries can receive tax deductions for paying group life insurance premiums. However, a business that is overly eager to find tax advantages for itself might inadvertently create tax problems for its employees. Unless group life insurance is of a certain variety and below a certain amount, covered employees might end up owing money to the IRS.

Depending on the type and amount of coverage, participants in group life insurance plans might be taxed on "imputed income." Within our discussion of life insurance, imputed income can be defined as something of financial value that is provided in the form of an employee benefit rather than in the form of money. An example of imputed income for an employee would be the portion of life insurance premiums paid by an employer. Even if employees pay all premiums, they might be receiving imputed income if their plan lets them buy insurance at rates below IRS standards.

According to IRS rules, benefits that would otherwise be considered imputed income don't apply to group term life insurance if the death benefit doesn't exceed $50,000. This exemption is intended mainly for groups with at least 10 people

in them, but smaller groups are eligible if they follow certain guidelines.

If death benefits in a group term life insurance plan exceed $50,000, some imputed income might be produced and be taxable to the employee. (The $50,000 cap on death benefits can be waived if the sole beneficiary is the employer or a charity.) To figure out the amount of imputed income for an employee who has been covered for the entire tax year, follow the instructions below:

1. Subtract $50,000 from the insurance's death benefit.
2. Divide the amount obtained in Step 1 by 1,000.
3. Look up the monthly cost per $1,000 of coverage, as determined by the IRS. (At the time this course was being written, the cost could be found in a table in the "Group Term Life Insurance Coverage" section in the IRS's "Publication 15-B." Costs appear in a table format and depend on the employee's age.)
4. Multiply the amount obtained in Step 2 by the amount obtained in Step 3.
5. Multiply the amount obtained in Step 4 by 12. (For employees who haven't been covered for the full tax year, use the number of months they've been covered instead of 12.)
6. Subtract any premiums that have been paid by the employee with after-tax dollars from the amount obtained in Step 5.

Contributory/Voluntary Group Plans and the $50,000 Rule

The limited tax exemption for group term life insurance can be difficult to work around in group plans when employees pay some of the premium and increase their death benefit beyond $50,000. Even if employer-paid coverage is non-existent or is capped at the $50,000 threshold, additional coverage that's purchased willingly by a plan participant can still result in imputed income under IRS rules.

In order to avoid taxation of imputed income in a plan that involves employee contributions of premium, a number of rules must be obeyed. According to various tax advisors, some of the more important rules and recommendations to consider include the following:

- Portions of the group plan that are optional for the employee should be addressed in a policy that is separate from any portions that are automatically provided to all eligible employees.
- Premiums for optional coverage should be paid entirely by employees.
- Rates for optional coverage cannot "straddle" the rates found in the aforementioned table from the IRS. (Straddling occurs when the age-based rates in the plan are higher for at least one age group than they are in the IRS's table and lower for at least one other age group than in the table.)

The three items mentioned here are presented only as a general summary. Any kind of layering of plan options that is designed to avoid taxation should be done with a professional who understands all the details.

Key Employees and the $50,000 Rule

The $50,000 exemption for imputed income and group term life insurance doesn't extend to key employees when a plan favors them on a discriminatory basis. According to rules from 2023 by the IRS, a key employee is any of the following individuals:

- An officer of the employer whose annual pay exceeds $215,000.
- An owner of at least 5 percent of the business.
- An owner of at least 1 percent of the business whose annual pay exceeds $150,000.

In order to preserve the $50,000 exemption for key employees, the group term life plan must be non-discriminatory toward other employees in regard to participation and benefits. To be non-discriminatory in regard to participation, a group term life insurance plan must satisfy at least one of the following requirements:

- At least 70 percent of employees are part of the plan.
- At least 85 percent of participants aren't key employees.
- Eligibility doesn't favor key employees, as determined by the Secretary of the Treasury.

To be non-discriminatory in regard to benefits, the plan must offer the same benefits to key employees and other participants. This rule doesn't prevent a plan from basing death benefits on a multiple of a participant's income. In other words, a plan that offers a death benefit equal to two years of salary to someone making $215,000 and someone making $50,000 isn't necessarily a discriminatory plan.

Other rules apply to cafeteria plans and insurance for shareholders at S corporations. They are beyond the scope of this course. Please note, as well, that the specific percentages and dollar amounts mentioned here could change based on amendments to tax laws and tax rules.

Taxation of Permanent Life Insurance

The $50,000 exemption on imputed income is for group term life insurance and not for permanent life insurance. However, some group plans will preserve part of the exemption by layering a permanent life insurance policy on top of a $50,000 term policy.

Tax issues for permanent life insurance are more complex, mainly because parts of the premiums are applied to the coverage's cash value. Money applied to the cash value can be invested and grow on a tax-deferred basis. If an employee has access to the cash value and decides to surrender the insurance or borrow from it, a portion of the money will probably be taxed as income. Death benefits, in most cases, will still be tax-free to the beneficiary, and the aforementioned rules for estate taxes will apply.

Permanent life insurance is sometimes a component within a "split-dollar" policy. In a typical split-dollar arrangement, the cost is shared between the employer and the employee. When the employee passes away, the employer receives a refund of its premiums or the policy's cash value, whichever is greater. Any remaining death benefits go to the employee's chosen beneficiary. Tax implications for all parties will depend on how the arrangement is structured. Split-dollar policies deserve to be mentioned in this chapter because of their connection to employers and employees, but be aware that they are generally considered a form of individual life insurance rather than a type of group coverage.

Conclusion

Group life insurance can be a valuable employee benefit, but it shouldn't be offered or accepted without some careful planning. While you encourage an employer to implement a plan, you'll want to make sure the right tax questions are asked and that administrative requirements are considered. While marketing a plan to eligible employees, you'll want to stress the ways in which

the death benefit might fit into their financial goals. By knowing what's available and analyzing the group's situation, you should be able to help people find attractive coverage at an affordable cost.

CHAPTER 6: COVERING YOUR AUTO RISKS

Introduction

In the 1928 campaign for the U.S. presidency, one of the two major political parties assured the public that a vote for its candidate was a vote for "a chicken in every pot and a car in every garage." That pledge reveals just how quickly the automobile had become part of the American dream. Perhaps more so than any other group, people in the United States love their cars and often treat them as status symbols. In some social circles, the kind of vehicle you drive can seem as important as the kind of house you own or the kind of job you have.

Even for the less materialistic among us, car ownership is typically viewed as a necessity. Without our cars, we would find it impractical to live very far from stores, schools or hospitals. We wouldn't be able to juggle as many tasks within our busy day. We'd probably need to rely on our neighbors more often, and we wouldn't feel as independent as we'd like.

The benefits of having a car are so central to our culture that we often come to think of driving as a sacred, uncontestable right. Anyone who doubts the validity of that statement ought to try taking the car keys away from a newly licensed driver or from an elderly person whose sight and reflexes have deteriorated. It's not easy, and even when you succeed at it, the person who is suddenly not allowed to drive might resent you for the major inconvenience.

Still, it is important to remind ourselves from time to time that driving is a privilege and not an absolute entitlement. Drivers who cannot demonstrate an ability to safely operate a vehicle are prohibited from getting behind the wheel, and even safe drivers usually cannot take to the road legally without being covered by insurance.

Given our society's love affair with cars, it's easy to understand why auto insurance is the most popular kind of property and casualty insurance. New policies aren't just being bought by the constant stream of freshly minted drivers. Many drivers look into buying different auto insurance each year.

These days, drivers are turning more and more to the internet to fulfill their insurance needs. In fact, surveys show the number of auto insurance purchases conducted online has surpassed the number of purchases conducted by phone. Yet this shift in delivery methods shouldn't lead you to think it's no longer important for an insurance producer to be knowledgeable about auto-related issues.

Most people who shop for auto insurance online without assistance from a licensed professional tend to shop on price alone. They want the minimum required amount of coverage at the lowest possible price, and they can't be bothered with investigating the potentially important provisions and exclusions found in a coverage form. They'll focus on the size of a quoted premium but won't, for example, think to consider how a policy might cover them in a hit-and-run accident or in a situation in which their spouse has damaged a rental car.

That's where you—an assertive, professional and informed insurance licensee—can be helpful. After reading this chapter, you should have basic knowledge of how to ensure that a driver is well protected against liability and property damage. You should also have a solid understanding of how applicants might obtain that valuable protection at a fair price. And even if you decide not to sell auto insurance, you might become a better shopper for your own coverage.

The Need for Auto Insurance

The cost and frequency of auto accidents have led most states to pass mandatory auto insurance requirements that impact anyone who owns a vehicle. But the truth is, it would still be wise for drivers to purchase auto insurance even if the government didn't force them to do it.

At some point, every driver, regardless of skill or fault, will be involved in an auto accident. Mandatory or not, auto insurance can help people recover financially from accidents. And perhaps just as importantly, it can provide financial assistance to victims who are physically harmed by a driver's mistakes.

Personal Auto Policies

The most common auto insurance policy is the Personal Auto Policy, which was crafted by the Insurance Services Office in the 1970s and has been revised on several occasions. The policy was designed for private passenger vehicles (as opposed to business vehicles) and generally provides four kinds of coverage:

- Liability coverage.
- Medical payments coverage.
- Uninsured motorist coverage.
- Physical damage coverage for the policyholder's own car.

Although each auto insurance policy has the potential to be different from all the others, mastering the contents of the Personal Auto Policy will help you answer common questions from motorists and make it easier for you to assess people's insurance needs.

Liability Coverage

When an auto accident occurs, an insurance company or a court will use common legal standards and state laws to determine who was at fault. When drivers are found to be at fault for an accident, damages are meant to be covered by their liability insurance.

Auto liability insurance covers motorists when they cause another person to suffer bodily injury or property damage. The term "bodily injury" can mean any harm to a person's body, including harm that involves an illness or causes death. "Property damage" usually involves harm to a person's vehicle, but it can also mean harm to other property, such as a house, a tree or items stored in a car.

The liability portion of an auto insurance policy does not compensate at-fault drivers for their own losses. Rather, it only provides money to other people who are harmed by a liable person's driving activities. Coverage for an at-fault driver's own losses is provided in other parts of the policy.

Auto liability insurance compensates victims for the actual size of their economic losses and can also provide money for their pain and suffering. Liability insurance for property damage is often less expensive than liability insurance for bodily injuries, possibly because awards for pain and suffering are less likely when an accident does not result in someone being physically harmed.

Auto liability insurance will also compensate drivers or pedestrians when they are faced with extra costs or losses of income that are thought to be the insured's fault. For example,

the liable driver's insurer will pay for an accident victim's rental car while the victim's regular vehicle is being repaired. Or if the victim is unable to work because of an accident, the at-fault driver's liability insurance should cover the victim's lost wages.

The maximum amount of money an insurance company will pay on account of liability is listed on the policy's declarations page. The limit might be listed as a single dollar amount or as three separate dollar amounts. When the limit is listed in three amounts, the policy is considered to have a "split limit."

A policy with a split limit gives the insured different amounts of liability coverage, with each amount depending on the kind of loss and the number of people who experience that loss. The three different kinds of limits are as follows:

- A limit for all bodily injuries sustained by one person.
- A limit for all bodily injuries sustained in a single accident, regardless of the number of people.
- A limit for all property damage that occurs in a single accident, regardless of the number of people.

To demonstrate how split-limit policies work, let's imagine that Joe has auto liability insurance with a $15,000 per-person limit for bodily injury and a $30,000 per-accident limit for bodily injury. Now suppose Joe causes an accident that results in $30,000 of medical expenses for the other driver. Even though Joe's per-accident limit is $30,000, the fact that his per-person limit is $15,000 means his insurance will cover only half of the victim's expenses in this case. The rest will have to be paid out of Joe's own pocket.

Split-limit policies exist because many states do not make drivers purchase equal amounts of bodily injury liability coverage and property damage liability coverage. Therefore, split-limit policies allow drivers to use their cars without having to purchase coverage that isn't legally necessary.

Still, whether it's accomplished through a split-limit policy or not, drivers might be interested in purchasing more liability insurance than is mandated by law. Since medical expenses and awards for pain and suffering can be so unpredictable, consumer advocates often suggest that drivers purchase liability insurance in an amount equal to the value of their personal assets. Drivers who don't own much but still want to be in a position to fully compensate accident victims will also want to buy extra protection.

Consumers can often opt out of purchasing many major kinds of coverage that are contained in an auto insurance policy, but liability insurance is generally the exception. In most states, people are not allowed to own a vehicle unless they have an acceptable amount of liability protection.

Who's Covered and in Which Cars?

One of the most important things to realize about auto liability insurance is that it doesn't just cover the driver who purchases it. With a few exceptions, the liability protection can apply to accidents caused by the policy's owner or any family members who live with that person. In most auto policies, the term "family member" refers to people who are related to the policy's owner by blood, marriage or adoption. In practice, the term even encompasses unlicensed family members who are too young to drive. People besides family members are covered, too, if they are driving the person's car with permission.

Drivers should also understand that their auto liability insurance extends to cars other than their own. If they borrow a friend's car, their own liability insurance can help pay for damages they cause while driving it. However, coverage beyond their own car generally does not extend to cases in which they are driving a vehicle that is readily available to them on a regular basis, such as a company car.

Liability protection for non-family members (as well as family members who do not live with the policyholder) does not apply if they are driving a vehicle that does not belong to the policyholder. Insurance also rarely offers any help to family members who live with the policyholder but get into accidents in their own cars.

Determining who can be covered under the liability section of an auto insurance policy can be a challenge. Therefore, it may be helpful to go over a few examples. If you have a personal auto policy, here are some hypothetical cases in which your liability insurance is likely to provide at least some financial assistance:

- You hit another vehicle while driving your car.
- Your spouse hits a pedestrian while driving your car.
- Your sister, who lives with you, borrows your car while hers is being repaired and crashes into your neighbor's fence.
- You run over another person's dog while driving a rental car.
- Your friend borrows your car with permission and injures a bicyclist.

On the other hand, here are some examples in which your auto liability insurance probably wouldn't be of much help:

- You injure someone while driving a company car that is frequently available to you.
- Your son, who doesn't live with you, purchases his own car and causes an accident with it.
- A thief steals your car and hits a pedestrian while making his getaway.
- Your roommate rents a car and crashes into your neighbor's tree.

Please note that although auto insurance policies can cover a driver's family members, policyholders may have to inform the insurance company ahead of time about any household family member who will have regular access to their car. Parents, in particular, will want to check in with their auto insurer before giving their children the keys to the family car. At the very least, the policyholder may be required to update the insurer about the number of licensed drivers in a household before the policy is renewed.

Liability Deductibles

When their auto liability insurer provides benefits to an accident victim, at-fault drivers typically do not pay a deductible. This is inconsistent with other types of auto coverage, such as physical damage coverage for an at-fault driver's own vehicle.

Defense Costs

If drivers get into an auto accident and are sued for damages, their insurance company can pay to defend them. Defense costs have no effect on a policy's dollar limit for liability, but there are a few restrictions to be aware of. Most importantly, the insurance company will stop paying for a driver's defense if it has already provided compensation to victims in an amount equal to the policy's benefit limit.

As an example, let's suppose Jill has liability insurance that will pay up to $30,000 for property damage. Jill hits someone's $30,000 car, and her insurer pays for the loss. However, the other driver also claims Jill is responsible for $5,000 in damage to

antiques that were stored in the trunk. Jill disputes this and ends up having to defend herself in court. But since the insurer already compensated the other driver in an amount equal to Jill's limit for property damage liability ($30,000), it will not pay her defense costs.

For defense costs to be covered by the auto insurance company, the legal dispute must relate to a loss that could reasonably be covered under the insurance policy. For instance, legal bills are likely to be covered if drivers accidentally hit another car with their vehicle. But because liability insurance does not protect them when they cause intentional damage, drivers probably would not get help with defense costs after purposely ramming into a spouse's vehicle during a bitter divorce.

In exchange for paying their legal expenses, auto insurance companies expect defendants to help them in matters related to their case. At the very least, potentially liable drivers must send the insurer copies of any legal documents involving a demand for money. They may also be required to attend and make statements at legal proceedings.

If drivers incur expenses as a result of assisting the insurer, the company will reimburse them. Coverage of these expenses, such as the cost of travel or lodging, will have no impact on dollar limits for property damage or bodily injury.

Similarly, drivers can receive up to a few hundred dollars per day if their involvement in the defense process forces them to miss work. Like coverage of extra expenses, this benefit does not affect the overall dollar limits for property damage or bodily injury.

Since the insurer is the one paying the defense costs, it has the power to settle a legal dispute without the insured's permission. If a matter reaches a judge who rules against the insured, the insurance company is also responsible for paying any court-awarded interest that is applied to the victim's losses.

Finally, liability insurance will provide a certain amount of money (often $250) for a bail bond. This provision has no effect on dollar limits for property damage or bodily injury, but it does nothing for a driver if an accident has not occurred. For instance, if a driver runs a red light without hurting anyone and is arrested for arguing with a police officer, money for bail will have to come from another source.

Pain and Suffering

We've already noted that monetary rewards for pain, suffering and other non-economic damages make having adequate liability insurance extremely important. If a driver were to have an accident that causes another person to lose a leg, the driver's financial responsibilities in regard to that person would almost certainly be greater than just the cost of pain medication and a prosthesis. The driver would probably have to pay reparations to the victim for permanently altering his or her quality of life.

Depending on where you live, though, there might be laws in place that prevent some accident victims from seeking payments for pain and suffering. These laws have been put in place to discourage motorists from breaking other laws. For instance, some states do not let a driver sue for non-economic damages if the person does not carry mandatory amounts of auto insurance. Other places forbid people from collecting this kind of compensation if they are hurt while intoxicated or while engaging in illegal activity.

To learn more about restrictions on pain and suffering in your area, you should speak with a local attorney.

Medical Payments Coverage

Medical payments coverage is probably one of the least understood parts of a personal auto insurance policy. In fact, many motorists may not even know they have it.

If you have medical payments coverage, this insurance can be utilized when you, a family member or anyone else who is riding in or driving your car is injured in an accident. Regardless of who is at fault, this coverage is not for the other driver in an accident or for that driver's passengers. Medical payments for the other driver and people riding with that person are meant to be covered by either your liability insurance or the other driver's medical payments coverage.

Medical payments coverage provides a few thousand dollars or more on a per-person, per-accident basis. The money can be used to pay for all reasonable medical or funeral expenses that are related to an auto accident and are incurred within three years of the accident. It does not compensate anyone for pain and suffering.

This traditional form of medical payments coverage usually does not exist in states governed by no-fault insurance laws. Instead, policies in those states are likely to provide "personal injury protection" (PIP) as an endorsement. PIP is very similar to medical payments coverage but can usually reimburse people for expenses besides medical ones. With PIP, injured motorists might be covered for non-medical household assistance while recovering from an accident, and they might receive payments for lost wages.

Who's Covered Where?

As is the case with auto liability insurance, eligibility for medical payments coverage under an auto insurance policy will depend on who the injured person is and where the injury occurs.

Coverage is broadest for the policyholder and the family members who live with that person. With a few exceptions, these people can receive medical payments whenever they are hurt by a vehicle. This includes instances in which they are driving a car, riding as a passenger in a car, sitting in a parked car or hit by a car while traveling on foot.

People besides those family members can receive medical payments through the policyholder's insurance policy if they are injured while in that person's vehicle. This includes when they are driving it, riding in it or just sitting in it. They are not covered by the policyholder's insurance while in someone else's car or on foot.

This part of the policy provides some broad protection, but it does contain some notable exclusions. If you have medical payments coverage, here are a few things to keep in mind:

- There's no coverage if you're hit while driving a vehicle without permission.
- There's no coverage if you're hurt in a vehicle due to nuclear reactions or war.
- There's no coverage if you're hurt in a vehicle at the location of an auto race.
- There's no coverage if your medical bills should be paid by workers compensation laws instead.
- There's no coverage if you're hit by a vehicle while riding something with less than four wheels on it. In effect, this means you might need separate insurance for bicycle accidents.

- There's no coverage if you're injured in your car while transporting goods or passengers for money. In these cases, you'd probably need a commercial auto policy.
- There's no coverage if you're injured while using your vehicle as a residence. In all likelihood, you'd need other insurance if you've parked your recreational vehicle and injured yourself while preparing a meal in it.
- There might not be coverage if you're injured while using your vehicle for business.
- There's no coverage if you're hit by a vehicle that isn't meant to be driven on public roads. Injuries caused by a snowmobile or golf cart, for example, are matters for your health insurer to deal with.
- There might be no coverage if you're hit by your own car. In other words, if your spouse runs over your foot in the driveway, don't count on your auto insurer to pay your bills.

The Pros and Cons of Medical Payments Coverage

Some states make insurers offer medical payments coverage to all their customers, but not every state makes drivers buy it. To help drivers determine if medical payments coverage should be dropped in order to lower premiums, you'll have to know its various pluses and minuses.

Some of the positive aspects of medical payments coverage are listed below:

- Medical payments coverage is no-fault insurance. This means people are eligible for payments from their own insurer regardless of who caused the accident. Unless medical expenses are greater than the benefit limit of the injured person's own policy, there's no need to deal with another driver's insurance company or instigate a messy lawsuit. If the injured person is not at fault for the accident, that person will receive payment from his or her own insurance company. Then the injured person's insurer will work with the at-fault driver's insurer to get its money back.
- Medical payments coverage can pay for things that your health insurance won't, such as funeral expenses.
- Medical payments coverage is available for drivers who can't afford or qualify for regular health insurance.

In spite of those attractive features, there are a few reasons why a driver might opt against paying for this insurance:

- Unlike health insurance, medical payments coverage only pays for treatment related to auto accidents.
- Most people already have health insurance that would cover injuries from an auto accident. If injuries are covered by a health plan, a person can't file a claim with the health plan and then use medical payments coverage to pay for non-medical expenses.

Uninsured Motorist Coverage

Whether we like it or not, there will always be people who believe the law does not apply to them and who will drive without liability insurance.

So what can people do if an uninsured driver hits them? They could, of course, sue the person. But that would probably involve finding a lawyer and rearranging their lives around court dates and other hassles. And even if they take legal action, victims might discover that the at-fault driver lacks enough personal assets to pay for damages in the first place.

A portion of an auto policy known as "uninsured motorist coverage" can help in situations like this one. It makes up for the liability coverage the other driver failed to purchase and can compensate victims for bodily injuries, pain, suffering, and (in some cases) property damage. It doesn't let the at-fault driver off the hook, but it gives injured people the money they need with a minimal amount of effort and frees their insurer to take action against the negligent motorist.

Auto insurers provide these benefits if any of the following circumstances arise:

- The policyholder is hit by someone who has no insurance.
- The policyholder is hit by someone who has less insurance than the law requires.
- The policyholder is the victim of a hit-and-run accident.
- The policyholder is hit by someone whose insurer becomes insolvent.

Uninsured motorist coverage is limited to a certain amount per person, per accident. By default, the benefit limit might be equal to the minimum amount of liability coverage that the other driver was required to buy. But drivers often have the option of raising the limit if they're willing to pay more in premiums. Some states require that insurers provide uninsured motorist coverage equal to a victim's own liability coverage.

Overall, the kinds of people and the situations that would be covered under the medical payments portion of an auto policy would also be protected by uninsured motorist coverage. If the policyholder or that person's family members are hurt by an uninsured vehicle while in any car or while on foot, they'll probably receive some insurance money. Non-family members (and family members who don't live with the policyholder) are also eligible for these benefits if they are hit while in the policyholder's car.

Policy exclusions for uninsured motorist coverage are nearly identical to those for medical payments coverage. For instance, drivers won't be helped if they're hit while carrying goods or people for money, and they aren't covered for accidents caused by snowmobiles, golf carts and similar vehicles. The main difference, though, is that uninsured motorist coverage is not no-fault insurance. In order to receive payments, the insured must convince the insurance company that damages were caused by someone else.

Uninsured motorist coverage is mandatory in about half of the country, and most states at least force insurers to offer it. Historically, those mandates have been restricted to bodily injury coverage, but coverage for property damage has become more popular over the last few decades.

Some consumers decline uninsured motorist coverage because they doubt they will be injured by an uninsured driver. Others opt for the injury protection but ignore the property protection because their car's value doesn't justify the expense. You'll learn much more about covering a driver's own car in later portions of this course.

Underinsured Motorist Coverage

A somewhat similar policy feature known as "underinsured motorist coverage" can help when an at-fault driver has the required minimum amount of liability coverage but still lacks enough to fully compensate a victim. When this coverage is purchased, the victim may be entitled to the difference between his or her losses and the other driver's liability limit.

For example, let's assume George has $100,000 of underinsured motorist coverage and gets into an accident that costs him $70,000 in medical services. The at-fault driver has complied with the law by purchasing $30,000 of liability insurance for bodily injuries, but this person obviously does not have enough to pay for all of George's medical bills. In this case, the other driver would pay his full $30,000 to George, and George's underinsured motorist coverage would handle the additional $40,000 (the difference between George's loss and the other driver's liability limit).

Although our example might make underinsured motorist coverage seem very simple, some important conditions must be met for the insurance to work. Most significantly, the victim's limit for underinsured motorist coverage usually must be greater than the at-fault driver's liability limit. If the victim has $100,000 in underinsured motorist coverage and the at-fault driver has $100,000 in liability coverage, this part of the victim's policy is likely to be irrelevant. Also, depending on the policy, underinsured motorist coverage might need to be equal to uninsured motorist coverage.

In most states, underinsured motorist coverage must be offered to all policyholders. However, in nearly every part of the country, drivers have the right to reject it. A few states only require that underinsured motorist coverage be included if the policyholder has also purchased a certain amount of uninsured motorist coverage.

Unsatisfied Judgment Funds

Though not mentioned in auto insurance policies, unsatisfied judgment funds might be a last resort for accident victims who are hurt by uninsured drivers. Where available, these state-created funds provide compensation to injured people. They may be funded in a number of ways, including through the sale of license plates or through assessment fees from insurers. When a victim receives money from one of these funds, the at-fault driver may be barred from operating a vehicle until the money is paid back.

Physical Damage Coverage for Your Own Car

In addition to providing important liability protection, auto insurance policies can cover damage to a driver's own car. Like the medical payments coverage mentioned earlier, this insurance can reimburse drivers regardless of who is responsible for an accident. If the policyholder files a property insurance claim for damage to his or her vehicle and the other driver was at fault, the policyholder's insurer can pay the claim and take actions against the other driver to get its money back.

Physical damage coverage insurance for a driver's own car comes in two varieties. "Collision coverage" pays for damage from crashes. "Comprehensive" (or "other-than-collision") coverage protects the policyholder financially from many other perils, including theft and fire (often any peril other than those excluded by the policy).

These two kinds of protection can be purchased individually or together. When both are in effect, a car is generally insured against most risks other than some tire damage, war-related losses, wear and tear and freezing.

Unlike other portions of the typical auto policy, insurance for physical damage to a driver's car usually calls for a deductible, which must be paid by the policyholder whenever an accident occurs. If multiple cars are involved in the same accident and are covered by the same policy, the deductible only needs to be paid once. If the insurance company takes action against the other driver and wins, the deductible will usually be refunded to the policyholder.

Unlike liability insurance, property insurance on a driver's own car is usually optional. In fact, many of the low auto rates advertised online and on television are quoted under the assumption that the customer will not insure his or her own vehicle against theft or property damage.

Opting against physical damage insurance for their own car does not prevent drivers from collecting from an at-fault driver's policy. However, it does bar them from receiving compensation for property damage if their car is damaged through no fault of another person. For instance, they would not be covered for repairs if they rear-end another car while following it too closely, and they probably wouldn't be compensated for their losses after skidding into a ditch or hitting a deer.

Drivers who don't insure their own cars against property damage aren't necessarily ignoring the probability of getting into an accident. In many cases, they might just already be aware that their car is constantly depreciating in value and that the cost of insuring their vehicle (plus the size of their deductible) exceeds whatever benefits they are likely to receive from their insurance company. Old cars, in particular, are often not insured for property damage unless the owner is fearful of even a relatively small loss.

Collision Coverage

As you can probably tell from its name, "collision coverage" is for damage that is sustained when a car collides with another object. Of course, the most obvious kind of object in this case would be another vehicle, but other kinds of crashes are covered, too. For instance, this insurance is likely to come into play when a driver hits a tree or crashes into a telephone pole.

We tend to think of car crashes in terms of two or more vehicles being in motion at the same time, but collision coverage can still apply while a vehicle is stationary. If someone opens a car door in traffic and has it knocked off by another vehicle, a collision has taken place. The same is true when someone hits a parked car.

Practically the only thing a driver can hit and not have the situation count as a collision is an animal. Collisions with deer and other living things are addressed through comprehensive/other-than-collision coverage.

Comprehensive/Other-Than-Collision Coverage

"Comprehensive coverage" (now often referred to as "other-than-collision coverage") tends to be cheaper than collision insurance and protects the driver against more perils. Generally speaking, comprehensive insurance is designed to cover the driver against most major risks other than collisions. Drivers who purchase this insurance are typically insured against the following causes of loss plus more:

- Theft (including property damage caused by thieves).
- Fire.
- Falling objects.
- Missiles.
- Explosions.
- Earthquakes.
- Wind.
- Hail.
- Floods.
- Vandalism or malicious mischief.

- Riots or civil commotions.
- Collisions with animals and birds.
- Broken glass.

Depending on the circumstances, broken glass can actually be covered by either comprehensive insurance or collision insurance. Broken glass that occurs because of a collision can be covered by collision insurance at the policyholder's option. This might be done in situations where a person has separate deductibles for collision coverage and comprehensive coverage and does not want to pay both of them on account of a single accident.

Actual Cash Value

If something destroys a car, the owner's insurance company is nearly guaranteed to not cover the cost of a brand-new replacement vehicle. Instead, the car is probably covered up to its "actual cash value."

An item's actual cash value is its replacement cost minus depreciation. Since cars depreciate as soon as they're purchased, a vehicle's actual cash value might be significantly smaller than the owner realizes.

When a car is damaged, the owner's insurance company is expected to pay the cost to repair the vehicle, the cost to replace the vehicle or the vehicle's actual cash value. If these amounts are not equal (and they rarely are), the owner will receive the lowest of the three amounts.

Due to the rapid rate of depreciation, the cost of repairing a vehicle might be higher than the car's actual cash value. When this happens, the car is considered to be a total loss ("totaled") even if it is technically still in drivable condition. Instead of repairing it, the insurer will pay the owner the actual cash value.

If a vehicle is totaled, the insurer might reserve the right to take possession of it and sell it to a salvage yard or a similar business. The owner might have the opportunity to keep the vehicle for sentimental reasons, but the insurer might be able to deduct whatever amount it would have gotten from the salvage company from the settlement check.

Though relatively rare, some policies will cover an automobile at its replacement cost rather than its actual cash value. Special riders are also available for owners of restored classic cars.

Auto Accessories

Modern automobiles have more nifty gadgets in them than ever before. A music lover might have a custom-made stereo system in his car. A mother might have a television in the backseat to entertain her children. A father might have a GPS system installed to help him find the location of his daughter's volleyball game. Some of these conveniences aren't cheap, so you might be surprised to learn that they tend to receive little protection under most auto insurance policies.

As a general rule, accessories like the ones mentioned above might be covered by a personal auto policy only if they are permanently installed in the vehicle. Whereas a radio that was put inside the car at the automotive factory will probably be covered if it is stolen, the same cannot be said for a personal MP3 player that is hooked up to the car via an adapter. Even covered items might be limited to a certain amount of coverage.

Items meant to be played on audiovisual equipment, such as cassettes, compact discs and DVDs, are excluded from coverage in most policies. Limited coverage for these items might be found in a homeowners insurance policy. Alternatively, it may be possible for a driver to add them to an auto policy at an additional cost.

Creditors and Gap Insurance

Up to now, we've been exploring auto insurance as if the policyholder were the outright owner of a vehicle. If a policyholder doesn't exactly own his or her car and purchased it with borrowed money, there are some additional coverage issues to consider.

In order to protect their interest in your car, lenders can list themselves on an auto insurance policy along with the driver. When this is done, their names can also appear on any checks the driver receives from the insurance company.

We noted earlier that physical damage coverage for a driver's own car is optional. Yet there is an exception when a vehicle is purchased with a lender's financial assistance. Until their auto loans are repaid in full, borrowers are required to maintain full coverage on their vehicles, including collision coverage and comprehensive coverage. Deductibles for property damage can be chosen by the lender.

When a vehicle is totaled and a driver is left without transportation, a lender will not forgive the debt out of sympathy. The driver remains responsible for the loan balance even if the vehicle's actual cash value (received as compensation from the insurance company) is less than the remainder of the loan.

To guard against this undesirable situation, a driver can purchase "gap insurance," which covers the difference between the remaining loan balance and the totaled vehicle's actual cash value. If a car is leased, the driver might already be paying for this insurance in the form of a built-in fee.

Kinds of Covered Autos

The auto market is loaded with many varieties of vehicles. A driver might own a station wagon for personal use, a truck for business use and a sport-utility vehicle for both. One way or another, all of those vehicles need to be insured.

Let's spend a few pages going over how insurers typically address these assorted vehicles, with a special emphasis on the distinction between personal vehicles and business vehicles.

Personal Autos

The standard personal auto insurance policy can be used to cover just about any kind of four-wheel vehicle that a person owns and reserves for personal use. For insurance purposes, a leased vehicle can be insured as if it were the driver's own car if it is being leased for at least six months.

Though there are many situations in which an insurer will pay for damages associated with a car that doesn't belong to the policyholder, a personal auto policy probably doesn't cover that kind of vehicle as comprehensively as it covers the person's "covered auto." In personal auto insurance policies, all of the following vehicles tend to qualify as a "covered auto":

- The vehicle listed on the policy's declarations page. (This is probably the vehicle that prompted the policyholder to purchase a policy in the first place.)
- Any other vehicle the policyholder obtains during the policy period. (This allows someone to buy a second car without having to tell the insurer ahead of time. Details can be found in the next section.)
- A vehicle the policyholder uses on a temporary basis while the person's regular car is not available.

- A trailer meant to be pulled by an automobile. (Trailers are covered automatically in regard to liability, but damage to them is not. To ensure that property damage to trailers is a covered loss, ownership must be declared prior to an accident.)

Vans and trucks can be covered by a personal auto policy as long as they weigh less than 10,000 pounds and are not used as delivery vehicles. When these larger autos do not meet those criteria, they may be covered by a commercial policy.

Unless a driver pays an additional premium for the proper endorsement, vehicles with fewer than four wheels, such as motorcycles, will have to be insured by something other than a personal auto policy. That said, the policyholder remains covered for liability while operating one of these vehicles in an emergency.

Coverage for New Vehicles

If a driver already has a personal auto policy, most new vehicles that the person buys during the policy period will be covered automatically. This ensures that currently insured drivers can buy new cars and drive them out of a dealer's lot without being in violation of the law.

Replacement Vehicles

When drivers replace a car that was covered by their auto insurance policy, their new vehicle automatically receives the same amount of liability coverage as their old one. Their new car is often covered by liability insurance for 14 days even if they don't tell the insurer about their purchase.

Drivers will be covered for physical damage to their replacement vehicle automatically for a limited time if their old car was also covered for the same kind of damage. In other words, if the old car was insured against collision losses, the new vehicle will be covered for those losses, too. This temporary coverage tends to last anywhere from a few weeks to a month depending on the policy. In order for physical damage to be covered for a longer period, the owner must contact the insurance company.

If the driver's previous car was not covered for physical damage, physical damage to the replacement vehicle will probably be covered for no more than a few days. Damage that occurs during that brief period might only be covered if the policyholder satisfies a deductible. If owners want coverage to extend beyond that short time, they must make arrangements with the insurance company.

Additional Vehicles

When people buy a new car without replacing another one, their liability limit for the car will automatically be equal to the highest liability limit among their other cars. For example, if Ellen already owns one vehicle covered by $100,000 of liability insurance and another car with $50,000 of liability insurance on it, her third car will temporarily be covered by $100,000 of liability insurance. In order to maintain this liability insurance on the additional vehicle, Ellen must contact the insurer within a set number of days (often 14 or 30).

Physical damage to an additional car is basically treated in the same way as physical damage to a replacement car. If any of a driver's other cars are covered for physical damage, an additional vehicle will be covered, too, if an accident occurs soon after the purchase. This insurance probably won't continue beyond a few weeks unless the owner specifically requests it.

If none of a driver's other cars are covered for physical damage, physical damage to an additional vehicle will probably be covered for no more than a few days. Damage that occurs during that brief period will only be covered if the policyholder satisfies a deductible. If owners want coverage to extend beyond that short time, they must make arrangements with the insurance company.

Driving Other People's Cars

As you already know, drivers remain insured while driving other people's cars with their permission. If a driver is involved in an accident while operating someone else's vehicle, the owner's insurance will usually pay for damages first. The driver's insurance will pick up whatever losses are above the owner's policy limits.

If drivers are involved in an accident while driving a vehicle that is not theirs but is regularly available to them (such as a company car), their auto insurer will probably not cover the losses. However, they still remain insured while driving a vehicle that is regularly available and owned by a household family member. So if spouses have separate auto insurance policies, they can borrow each other's cars without having to worry about being covered.

Rental Cars

Many travelers are unsure about whether they should purchase insurance from rental car companies. The decision to buy or not to buy the coverage is often made at the last minute, with some people choosing to leave themselves unprotected from major risks and others paying relatively large sums of money for something they don't really need.

Whether coverage is purchased or not, drivers should definitely consider the risks involved with rented vehicles. If someone has an accident with one of its cars, the rental company might be able to hold the person liable for all the damages regardless of who was at fault. Along with having to pay for another person's injuries and damage to any vehicles involved, the renter can even be held accountable for loss-of-use costs if the accident leaves the rental company without enough cars to meet customer demand. (It should be noted, however, that some states have passed laws that limit a person's liability while operating rented vehicles.)

Many of these risks can be managed by purchasing a "collision-damage waiver" (also known as a "loss-damage waiver") from the rental company. But such waivers might not always be helpful. For example, some waivers still leave renters liable for damages if they let a companion take the wheel or if they drive the rental car through rough road conditions. The waivers are also relatively expensive. If drivers buy all the insurance presented to them by the rental company, they might end up paying more for coverage than for use of the vehicle.

Before purchasing a waiver, drivers might want to see if the risks of renting a car are covered by other insurance. If they have a personal auto policy, they are usually already covered for liability while operating a rental car. Most kinds of damage to the car will be covered, too, if renters have collision coverage and comprehensive coverage for their own vehicles. Bodily injuries that drivers suffer in an accident will fall under their auto policy's medical payments coverage, and homeowners or renters insurance should cover any belongings damaged in the car.

Once drivers know how their own insurer treats rental cars, they can contact their credit card company and inquire about any additional protection. Most card companies provide free insurance for rental cars if the driver's own policy is insufficient. Of course, in order to receive insurance benefits from a particular

creditor, the driver must pay for the rental with the appropriate credit card.

The options available from a renter's auto insurer and credit card company might make coverage from the rental company seem pointless, but these sources of protection do have some limitations. Some of the potential problems with auto insurance or free coverage from a credit card company are listed below and might be avoided by purchasing a loss-damage waiver:

- A personal auto policy might not cover a rental car if it is being used for business purposes.
- Coverage for a rental car might be limited to a specific number of consecutive days.
- A personal auto policy usually doesn't cover vehicles rented outside of the United States and Canada. Credit card companies offer broader protection but still tend to exclude vehicles in certain countries.

Business Vehicles

Personal auto policies are meant to cover people's personal vehicles. Coverage for automobiles that are used in business is either excluded from these policies outright or is only provided on a limited basis.

Admittedly, some circumstances that are indirectly related to business are not excluded under most policies. Driving to and from work is generally not considered a business activity, so a driver remains covered by his or her own policy while performing those tasks. Similarly, it is possible for an employee to remain covered by a personal auto policy while running an occasional errand for an employer in his or her own car.

Still, there are plenty of business-related exclusions that ought to be mentioned here. To manage these risks and avoid confusion, people who use their cars in business may want to purchase a commercial auto policy:

- Vehicles owned by a company or some other business-related entity (other than an automobile from a rental company) are usually not covered by a personal auto policy if they are regularly available to an employee.
- Drivers are not covered while using their personal auto to carry people or things for a fee. (For example, this exclusion has been known to cause problems for drivers who use their personal vehicle to deliver food. Whereas some insurers don't view this type of delivery as "business," others disagree.)
- A personal auto policy doesn't cover liability while a car is being operated by someone in the course of auto-related business. (For example, a mechanic probably isn't covered while road-testing a vehicle, and a valet might not be covered while parking a car.)

For specifics about business auto coverage, you may want to review the ISO's Business Auto Coverage Form.

Carpools

As a way to save on gas and share the stress involved with their daily commute, some employees band together and transport one another in one car. If drivers use their own vehicle as part of a carpool and take money from passengers, their personal auto insurance remains in force. This is an exception to the general rule regarding business vehicles, which forbids people from being covered while transporting people for a fee.

Exclusions

Personal auto policies have several exclusions besides the ones involving business vehicles. As is the case with all other kinds of insurance, making applicants aware of these gaps in coverage early in the buying process can reduce the chances of conflict between carriers and consumers at claim time. The most significant exclusions in the typical auto insurance policy are explained in the next several sections.

Wear and Tear

Automobiles don't remain in good condition forever. Parts periodically need replacing. Exterior features sometimes need retouching. Repairs and tune-ups are inevitable, and they can be expensive.

Unfortunately for owners, trips to the mechanic and all the costs of parts and labor are generally not covered by auto insurance unless they are needed after an auto accident. Coverage of weather-related damage and theft are probably the closest a policy comes to protecting an owner against perils other than accidents, and even those protections are only available to people with comprehensive coverage.

Intentional Acts

As should be expected, auto insurers will not compensate a driver who intentionally causes an accident. If drivers intentionally hit someone with their car, they will be stuck paying for their own property damage and medical expenses, as well as any other reparations that are awarded to the victim.

Driving Without Permission

Auto insurance doesn't cover people when they drive another person's car without permission. This exclusion often does not apply when the driver and the owner are relatives living in the same house.

Damage to Non-Auto Property

Other than the vehicle itself, property that a driver owns or is in the driver's possession at the time of an accident is not covered by auto insurance. For example, if a driver leaves a suitcase in a car and it is damaged by fire, the insurance company will not pay to replace it. Likewise, if a friend leaves a computer in a driver's car and it is damaged in a fire, the driver is not covered by auto liability insurance if the friend decides to sue. Personal belongings ought to be covered by some form of homeowners insurance or other type of personal property insurance.

In regard to liability, this exclusion does not apply to a home or garage. If the policyholder is renting another person's house and crashes into it with her car, her auto insurer can still pay for the homeowner's losses and handle the driver's defense costs.

Wars and Nuclear Accidents

Drivers are not covered for medical payments or property damage if an accident occurs because of war or a nuclear attack. In a somewhat related matter, the Terrorism Risk Insurance Act of 2002 required commercial auto insurers to offer government-backed terrorism coverage to their customers, but this requirement ended when Congress revised the law in 2005. The law is not applicable to personal autos.

Other Restrictions

Finally, personal auto insurance typically does not cover people for liability and/or property damage in the following situations:

- When the government seizes or destroys their car.
- When they are involved in an accident while engaging in an automobile race.
- When they are acting as an employer and are liable for an employee's injuries.

Underwriting Factors

When evaluating an applicant for auto insurance, underwriters might consider hundreds of pieces of information. Certain characteristics of a particular driver can have an impact on the price of coverage, the availability of coverage or both, depending on the company and what is allowed under state law.

Since each piece of information about a driver may be weighted differently by each insurer, it is impossible to make concrete statements here about how much insurance will cost for a specific person or who will or will not be eligible for coverage in the first place. Nevertheless, we can make some general statements about the kinds of information that auto underwriters consider favorable and the kinds that make them nervous.

As we go over some of the more common underwriting factors in the auto insurance industry, keep in mind that a person's eligibility for affordable coverage can be impacted greatly by major life changes. So even if a consumer is not interested in shopping around for a new policy prior to every renewal period, it may be wise for people to at least get a few new quotes when they move, change jobs, retire or get married. The reasons behind that strategy, as well as other potentially useful information, are explained in the next several sections.

Driving Record

For obvious reasons, a person's driving record is one of the most important influences on the price of auto insurance. From an insurer's point of view, getting into a recent accident increases the likelihood of being involved in future accidents.

When calculating premiums, an auto insurer will examine an applicant's driving record over a set period of time (usually three years) and take note of any moving violations or any accidents for which the person was at fault. If family members in the same household have regular access to the person's car, their records will be examined, too.

Each blemish on someone's driving record is worth a certain number of points, and each additional point will increase the cost of coverage. The number of points for an accident or violation will depend on the severity of the event. Whereas getting a ticket for a broken taillight might be worth only a few points, being convicted of drunk driving or involuntary manslaughter with a vehicle will be worth several points and will seriously jeopardize a person's insurance status. Drivers may also be charged points if the damage they cause exceeds certain dollar thresholds.

Some policies contain "accident forgiveness" features, which permit drivers to get into the occasional accident without having it affect their insurance costs. For instance, policyholders might pay a little more in order to obtain a policy that gives them one free accident or moving violation from the start of the policy period, or they might be rewarded with a free accident or moving violation after compiling a clean driving record over a number of years.

Applicants should not try to hide past accidents from the insurance company. Insurers have access to state driving records as well as accident information from industry databases. If drivers lie about their record and are found out, the insurer might have the right to cancel coverage.

To an extent, not having a driving record is almost as bad as having a poor one. If an applicant has never had a license, an insurance company will not assume the person is safe and will charge him or her more for insurance than someone with years of experience. Be warned, though, that while experience can be used as an underwriting factor, it is illegal in some states to base an underwriting decision on the fact that a person has never had their own auto insurance. This might be an important point for younger drivers who have been covered by their parents' insurance.

Vehicle's Age, Make and Model

Despite the importance of a person's driving record in calculating auto insurance premiums, two equally skilled drivers can still expect to pay different amounts for insurance. This disparity is likely because insurance companies care not only about who is driving a vehicle, but also about the vehicle's characteristics.

When faced with insuring two similar vehicles, insurers will charge less for the older one. The vehicle's age matters because cars depreciate in value over time. A greatly depreciated vehicle will have a relatively low actual cash value, and a relatively low actual cash value means the insurer won't have to pay much if the vehicle is a total loss.

Of course, two different cars can have the same age and still have significantly different actual cash values. Since new luxurious cars can be worth so much more than the average automobile, they can have a large actual cash value even after a few years of depreciation. So, all else being equal, it would probably cost more to insure a five-year-old Rolls Royce than a five-year old Volkswagen Beetle.

When a driver chooses comprehensive coverage, an underwriter won't just be thinking about actual cash values in terms of accidents. The likelihood of theft will also be a concern. Though there are other factors (including location) that can help people calculate the probability of a car being stolen, the vehicle's make and model is certainly part of the equation. In part because of the difference in actual cash value, a sports car will almost always be more attractive to a criminal than a station wagon. Therefore, the owner of the sports car who wants comprehensive insurance will have a higher insurance bill.

A few insurers have even suggested that the kind of car people drive says something about their behavior on the road. For instance, beginning in the 21st century, some companies determined there may be a link between being environmentally responsible and being a careful driver. This has sometimes led to discounts for owners of hybrid vehicles.

Part of being a safe driver, though, entails making sure that you're driving a relatively safe machine. A vehicle that can't withstand much impact puts drivers' health at risk and won't score them any points with their insurance company. Cars that go above and beyond safety standards should be involved in fewer accidents and might be insurable at a reduced price.

Vehicle Location

For many auto insurers, the first underwriting factor to consider when calculating an appropriate premium is the location of the vehicle. For the sake of practicality and because so many auto accidents occur close to home, the insurer will care more about where a car is typically garaged than where it is being driven.

Insurers formulate different rates for different geographic areas. More often than not, the insurer will use a different rate for each ZIP code. Rates for city dwellers tend to be higher than rates for

people in rural areas. This reflects the greater amount of traffic in urban communities, as well as the higher frequency of theft. Other geographic factors that may be considered include the rate of uninsured drivers in the area and the effect local weather has on road conditions.

Underwriting on a geographical basis has become somewhat controversial in the last few decades due to the demographics of many cities. Since low-income minorities are more likely to live in urban neighborhoods, some critics of the industry wonder if using location to set rates is unfairly discriminatory.

This practice, known as "territorial rating," is allowed across the country, but states have addressed some of the discrimination-related concerns by putting limits on its use. In some areas, insurers may only take a driver's location into consideration if other factors, such as one's driving record, are more important in the determining of premiums. If an insurer wants to use territorial rating to calculate premiums, it generally cannot just draw lines on maps and charge higher premiums in whichever neighborhood it wants. Insurance regulators must first agree that a particular area is eligible for its own rating.

Miles Driven

Since the likelihood of having an accident increases the longer someone is in traffic, the number of miles driven can affect a person's premiums. To determine the appropriate rate, an insurance company will ask applicants to estimate how often they use their cars. If an applicant is unemployed or uses alternative transportation to get to work, premiums will probably be lower than for someone who drives a few miles each day to get to the office. Similarly, someone who drives just a few miles to get to work might be charged less than a coworker whose daily commute is 50 miles.

Yearly estimates from drivers, though, aren't always accurate, and some of the traditional ways of underwriting based on mileage have not always benefited people who drive less than the average person. In response to those concerns, a few insurers in several states have begun offering "pay-as-you-drive" coverage, which allows an insured's premiums to go up or down depending on the actual number of miles they have recently driven. When a driver is approved for this coverage, a GPS-like device is sometimes installed in the covered auto, and the technology sends periodic readings to the company. While some of these devices are also used to judge whether a driver is obeying speed limits and demonstrating other signs of responsible driving, they are not designed to track a vehicle's location.

Proponents of pay-as-you-drive products argue that the coverage incorporates societal benefits, as well as money-saving opportunities for consumers. According to the Brookings Institution, a nationwide switch to a pay-as-you-drive system would encourage people to drive less and could result in roughly $50 billion in savings by reducing traffic, cutting pollution, lowering the amount of accidents and lessening dependence on fossil fuels.

Detractors worry that allowing insurers to collect mileage data in such a direct manner could put drivers' privacy at risk. Due to those concerns or just the relative newness of the concept, pay-as-you-drive insurance was not available in every state when this course was being written.

Age of the Driver

A combination of experience, maturity and health makes age an important underwriting factor at certain points in a driver's life. When allowed by insurance regulators, an auto insurer will rate drivers depending on what age range they fit into. This practice results in higher premiums for people at opposite ends of the spectrum, namely people who are either younger than 25 or older than 70.

Despite the widespread use of age as an underwriting factor in many parts of the country, a fair warning is in order. A few states allow insurers to base premiums on a driver's experience but do not let insurers consider a person's age.

Insurance for Young Drivers

Younger drivers pay the most for auto insurance because they are the ones who are most likely to be involved in auto accidents. The Insurance Institute for Highways Safety has said that drivers between the ages of 16 and 20 are involved in more accidents per mile than people in any other age range and that car crashes are the number-one cause of death among teenagers. Statistics also show that most teenagers who die in car crashes as passengers were being driven by someone in the same age group.

Statistics like those explain why adding a teenager as a regular driver on an auto insurance policy can often double the size of a parent's premiums. Still, the cost of adding a teenager to a parent's insurance is usually cheaper than insuring a young person through a separate policy. By adding a child to their insurance, parents with a respectable driving record will cancel out some of the high risk associated with a new driver. Also, if parents purchase a separate car for their child and insure it under their policy, they might benefit from a multi-car discount.

Even though personal auto insurance will often cover people who occasionally borrow a policyholder's car, parents should contact their insurer before giving a child regular access to a vehicle. In most cases, notice can be given once a teenager becomes licensed rather than at the time he or she is issued a learners permit. At the very least, policyholders may be required to report any newly licensed drivers in their household when coverage is being renewed.

Unlike health insurance and homeowners insurance policies, auto insurance policies do not have an age limit for sons and daughters who are protected by their parents' coverage. All that matters is that the son or daughter is licensed and lives in the same household. If a son or daughter is temporarily away at school, the student can still be considered an insured member of the household, as long as the child's primary residence is with his or her family. However, the insurer should be contacted about this issue, especially if the child will be taking a vehicle to school.

Auto insurance for young drivers is expensive, but there are many ways for new motorists and their parents to cut down some of the cost. Here are a few of the most common price-reducing strategies for consumers:

- Tell the insurer if the son or daughter has at least a "B" average or has received any academic honors at school. Since good students are considered safer drivers, most companies will give a teenager a discount if academic achievements can be verified.
- Tell the insurer if the son or daughter is attending school away from home and not using a car while there. Discounts are usually available if a student lives more

than 100 miles away during the academic year and only drives the family car during break periods.
- In case a discount is available, tell the insurer if the son or daughter has successfully completed a defensive driving course.
- If a family owns more than one vehicle, consider only allowing the son or daughter to use the vehicle with the lowest actual cash value.
- If parents are in a position to choose a car for their son or daughter, they should consider a dependable, non-flashy one that is less likely to encourage reckless driving.

Insurance for Older Drivers

People with good driving records will usually not be subjected to age-related penalties once they reach their late 20s. As they gain more and more experience and are therefore deemed more responsible, they may even qualify for a special senior discount during late middle-age.

Where available, age-related senior discounts on auto insurance are unlikely to be extended to people who are in their 70s or older. Though these older drivers tend to drive less than other adults and are still statistically safer than teenagers, accident rates are relatively high in this age group on account of health issues. Seniors who are interested in reducing their auto insurance costs might benefit from taking a defensive driving course.

Credit Scores

Examining an applicant's credit history has been commonplace in the lending industry for as long as anyone can remember. Since the 1990s, many auto insurers have done it, too, believing that people's ability to meet financial obligations says something about the number of claims they're likely to make.

In most states, what a driver pays for auto insurance can depend on something known as an "insurance score." Insurance scores are similar to the credit scores available from any of the three major credit bureaus. They tend to reflect the kinds of debts people have, the amount of credit available to them and many other variables related to a driver's financial situation.

However, even though an insurance score and a credit score can relate to the same data, a formula for computing a credit score might weigh each piece of data differently than a formula for computing an insurance score. As a result, it is technically possible to have a high credit score but a low insurance score, and vice versa. Each insurer might have its own way of calculating an insurance score, and the specifics behind that method are unlikely to be disclosed to consumers.

Through its increased emphasis on insurance scores, the industry has argued that a driver with a poor credit history represents a bigger risk than a driver with a good credit history. While studies show there seems to be a link between bad credit and insurance claims, the reason for that link is unclear. Some of the theories that have been proposed over the years include the following:

- If drivers have bad credit, they might not have the money to properly maintain their vehicle, which could lead to accidents.
- If drivers have bad credit, they might not have the money to pay for relatively minor auto accidents, which puts a greater burden on their insurer.
- If drivers have bad credit, they might be tempted to commit insurance fraud.

Many drivers have been rewarded with lower premiums because of their high insurance scores. Nevertheless, the use of credit as an underwriting factor has pitted insurance companies against many consumer advocates.

Those opposed to insurance scoring question what a person's credit has to do with their ability to operate a vehicle safely. Is it fair when a scoring system forces a driver with bad credit but no accidents to pay more for auto insurance than someone with one accident and a positive credit history? And what about people who have bad credit due in large part to a job loss, or a person who has a thin credit history due to a general preference for cash and living within one's means? Are these people less deserving of affordable auto insurance than the rest of us?

The use of credit-based underwriting has also led to accusations of indirect discrimination. Though insurance scoring is not supposed to take a person's race, ethnicity or income into account, studies have shown that racial and ethnic minorities and low-income people are disproportionately likely to have lower insurance scores.

Congress has considered bills from time to time that would put major restrictions or an outright ban on credit-based underwriting in the insurance industry, and nearly every state has implemented limits of its own. For example, California generally prohibits auto insurers from using credit as a factor when underwriting or pricing coverage. In many other states, insurance scores are allowed but cannot be used as the sole reason for raising premiums or rejecting an applicant. Questions about what is specifically permissible on a state level ought to be answered by an expert in your community.

Gender

In states where insurers can use gender to set auto insurance rates, pricing tends to favor women. Numbers reported in the Journal of Insurance Regulation show that despite a nearly equal amount of drivers, men cause slightly more accidents than women and are responsible for nearly three-fourths of auto fatalities.

Marital Status

Though there does not appear to be much difference among women, a young married man is likely to have less accidents than a young single man and, therefore, will often pay less for auto insurance. If he is married with children, he may represent an even better risk. However, not every state allows insurers to use marital status as a factor in determining rates or offering coverage.

Other Factors

We've touched on some of the most common pieces of information that can influence a driver's auto insurance costs, but there are many more that an insurer might consider. Like the factors we have already mentioned, some of them are within the driver's control and some are not.

Depending on the insurer, answers to the following questions might influence a driver's premiums:

- Does the person usually drive during rush hour or late at night?
- Has the insurer lost a lot of money recently because of fraud committed by consumers?
- Is the insurer losing money because of increases in the cost of medical care or car repairs?

- What is the driver's occupation? (Some companies have been known to charge less if a driver has a white-collar job.)
- What is the driver's education level? (At some companies, drivers will be viewed more favorably if they've had a lot of schooling.)
- Is there evidence to suggest that the driver has operated a vehicle without insurance? (Some companies might be less inclined to insure someone who had insurance in the past, canceled it and is reapplying for coverage after a significant gap in time. However, this practice is illegal in some states.)

After an Accident

Being in an auto accident can be inconvenient to say the least. Besides the possible anger and physical pain that might be caused by a collision, affected drivers might be extremely concerned about how they will get their vehicle fixed and whether they will end up being involved in a lawsuit.

Drivers who are already aware of what to do after an accident are likely to experience less stress when one actually occurs. With this in mind, you may find it helpful to review what services an insurer owes to a policyholder after a loss and what a policyholder owes to an insurer.

Transportation Expenses

If drivers are in an accident and are unharmed, their most immediate problem might be how to get around while their vehicle is being repaired. If their car sustained significant damage, they might be facing several weeks of taking buses and trains or using a rental car.

These unexpected travel expenses can add up, and you may wonder who is responsible for paying them. If another driver caused the accident, the at-fault driver's insurance should pick up the costs of the alternative transportation. But what if the accident wasn't someone else's fault? Or what if the victim doesn't want to bother with the other driver's insurer and just wants expenses to be covered quickly?

Drivers who are in either of those situations might be covered if they purchased collision coverage or comprehensive coverage for their vehicle. If they have comprehensive coverage and their car is stolen, their insurer will give them a limited amount of money for temporary transportation expenses. To be eligible for this benefit, the damaged vehicle might need to be unavailable for at least two full days.

If a car is unavailable because of property damage, the owner's insurer might provide a limited amount of transportation coverage after a 24-hour waiting period. To be eligible for this benefit, the owner must have the proper kind of property insurance and must pay an additional premium.

Towing and Labor Charges

We noted earlier that auto insurance does not cover losses associated with wear and tear. That's generally true, but a very minor degree of coverage can be added for an extra charge.

If drivers are willing to pay more money, their insurance company will cover them for emergency roadside assistance, even if their vehicle simply won't start. This additional insurance will pay for towing a car to a repair shop. The cost of labor is covered, too, but since this only applies to work done at the site of the emergency, coverage will probably be limited to relatively simple tasks like changing a tire.

In some cases, insurance claims for roadside assistance will be treated in the same way as liability claims or property damage claims and could impact a driver's eligibility for affordable insurance at a later date. To avoid this problem or to see what similar coverage options might be available, consumers might consider contacting a motor club.

Duties of the Insured

When drivers are in a car accident, there are certain things they must do in order to be reimbursed by their insurer. There are also several things that, required or not, should be done in order to get their claim paid quickly.

Of course, safety comes first. If an accident results in bodily injury, someone at the scene should call for help. If there are no injuries, state laws might still require that the police be notified. For their losses to be covered, drivers must call the police if their car has been stolen or if they have been the victim of a hit-and-run accident.

After calling for emergency assistance, drivers should do what they can to prevent further damage to their vehicle. If possible, damaged autos should be moved away from traffic so that an even bigger accident does not occur.

While waiting for police assistance, drivers can start taking important notes. Names should be obtained from all drivers, passengers and other witnesses. Insurance information should be shared among the group, and each party should verify the make and model of any damaged vehicles. When law enforcement arrives, drivers should explain the situation and inquire about obtaining a copy of the police report.

After everyone's safety has been secured and all information has been exchanged, policyholders should make contact with their insurance company. Upon learning of the accident, the insurer will assign a claims adjuster, who will usually contact the insured in a matter of days.

If the accident is likely to involve a liability claim, drivers must cooperate with the insurer so that a fair settlement can be reached in a timely manner. If drivers receive notice that they are being sued, or if they intend to pursue a suit against someone else, copies of all legal notices must be sent to the insurance company. If drivers incur expenses or miss work as a result of helping their insurer with a liability dispute, reimbursements will be provided by the insurer up to certain dollar limits.

If a claim involves the medical payments portion of a policy, the insurer can force the injured party to be examined by a physician of its own choosing at its own expense. The insurer may also request access to the party's medical records.

If drivers want property damage covered by their insurer, they should hold off on doing repairs until a claims adjuster has examined the vehicle. After inspecting the damage, the appraiser will calculate a possible settlement amount, which the vehicle's owner can either accept or decline. According to the Insurance Information Institute, insurers cannot force a driver to have repairs done by a particular garage or body shop, but they can require drivers to obtain multiple estimates of repair costs.

If a policyholder and a claims adjuster cannot agree on a settlement for property damage, the insurer and the insured can go through the arbitration process. Each party will hire an appraiser at its own expense, and if the two appraisers cannot agree on a settlement, an impartial arbitrator will be asked to resolve the dispute.

The Impact of Other Insurance

If multiple insurance policies or other forms of compensation can be applied to the same loss, it can be difficult to determine who pays and in what amount. As usual, much will depend on policy language and state law.

If a policyholder is involved in an accident while driving someone else's car, the vehicle owner's insurer usually pays first. If the owner's insurance is not enough to cover the entire loss, the driver's policy will make up the difference.

From a compensation standpoint, accidents involving the insured's car and multiple policies are usually more complicated. If a driver has multiple policies that could be used to cover the same loss, the amount paid to the insured under each policy will be based on the relationship between each policy's dollar limit and the cumulative dollar limit for all applicable policies.

For example, pretend Pete is in an accident and is sued for $50,000. If Pete has an auto policy with a $100,000 liability limit and another liability policy that could cover the same loss up to $200,000, his auto insurance company might add the two dollar limits together for a total of $300,000. By dividing its own liability limit ($100,000) by the total liability limit ($300,000), the insurer would get an answer of one-third. Based on those calculations, Pete's auto policy might cover one-third of $50,000 and leave the rest to be covered by his other insurance. As a practical matter, many non-auto insurers avoid this issue by specifically excluding auto liability from their coverage forms.

Stacking

If drivers insure multiple vehicles under the same policy, some states will allow them to combine the benefit limits for each vehicle and apply the total to a single accident. This option, known as "stacking" can require an additional premium and is most commonly offered as part of a driver's uninsured and underinsured motorist coverage.

Imagine that Sue owns two vehicles and covers them under the same policy with a $100,000 limit for uninsured motorist coverage. If Sue is hit in either car by an uninsured driver and her losses exceed $100,000, she could multiply $100,000 by two and be covered for as much as $200,000. Most states, though, either forbid or have put limits on stacking, and an insurer might still refuse to offer it as an option even where it is allowed by law.

Auto Insurance Laws

By itself, a driver's license does not allow people to buy a car and take it out on the road. Vehicle owners must abide by local auto insurance laws before they drive.

Since auto insurance laws are different in every state and can be replaced with new legislation, this is not the place for specific, up-to-date information about a particular state's requirements. We can, however, make some general comments about what these laws demand from drivers and how they impact the public.

Compulsory Insurance Laws

Nearly every state has "compulsory" auto insurance laws. Under these laws, anyone who owns a car must be covered by a minimum amount of insurance. Proof of this insurance usually must be given before a vehicle can be registered.

At the very least, a compulsory insurance law requires drivers to be covered by a minimum amount of liability insurance. As you might recall from our discussion of split-limit policies, a state might have three different minimum liability amounts:

- One amount for all bodily injuries sustained by one person.
- One amount for all bodily injuries sustained in a single accident, regardless of the number of people.
- One amount for all property damage that occurs in a single accident, regardless of the number of people.

If a state has three separate limits for liability, drivers must comply with all of them. Depending on where they live, drivers might not be required to purchase other forms of auto insurance, such as medical payments coverage, uninsured motorist coverage or collision coverage for their own vehicle.

Compulsory auto insurance laws were created to make it easier for accident victims to be compensated for their losses, but they do not guarantee that innocent people will receive all the money they deserve. Obviously, someone who only purchases the minimum amount of liability coverage might not have enough to compensate someone following a major accident.

It's also inevitable that some drivers will either ignore compulsory laws altogether by not registering their vehicles or attempt to sidestep state requirements by cancelling coverage soon after registration is complete. Some states have tried to crack down on these uninsured drivers by requiring auto insurers to report former policyholders who have canceled or failed to renew their coverage.

Financial Responsibility Laws

States without compulsory insurance laws still have a "financial responsibility law" that must be obeyed. In fact, although not all financial responsibility laws are compulsory insurance laws, all compulsory insurance laws are financial responsibility laws.

In regard to driving, financial responsibility laws basically say that if drivers cause an accident, they must prove that they can compensate any victims up to a certain dollar amount. To comply with these laws, a driver might purchase insurance, post a bond or make some other kind of deposit. If someone is in an accident and cannot demonstrate an ability to compensate people for their losses, the state can take the person's driving privileges away.

Tort vs. No-Fault

The kind of insurance drivers need to obtain will depend partially on whether their state has tort insurance laws or no-fault insurance laws. Up to now, the information provided in this course has assumed that a driver is from a tort state. No-fault states take a different attitude toward liability insurance, so coverage in these parts of the country is different in some significant ways.

Tort States

Most states use a tort system for auto insurance. Under a tort system, drivers receive limited or no compensation after an auto accident unless they can prove another person was at fault. If an accident victim suffers bodily injury or property damage, the at-fault driver's liability insurance will cover the losses. Accident victims can also collect compensation from the at-fault driver for non-economic losses, such as pain and suffering.

Tort systems make it more likely that the cost of an accident will be the responsibility of the person who caused the damage, but they do not always make it easy for victims to receive insurance benefits quickly and in full. If victims do not have medical payments coverage or property damage coverage for their own car (or if their losses exceed their benefit limits for such coverage), they might have to deal with the at-fault driver's

insurance company, and they may have to take the at-fault driver to court. Both of those endeavors can involve a lot of stress and time. Some critics of tort systems have also argued that a lack of limits on rewards for pain and suffering is at least partially responsible for the high cost of liability insurance.

No-Fault States

Drivers in roughly one-third of the country are governed by a "no-fault" insurance system. Under no-fault laws, losses that drivers sustain as a result of bodily injury are handled by their own insurance company even if an accident is caused by another person. In exchange for the supposed simplicity of having to deal only with their own insurer, drivers give up a significant portion of their right to sue the at-fault individual.

Drivers in a no-fault state are usually required to purchase "personal injury protection" (PIP). PIP is very similar to the medical payments coverage in other personal auto policies, but in addition to reimbursing the insured for medical expenses, it can also help people recoup lost income, funeral costs and other extra expenses that are linked to an accident.

In no-fault states, any losses that relate to an injury will first be covered by the injured person's PIP. If the injured person did not cause the accident and losses exceed his or her PIP dollar limit, the other driver's liability insurance might make up the difference. Compensation for non-economic damages, such as pain and suffering, is often prohibited. As in tort states, compensation for property damage is usually provided to victims by the at-fault driver's insurer.

Drivers in no-fault states are only allowed to sue another driver for pain and suffering if the consequences of an accident are serious. Within the context of insurance, the consequences of an accident are considered to be serious if they exceed a statutory threshold.

Depending on state law, a statutory threshold may be either monetary or verbal. With a monetary threshold in place, drivers can sue for pain and suffering if their injuries cost them more than a particular dollar amount. If a state has a verbal threshold, the actual size of people's medical bills aren't important, but they can sue when the severity of their injuries is at least equal to the severity described in an applicable insurance law. For example, under a verbal threshold, a driver (or a driver's estate) might be allowed to sue for pain and suffering whenever an accident results in death, permanent disfigurement or long-term disability.

A few states are considered "choice" states because they let drivers choose between no-fault coverage and traditional tort coverage. In places where this option is available, drivers who opt for no-fault coverage tend to pay lower premiums.

The fact that there are three basic kinds of auto insurance systems in the United States suggests that neither tort systems nor no-fault systems are perfect. When several states passed no-fault insurance legislation in the 1970s, regulators assumed that such measures would cut down on lawsuits and reduce the waiting time for victims to receive benefits. No-fault systems, though, have not always been effective in reducing costs for consumers, and some critics argue that they force good drivers to subsidize bad ones. Concerns about cost were at least one reason why many states that had enacted no-fault laws in the 1970s eventually switched back to a tort system.

Keep in mind that each no-fault state has its own specific features and that requirements can change over time. If you receive auto-related questions from someone in a no-fault state, you may want to research current laws and requirements in the person's area.

Coverage in Other States and Other Countries

Considering all the different variations on auto insurance requirements in the United States, drivers might wonder what happens to their coverage when they travel across state lines. If they at least have the minimum amount of auto insurance in their own state, they can journey from coast to coast without much anxiety.

As a vehicle travels into another state, the owner's coverage automatically adjusts, insuring the driver for at least the minimum required amount in that other state. It doesn't even matter if drivers live in a tort state and get into an accident in a no-fault state. They can operate their car anywhere in the nation and still be in compliance with the law.

Insurance for vehicles that are driven in foreign countries is a different story. A personal auto policy usually only pertains to accidents that occur in the United States, Canada or one of those countries' territories. It often does not even protect U.S. drivers who cross the border into Mexico.

Travelers who go overseas can obtain coverage from a rental company in another country. They might also have some protection from their credit card company. Either way, it is very important to secure adequate insurance. If a driver is in an accident outside of the United States and Canada and does not have insurance, local authorities may be able to detain the person until the matter is settled.

Helping High-Risk Drivers and the Uninsurable

Since auto insurance is mandatory for drivers in just about every corner of the country, insurance professionals are guaranteed to come in contact with applicants who are not good risks. These people might be inexperienced behind the wheel, have a poor driving record or display any one of many characteristics that make high premiums necessary. Depending on a company's underwriting guidelines, an application from a high-risk driver might even be turned down.

Despite their unattractiveness from a business perspective, high-risk drivers still deserve quality service from auto insurance experts. For many of those drivers, that service might include being told what can be done to lower their high insurance costs. For others, it might involve receiving some advice about what to do when insurance has been denied, canceled or not renewed. We'll conclude this portion of our course with some general guidance regarding these consumers.

Dealing With High Premiums

In order to manage risks and keep costs manageable for reliably safe motorists, auto insurance companies must price coverage in a way that makes some drivers pay more than others. However, consumers who are unhappy with the size of their auto premiums are not entirely powerless in the matter. If they want to save money, they can adjust their coverage or take steps that make them seem less likely to get into major accidents.

This section contains a number of cost-conscious strategies, many of which have already been mentioned in our course. Keep in mind, though, that some of these tips reduce the benefits that are available to policyholders after an accident. Before agreeing to a reduction in coverage as a way of reducing costs, drivers should be made to understand the possible consequences of

their decision. As always, the cheapest option is not always the best option.

Drivers who are mainly concerned about price may want to consider taking some of the actions listed below:

- Purchase auto insurance from the same company that insures their home, their health or their lives.
- Take a defensive driving course.
- Tell the insurer if they only drive a few thousand miles or less each year.
- Elect to pay for coverage in a lump sum rather than in monthly installments.
- Opt for a vehicle with excellent safety features.
- Install an anti-theft device in their vehicle.
- Increase deductibles.
- Let the insurer know if they take a carpool to work.
- If they have multiple vehicles, insure them all under the same policy.
- Drop comprehensive and collision coverage for vehicles with a low actual cash value.
- Drop medical payments coverage if they and their passengers have adequate health insurance.
- Exclude high-risk members of the household from their policy.
- If they are parents and plan on covering a son or daughter, cover all family members under the same policy rather than through a separate policy.
- Improve their credit score, and check for errors in their credit reports.

Dealing With Cancellations and Non-Renewals

Auto insurance policies tend to cover drivers for six months or a year, but coverage can end at any time if the policyholder or the insurer cancels it.

Consumers don't need a reason to cancel their auto insurance. They merely need to give the insurer notice of the cancellation. This can be done by sending the insurer a written statement that indicates the exact date when coverage should end. It can also be accomplished by sending the policy back to the insurance company.

Requirements for cancellation are stricter when the insurer is the one ending the relationship. In most cases, an insurer cannot cancel a person's auto insurance unless at least one of the following statements is true:

- The person failed to pay premiums.
- The person is no longer allowed to operate a vehicle.
- The person misrepresented important facts to the insurance company.

If an insurer plans on cancelling someone's auto insurance, the person must receive notice of the cancellation before coverage actually ends. The amount of required notice will depend on state law.

Proper notice is also required if the insurance company chooses not to renew someone's auto insurance. In this scenario, coverage will not be interrupted during the current policy period but will stop once the policy period ends. Depending on the circumstances, non-renewal may occur if a driver makes too many insurance claims, violates a major rule of the road or is responsible for a serious accident. In general, an insurance company's ability to non-renew someone's coverage is broader than its ability to cancel that coverage.

Drivers who are faced with cancellation or non-renewal should try to secure replacement coverage as soon as possible. If they cancel their insurance and go without coverage for a significant length of time, they might encounter pricing problems when they reapply for coverage in the future. And, of course, if they continue to drive without any insurance, they could be breaking the law.

The Residual Auto Insurance Market

If a state makes auto insurance mandatory, it must ensure that everyone with a valid driver's license has an opportunity to purchase minimum coverage. Each state has a "residual market," which provides insurance to high-risk drivers who are denied coverage from an insurance company.

Many states operate some form of "assigned-risk program." In an assigned-risk program, all auto insurers in the state are required to cover a certain portion of high-risk drivers. The number of high-risk drivers who must be covered by a particular insurer will generally be proportionate to that company's market share. A large insurer will usually be responsible for covering more high-risk drivers than a small insurer.

A few states have dealt with high-risk drivers by covering them through "joint underwriting associations." A joint underwriting association consists of several insurance companies. When a driver suffers an insured loss, all of the members are financially responsible for covering a portion of it. The size of an insurer's portion will depend on how much business the company does in the state. (Again, large insurers will contribute more than small insurers.) However, only a few members will be held responsible for actually dealing with consumers and doing all the administrative work involved with issuing policies and handling claims.

Instead of being part of an assigned-risk program or joint underwriting association, an insurer might cover high-risk drivers through a reinsurance pool. When an insurer is part of a reinsurance pool, it generally cannot deny insurance to an applicant. It can, however, require that all other insurers in the state share a portion of the presented risk. After a loss, a driver contacts his or her own insurer, and each pool member must fund a portion of the benefits.

Since it's meant for high-risk drivers, insurance from the residual market is very expensive. The market exists to make insurance accessible, not to make it affordable. Drivers who find themselves in it will want to improve their driving record so that they can eventually obtain cheaper, more comprehensive coverage in the regular market.

Conclusion

Though car owners generally know they must purchase auto insurance, they are probably not aware of all the different ways it can help them manage the risks of the road. By studying and explaining the contents of a typical auto policy, you can get people to think about more than minimum legal requirements. You might even make it possible for your customers to recover from the inevitable accident with a limited amount of loss and stress.

Below is the Final Examination for this course. Turn to page 117 to enroll and submit your exam(s). You may also enroll and complete this course online:

InstituteOnline.com

Your certificate will be issued upon successful completion of the course.

FINAL EXAM

1. In general, insurance is a contractual arrangement whereby one party agrees to _____ in exchange for compensation.
   A. pay money
   B. invest premiums
   C. absorb a risk
   D. evaluate a risk management plan

2. A peril is the _____.
   A. item being insured
   B. basic cause of a loss
   C. person being insured
   D. amount of risk posed by an applicant

3. A physical hazard is an environmental factor that could increase either the likelihood or severity of a _____.
   A. loss
   B. policy rescission
   C. reduction in benefits
   D. claims investigation

4. A(n) _____ is an incentive or opportunity for someone to commit unethical or even illegal activity.
   A. moral hazard
   B. insurable interest
   C. warranty
   D. unfair claims settlement practice

5. Adverse selection occurs when insurance is purchased disproportionately by people who are _____.
   A. healthier than most people in their age group
   B. at the highest risk of suffering a loss
   C. less likely to commit insurance fraud
   D. uneducated about insurance products

6. Insurance policies are contracts between the company issuing the policy and the _____.
   A. underwriter who is evaluating it
   B. adjuster who is assigned to it
   C. broker who is selling it
   D. consumer who is purchasing it

7. A unilateral contract is a contract in which only one of the parties _____.
   A. is protected by insurance laws
   B. is an actual person
   C. makes a legally enforceable promise
   D. understands the agreement

EXAM CONTINUES ON NEXT PAGE

8. In order to insure a person or thing, the individual wanting the insurance must have a(n) _____ in that person or thing.
   A. emotional investment
   B. insurable interest
   C. ownership interest
   D. business concern

9. When entering into an insurance contract, consumers are expected to _____.
   A. remain with the insurer for several years
   B. regularly complete a valuation of their property
   C. act in good faith
   D. consult an attorney

10. In regard to insurance contracts, a(n) _____ is a statement that must be literally true in order for the insured to keep the policy in force.
   A. waiver
   B. endorsement
   C. adhesion
   D. warranty

11. _____ occurs when, instead of directly providing false information, a consumer merely fails to disclose something to the insurance company.
   A. Estoppel
   B. Concealment
   C. Insolvency
   D. Morale hazard

12. “Concurrent causation” occurs when a loss is created by _____.
   A. an uninsured party
   B. more than one peril
   C. the owner of damaged property
   D. a negligent professional

13. In property insurance, insurable interest must exist _____.
   A. at least one year before a loss
   B. at the time of loss
   C. at least 90 days after a loss
   D. before an application is reviewed

14. In order to ensure that _____ serve their intended purpose, they usually cannot be covered by liability insurance.
   A. compensatory damages
   B. punitive damages
   C. workers compensation losses
   D. losses for pain and suffering

15. An endorsement is an amendment to an insurance company’s _____.
   A. standard policy
   B. marketing disclosures
   C. policy riders
   D. corporate bylaws

16. _____ act as intermediaries between consumers and insurance companies.
   A. Underwriters
   B. Insurance lawyers
   C. Licensed insurance producers
   D. Federal securities regulators

EXAM CONTINUES ON NEXT PAGE

17. Agents are typically required to engage in good _____ by not overburdening an insurance company with high risks.
    A. high-profit business
    B. field underwriting
    C. lowballing of settlements
    D. adverse selection practices

18. Under the common rules of agency, information that is made known to the agent is generally considered by law to be _____.
    A. known by the insurance company
    B. unknown by the insurance company
    C. a trigger for post-claims underwriting
    D. public information exempted from privacy laws

19. Independent agents can _____.
    A. deposit premiums into their general operating account
    B. disclose protected health information to families without consent
    C. provide legal advice regarding insurance laws
    D. represent multiple insurance companies

20. A "_____" is proof of insurance that is provided by the insured to a third party.
    A. policy rider
    B. non-written binder
    C. certificate of insurance
    D. waiver of premium

21. Many insurance policies contain a "_____ clause" that takes the consumer's right to sue someone for an insured loss and transfers it to the insurance company.
    A. subrogation
    B. coinsurance
    C. proof of loss
    D. assignment

22. Errors and omissions insurance is intended to help professionals when they are accused of _____.
    A. causing bodily injury to strangers
    B. damaging their clients' personal property
    C. negligence or incompetence in their work
    D. selling insurance without a license

23. Most forms of errors and omissions insurance include a _____.
    A. duty to defend the insured
    B. medical payments clause
    C. choice of beneficiary
    D. annual background-check requirement

24. A _____ is the amount, in dollars, that an insured must pay after a loss in order for the insurer to start paying benefits.
    A. post-audit premium
    B. pro-rated fee
    C. deductible
    D. coinsurance fee

EXAM CONTINUES ON NEXT PAGE

25. Under a claims-made policy, the insured is covered for liability if the claim that resulted from an error or omission occurred _____.
    A. while the policy was in place
    B. before the policy was issued
    C. after the policy period expired
    D. within five years of the effective date

26. Traditionally, the insurance community and local regulators have favored _____.
    A. state regulation
    B. federal regulation
    C. no regulation
    D. heavy regulation

27. The Safeguards Rule requires all financial institutions to design, implement and maintain safeguards to protect _____.
    A. consumer information
    B. government employees
    C. policy dividends
    D. minority policyholders

28. Insurance laws are passed by _____.
    A. judges
    B. attorneys
    C. legislators
    D. business groups

29. The insurance department in most states is headed by a(n) _____.
    A. insurance commissioner
    B. elected state senator
    C. licensed consumer advocate
    D. FINRA-registered representative

30. Formerly known as the National Association of Securities Dealers (NASD), FINRA is a private, non-profit self-regulator for the _____.
    A. securities industry
    B. mortgage industry
    C. casualty insurance industry
    D. excess and surplus industry

31. Above all else, the purpose of insurance regulation is to _____.
    A. protect the public
    B. disrupt the market
    C. collect regulatory fines
    D. eliminate risk-related discrimination

32. State guaranty funds are used to compensate claimants whose insurance is from a(n) _____.
    A. solvent carrier
    B. insolvent company
    C. fraternal organization
    D. non-admitted insurer

33. In regard to licensing, a licensed insurance company is considered a domestic insurer in _____.
    A. its home state
    B. every state
    C. foreign countries
    D. North America

EXAM CONTINUES ON NEXT PAGE

34. In order to become licensed as a producer, a person must complete pre-licensing education, pass a state exam, pay various fees and _____.
    A. have a college degree or equivalent diploma
    B. serve an apprenticeship under another licensee
    C. specify whether compensation will be paid as commissions or fees
    D. undergo some kind of background check

35. Upon the conclusion of a license term, a producer can usually renew his or her license by submitting documentation to the department of insurance, paying required fees and _____.
    A. obtaining sponsorship from a supervisor
    B. completing continuing education
    C. writing to the state insurance commissioner
    D. attending a disciplinary hearing

36. Consumers who experience a loss should _____.
    A. refrain from moving valuables to a different location
    B. file a notice with the state insurance department
    C. hire an appraiser to determine property's market value
    D. report the situation to their insurance company as soon as possible

37. After a claimant notifies the insurance company of a loss, the person's case will often be passed along to a specially trained _____.
    A. field underwriter
    B. state regulator
    C. claims adjuster
    D. independent insurance agent

38. Individuals known as "public adjusters" represent _____.
    A. insurance companies
    B. claimants
    C. insurance regulators
    D. property appraisers

39. When consumers believe a claims decision is unfair or inappropriate, they often have the ability to _____.
    A. receive a partial return of paid premiums
    B. withhold commissions from their agent or broker
    C. upgrade their coverage on a retroactive basis
    D. appeal the decision through some kind of internal review board

40. _____ involves the use of a single insurance policy to insure the lives of several people.
    A. Permanent life insurance
    B. Term life insurance
    C. Group life insurance
    D. Buy-and-sell planning

41. The most traditional form of group life insurance covers enrollees for _____.
    A. guaranteed-renewable, one-year terms
    B. guaranteed-renewable, three-year terms
    C. conditionally renewable five-year terms
    D. conditionally renewable 10-year terms

42. _____ from group life insurance will equal a flat dollar amount, a multiple of an employee's salary or a combination of the two.
    A. Death benefits
    B. Conversion options
    C. Future-purchase rights
    D. Deductibles

EXAM CONTINUES ON NEXT PAGE

43. Unlike term life insurance, permanent life insurance is designed to keep somebody insured _____.
    A. until retirement
    B. until age 65
    C. for only a few years
    D. for the rest of their lifetime

44. Life insurance death benefits are usually _____.
    A. provided to the business owner
    B. not taxable as income to beneficiaries
    C. subjected to high capital gains taxes
    D. given to minor children

45. Life insurance will be considered part of the deceased's estate for tax purposes if _____.
    A. the policy was cancelled more than five years before death
    B. the estate was listed as a beneficiary
    C. the deceased had no ownership interests in the policy
    D. the insurance was purchased and owned by a spouse

46. The most common auto insurance policy is the _____.
    A. Personal Auto Policy
    B. Commercial Auto Policy
    C. Collision Auto Policy
    D. Comprehensive Auto Policy

47. Auto liability insurance covers motorists when they cause another person to suffer bodily injury or _____.
    A. higher premiums
    B. wear and tear
    C. advertising injury
    D. property damage

48. An item's actual cash value is its _____.
    A. replacement cost
    B. replacement cost minus depreciation
    C. manufacturing cost
    D. original market value

49. Auto insurance doesn't cover people when they drive another person's car _____.
    A. beyond state lines
    B. without permission
    C. on a temporary basis
    D. with the owner as a passenger

50. Compulsory auto insurance laws were created to make it easier for accident victims to _____.
    A. understand consumer protections
    B. find competent legal counsel
    C. be compensated for their losses
    D. contact the liable party's insurer

END OF EXAM

Turn to page 117 to enroll and submit your exam(s)

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ABOUT THIS COURSE

"Providing Insurance Solutions" examines a wide range of insurance products that might be sold to individuals, groups or businesses. Its purpose is to alert insurance professionals to the many different kinds of risks that can be managed with the help of the right product and the right advice. Along with some general topics that apply equally to all major lines of insurance, the course will introduce or reinforce some of the most important concepts and features of life, health, property and casualty-related coverage options:

- Chapter 1 helps property insurance producers understand typical methods of covering commercial property.
- Chapter 2 gives health insurance producers in-depth information related to long-term care insurance.
- Chapter 3 allows life insurance producers to review essential facts related to annuities.
- Chapter 4 invites property and casualty producers to consider the impact of data breaches and other cyber risks on their insurance clients.
- Chapter 5 alerts all types of producers to the warning signs of consumer-initiated insurance fraud.

As always, we hope this course helps you recognize how each corner of the insurance business plays a valuable role in protecting the public. By continuing in your insurance career and completing high-quality continuing education programs, you can help your clients become more informed and put them in a position to make smart decisions.

CHAPTER 1: COVERING COMMERCIAL PROPERTY

Introduction

Running a business is difficult enough without having to worry about theft, accidents or natural disasters that could result in the loss of property. Good property insurance will not be able to stop those unfortunate events from occurring, but it can certainly help a business get back on its feet.

The most common kind of property insurance for businesses is based on contractual language from a document called the "Building and Personal Property Coverage Form." The form was created by the Insurance Services Office (ISO), a private company specializing in information about property and casualty insurance. This course material contains explanations of the ISO form. However, some companies use policy forms that are broader or more restrictive.

The Basics of the Building and Personal Property Coverage Form

Before going into great detail about specific clauses in commercial property insurance policies, we ought to address a few simple insurance topics that might be important to a new business. These topics include the purpose of the declarations page, the length of the policy period and the definition of a loss.

Although Insurance professionals are probably familiar with these concepts, they should not forget that elementary insurance matters are often foreign to the buying public. Since agents and brokers might need to review these concepts with potential clients, it seems appropriate for us to briefly mention them here.

The Declarations Page

The "declarations page" is a basic summary of the insurance policy and can be thought of as the policy's cover sheet. Often found on the policy's first page, it usually contains the following information:

- The name of the insurance company.
- The name of the people, business or other entity insured by the policy.
- The location of insured property.
- The length of the policy period.
- The cost of the insurance.
- The policy's deductible.
- The policy's dollar limit.

A policy's dollar limit is also known as the insurance company's "limit of liability." Depending on the policy, the insurance company might list multiple limits of liability. For example, the insurer might have one limit for damage to a business's building and another limit for damage to a business's personal property. When a declarations page lists multiple limits of liability and a loss is larger than one of those limits, the business generally cannot dip into another limit of liability to make up the difference.

A declarations page for a commercial property insurance policy will also contain important information pertaining to whether specific kinds of losses will be covered in their entirety. For example, it might mention the causes of loss that the business's property is insured against and may list a coinsurance requirement that the business must satisfy. Causes of loss and the importance of coinsurance clauses will be addressed in later portions of this course.

The Policy Period

The time between the policy's issue date and expiration date is known as the "policy period." The length of the policy period can be found on the declarations page and typically spans one year. All losses that occur during the policy period and are not otherwise excluded in the insurance contract will be covered.

Near the end of the policy period, the business and the insurance company may choose to renew the coverage by mutual consent. Alternatively, either party can refuse to renew the policy and insist on a new contract with different terms and conditions.

When coverage is renewed, a new policy period begins. Like the original policy period, the period for the renewed insurance is usually 12 months.

Policy Premiums

Insurers base premiums for commercial property insurance on the level of risk posed by the business. Premiums may be paid annually or on some other schedule the carrier and the insured have agreed to.

In general, the named insured on the declarations page is the person or other entity who must pay the first premium and all subsequent premiums. Although the insurance company will gladly accept money from people other than the named insured, it will hold the named insured responsible for any missed or late payments. The named insured on the declarations page is also the person who will receive money from the insurance company if a refund is ever in order.

What Is a Covered Loss?

Defining the term "covered loss" isn't as simple as you might think. After all, if it were absolutely clear what a covered loss is,

honest carriers and policyholders would never fight over an insurance claim. The prevalence of insurance disputes proves that the public's definition of a covered loss is often different from the insurance industry's definition.

Before we define what a covered loss is, let's mention what it is not. In the context of the Building and Personal Property Coverage Form, a covered loss is not indirect harm to the insured's property. It is not, for example, the amount of income a company loses due to an interruption in its business (such as the loss of income experienced by many businesses during the COVID-19 pandemic). If a company wants to insure itself against these indirect kinds of losses, other coverage forms—not the Building and Personal Property Coverage Form—are appropriate.

A "covered loss" can be defined as direct physical elimination of or damage to covered property that is caused by a covered peril. Though this definition isn't especially long-winded, it requires an extensive amount of explanation. What exactly is covered property? And what causes of loss are considered covered perils? Those are important questions, and we will attempt to answer them throughout the remainder of our study.

What Is Covered Property?

There are three basic kinds of covered property, with each one having its own dollar limit. These three are listed below and will be addressed one at a time in the next few sections:

- The business's building.
- The business's personal property.
- Personal property of others in the business's possession.

The Business's Building

The building is the place of business described on the policy's declarations page. Although we generally view buildings as singular structures, a "building" can mean any of the following locations:

- The entire structure at a single address.
- Multiple structures described on the declarations page.
- A single unit in a multi-unit building.

Building coverage is for more than just walls, ceilings, windows and doors. It is broad enough to include additions the insured makes to the building and various fixtures, equipment and machinery that are permanently installed in the building. Depending on the carrier's interpretation of the term, "permanently installed property" might have any of the following definitions:

- Something merely attached to the building.
- Something that can't be removed without changing the building's structure.
- Something that was specifically listed in the real estate contract when the owner bought the building.

Building coverage even insures many personal items the business owns and uses to maintain the building and the surrounding area. Here are a few items that are commonly insured through the policy's building coverage:

- Carpeting and other flooring materials.
- Fire extinguishers and hoses.
- Outdoor furniture.
- Refrigeration and ventilation equipment.
- Appliances used for cooking, dishwashing or laundering.

Unless coverage already exists through another policy, building coverage can be applied to incomplete additions to the business premises. Tools and materials that are used to complete these additions can be covered, too, if they are lost or damaged within 100 feet of the building.

If a business rents space from a property owner, it might not be responsible for insuring the building. Tenants should review their leases carefully and discuss their insurance obligations with their landlord. Then they should determine what additional insurance ought to be purchased for their own protection.

The Business's Personal Property

Coverage for a business's personal property generally applies to any item inside the insured building or within 100 feet of the premises. More specifically, the typical policy states that the following items are insured:

- Office furniture and fixtures.
- Machinery and equipment used to conduct business.
- Property the insured owns and uses for business purposes.
- Outdoor signs (valued up to $2,500).
- If the insured is a tenant, any improvements the insured has made to the building that were not paid for by the owner.
- Leased property that the business agrees to insure.
- Improvements made to other people's property, such as replacement parts installed by the business.

Stock could also be part of the above list. In regard to the Building and Personal Property Coverage Form, "stock" can be defined as follows:

- Items currently being sold by the business.
- Items the business plans on selling but is keeping in storage.
- Items the business is in the process of producing.
- Any raw materials the business uses to make its products.

Businesses are also covered for the materials they use to ship their stock, including padded envelopes and crates.

Property of Others

Commercial property insurance can cover other people's property while it is in the business's possession. For this kind of property to be covered, it often must be either inside the insured building or within 100 feet of the building. If the property is outside the building, it can be either out in the open or in a vehicle.

The insurance for property of others is explained in an early portion of the Building and Personal Property Coverage Form and typically has its own dollar limit, as chosen by the business. It can be capped at any amount and is designed for businesses that commonly keep customers' property on their premises.

Alternatively, if a business doesn't normally take possession of other people's property and doesn't want to spend extra money to manage a comparatively small risk, it may be able to apply a small amount of its own personal property coverage to "personal effects" and "property of others." This option is often available at no additional expense and reimburses the policyholder and various employees when their personal items are lost or damaged at the business premises. The coverage also applies to the property of others that is in the business's care. However,

items pertaining to this optional, extended insurance are only covered for up to $2,500 at each premises.

Replacement Cost v. Actual Cash Value

Property can be insured for either its "replacement cost" or its "actual cash value." A business that does not understand the difference between the two may be in for some unpleasant surprises after a loss.

Property's "replacement cost" is the amount it would take to rebuild or replace the property without taking depreciation into account. If the property is to be replaced, the replacement property and the old property must be of like kind and quality. When a building is to be replaced at its replacement cost, the new building and the old one do not need to be identical in every little way. However, the essential features must be the same.

An item's "actual cash value" is its replacement cost minus depreciation. The actual cash value may be determined by taking the replacement cost and multiplying it by the remaining amount of time the item would otherwise be expected to last. For the purpose of an example, pretend a new computer costs $800 and is expected to last 10 years. If the insured has owned a similar computer for five years (50 percent of 10 years) and loses it in a fire, the insurer might calculate the item's replacement cost as $400 ($800 multiplied by 50 percent).

By default, most kinds of commercial property will only be covered up to their actual cash value. Replacement-cost insurance can be included for an additional price. Annual adjustments for inflation are also available.

Coverage for Specific Kinds of Property

There are some types of business property that the insurance company will only cover under specific conditions. There are others that the insurer will not cover at all. The next several sections attempt to present these conditions and exclusions as comprehensively as possible.

Outdoor Property

Even though commercial property insurance generally covers outdoor property when it is within 100 feet of the business premises, some items can only be insured while they are inside the building. A partial list of belongings that must remain indoors appears below:

- Crops.
- Fences.
- Antennas.
- Satellite dishes.
- Trees, shrubs or plants (other than stock).

Before moving on to another kind of property, we should mention that some of the above items can be covered outdoors if a policy contains a coinsurance requirement of at least 80 percent. (You'll read more about coinsurance in a later section.) In exchange for accepting the proper coinsurance clause, a business has the option of extending its personal property coverage to include all of the outdoor items mentioned above, other than crops. This extended insurance is limited to $1,000 per occurrence and only applies when property is lost or damaged due to the following perils:

- Fire.
- Lightning.
- Explosion.
- Riot or civil commotion.
- Aircraft.

Commercial property insurance, like the most common homeowners insurance policy, often also puts a cap on reimbursement for single trees, shrubs or plants.

Off-Premises Property

Basic commercial property insurance only insures property within 100 feet of the business premises, but extended coverage is available to some applicants. Like other kinds of extended coverage, off-premises property can be covered (for up to $10,000) if the insured is willing to accept at least an 80 percent coinsurance requirement.

Through this extended coverage, property is covered beyond 100 feet of the business premises if it is being stored temporarily at places the insured does not own, operate or lease. The property can be held in storage at a leased location if the lease went into effect after the beginning of the policy period. The property can also be stored temporarily at a trade show or exhibit.

Off-premises property generally is not covered beyond 100 feet when it is in a vehicle or under the care of a business's salesperson. However, the property remains insured under a salesperson's care while it is stored at a trade show or exhibit.

Newly Constructed or Acquired Property

Coverage for newly constructed or acquired property is available if the business satisfies an 80 percent coinsurance requirement. If a business constructs a new building during the policy period, damage to the building, while under construction, can be covered if the new building is on the premises described on the declarations page.

A newly acquired building can be covered by the same policy if it is used for the same purpose as the building described on the declarations page. Alternatively, the business may cover a newly acquired building if it is used only as a warehouse.

The business also has the option of extending coverage to include its personal property at these new locations. Personal property of others is not covered in these buildings if it is being serviced in some way by the business.

This extended insurance for newly constructed or acquired buildings is limited to $250,000 per building. The extended insurance for a business's personal property at these buildings is limited to $100,000 per location. The insurance expires when any of the following events occur:

- The policy period ends.
- Thirty days pass after either the time of acquisition or the beginning of construction.
- The insured reports the new property's value to the insurance company.

Property in Transit

Typical commercial property insurance might not cover business property while it is being transported from the insured building to another place. The lone exception to this rule is when property is in a vehicle that is no further than 100 feet from the business premises. If businesses are concerned about property while it is shipped to and from various locations, other insurance products (such as an inland marine insurance policy) might be appropriate.

Land, Water and Crops

The physical property on a piece of land is covered by commercial property insurance, but the land itself is not. If the

insured owns the land surrounding the business premises, there will be no coverage for any decrease in the land's value.

The policyholder is also not covered for damage to ponds, lawns or crops, even if crops could otherwise be thought of as stock. Crop damage can be covered by other kinds of commercial insurance.

Paved Surfaces

There are a few items the insurance company will view as neither personal property nor part of the building and might therefore be excluded. Specifically, the policy does not cover patios, sidewalks, driveways or any other paved surfaces. Bridges, wharves, piers and docks are also excluded.

Trees, Shrubs or Plants

As we mentioned earlier, the optional extended coverage for outdoor property provides some insurance for a business's trees, shrubs or plants. Though there is a $1,000 overall limit for this outdoor property, there is also a per-item limit. In a manner similar to most homeowners insurance contracts, commercial property insurance might only cover trees, shrubs or plants up to no more than $250 each.

Valuable Papers and Records

The business premises is likely to contain valuable documents that are susceptible to various risks. The cost of replacing these documents can be high, and the time spent on reproduction can be long.

Account records, deeds and various manuscripts can be covered by a bit of insurance if the commercial property policy contains an 80 percent coinsurance requirement. When the business agrees to this condition, valuable records and papers are covered for as much as $2,500 per location. This extended insurance can help the business pay for replacement documents if duplicates do not exist.

This extended coverage does not apply to electronic data. Records that are accessible by computer receive limited coverage under another portion of the policy.

Electronic Data

With so many aspects of business being run by computers these days, policyholders are probably thankful that commercial property insurance covers at least some electronic data. "Electronic data" basically means any kind of information or program that can be stored or accessed on a computer. This includes data on CDs, floppy disks, hard drives and USB drives.

The insurance for electronic data might be limited to $2,500 per year, regardless of the number of occurrences and the location of those occurrences. If a loss is less than $2,500, the business may use the remaining insurance to handle similar losses during the same year. However, electronic data coverage generally cannot be carried over from one year to the next. This is additional insurance and has no impact on the insurer's limit of liability for other personal property. (As threats related to lost data have increased, many carriers are including higher amounts of coverage in today's market.)

In addition to being covered for the same kinds of losses as other personal property, electronic data is insured against viruses unless they are caused by someone working for the business. Some insurers will include collapse as a covered peril for electronic data even if the rest of the business's personal property is not insured for that peril.

Money

Commercial property insurance often does not cover money or anything similar to it. This means there is no insurance for cash, food stamps, securities or un-cashed checks. The form makes an exception for unsold lottery tickets, which are treated as if they were part of a business's stock.

Animals

For the most part, the Building and Personal Property Coverage Form does not cover animals, even if they are hurt or killed by a peril such as fire, lightning or explosion. The policy makes exceptions to this rule when the business boards animals for other people or has animals as part of its stock. The first exception might provide coverage to kennels, while the second might provide coverage to pet shops and some meat suppliers.

Vehicles

The Building and Personal Property Coverage Form generally does not cover vehicles that are either licensed to be used on public roads or used beyond the business premises. Even car dealerships, which could argue that vehicles are part of their stock, will need to look elsewhere for adequate protection.

Commercial property insurance can cover vehicles at the business premises if the business manufactures them or keeps them in a warehouse. Small watercrafts, such as rowboats and canoes, are not excluded from coverage, and non-auto vehicles being sold by the business can be treated as stock.

Trailers

Under limited circumstances, businesses that agree to an 80 percent coinsurance requirement can have trailers treated as personal property. In order for a trailer to be covered for as much as $5,000, all of the following statements must be true:

- The trailer is not owned by the business.
- The trailer is used by the business.
- The trailer was at the business premises at the time of the loss.
- The business is required to pay for the loss.

Trailers are often not insured by while they are attached to a vehicle of any kind. It makes no difference whether the vehicle is in motion or not.

Contraband

Unsurprisingly, commercial property insurance does not cover the loss of illegal or stolen property. In effect, this means illegal gun shops cannot insure their stock, and a business is not covered for any banned fireworks or narcotics sold in backrooms.

Glass

Even if a business opts for replacement-cost coverage, the insurance company might not pay to replace real glass with something identical. Instead, where ordinances require it, the insurer will pay to replace regular glass with safety glass.

Improvements and Additions by Tenants

Relationships between business tenants and their landlords will depend on the people involved. While some tenants will be allowed to make their own improvements at the business premises and receive compensation from the property owner, others will have to pay out of pocket for any non-essential work they want done to the building. The tenant's financial

responsibility for repairs, improvements and additions may also be determined on a case-by-case basis.

Both landlords and their tenants can have commercial property insurance, but it is highly unlikely that the insurance company will compensate both parties for the same exact loss. Additions to the building are generally not covered by a landlord's policy if a tenant paid for them and was not compensated by the landlord. Similarly, additions aren't covered by a tenant's policy if they were financed by the building's owner. If a tenant suffers a loss and property is repaired or replaced at the landlord's expense, the tenant's insurance company can deny a claim for the damage.

Covered Perils

Along with choosing how much insurance to buy, a business needs to decide which "perils" or causes of loss should be covered. There are usually three options to choose from:

- Basic.
- Broad.
- Special.

The most basic kind of property insurance will typically cover businesses against losses caused by the following perils:

- Fire.
- Lightning.
- Explosion.
- Windstorm or hail.
- Smoke.
- Aircraft or vehicles.
- Riot or civil commotion.
- Sinkhole collapse.
- Volcanic action.
- Vandalism.
- Sprinkler leakage.

An intermediate ("broad") form of property insurance will also help pay for losses caused by four additional perils:

- Falling objects.
- Weight of snow, ice or sleet.
- Accidental discharge of water or steam (from a system or appliance).
- Sudden collapse.

Particularly when tasked with insuring a building, most businesses go a step further and purchase "special" (all-risk) property insurance. This covers them against all perils other than those specifically excluded in their policy.

Let's spend the next several sections looking at how commercial property insurance commonly deals with the most basic kinds of losses.

Fire

The Building and Personal Property Coverage Form does not define the word "fire," but insurance professionals and legal experts generally agree that coverage only applies when both of the following statements are true:

- The fire involves a visible flame.
- The fire was either unintentional or was at least unintentionally allowed to spread beyond the confines of safety. (Since a fire in a fireplace is within its proper confines, the insured might not be covered if personal property accidentally falls into the flames.)

Lightning

The inclusion of lightning as a covered peril ensures that fires caused by natural electricity are covered. It also is meant to differentiate between losses caused by natural electricity and losses caused by artificially produced currents.

Explosion

In general conversation, it's easy to assume that bursting and exploding are essentially the same thing. But as far as commercial property insurance is concerned, explosions are generally limited to blowups caused by interactions between various gases. Explosions caused by water or pressure might not be covered by insurance unless the business has purchased a boiler and machinery policy.

Common forms of commercial property insurance usually do not cover explosions of steam pipes, steam boilers, steam engines or steam turbines. However, if the explosion of one of these items causes a fire or some kind of combustion, the insurer will often pay for damages caused by the fire or combustion.

Windstorm or Hail

When a business chooses to insure itself against damage from windstorms and hail, it is managing risks related to several kinds of weather disasters, including tornadoes and hurricanes. However, the inclusion of windstorm or hail as a covered peril usually does not insure a business when losses are caused by snowstorms, ice or sleet.

Damage done to property inside a building by rain, snow, dust or sand will not be covered unless wind or hail has created an opening in the walls or roof.

Smoke

Smoke damage can be covered at the business's request, but it must be sudden, accidental and within the building. Losses related to industrial smoke or agricultural smoldering are usually excluded.

Aircraft or Vehicles

Commercial property insurance can cover losses when a business's building or personal property is damaged by a vehicle or aircraft. This coverage includes losses brought on by spacecrafts, missiles or anything that is propelled by a vehicle and makes contact with the business's property.

Unless all-risk insurance is purchased, businesses cannot use the Building and Personal Property Coverage Form to cover damage done by a vehicle when the vehicle is used by them or belongs to them. So if a company's delivery driver were to accidentally back a truck into the wall of the business's warehouse, reimbursement would not be available from the insurance company.

Riot or Civil Commotion

"Riot or civil commotion" includes damage done by a business's striking workers, as well as any looting during a moment of civil unrest.

Sinkhole Collapse

As soil erodes, sinkhole collapse can become a concern for businesses in many states. Businesses can extend their property insurance to include sinkhole collapse, but the insurer will usually still not pay to fill any sinkholes. Collapses related to manmade holes might also be excluded.

Volcanic Action

Volcanic activity is one of the trickier perils that businesses and insurance professionals might need to deal with. Commercial property insurance typically does not cover damage from "earth movement," and volcanic eruptions are generally considered one kind of earth movement. Still, optional coverage is available for "volcanic action," which we will generally define as the effects of eruption that do not include sinking, shifting or rising of earth. Among other things, volcanic action might include lava flow and the blowing of ash or other debris onto property.

For the removal of volcanic debris to be covered, the debris needs to have damaged covered property. For example, the insurance company might pay to remove ash from a business's building, but it might not pay to remove ash from a business's walkways. After all, walkways are not considered covered property under the Building and Personal Property Coverage Form.

Volcanic action and eruptions are often followed by additional action and eruptions. For the purpose of calculating the appropriate deductible, commercial insurers will usually treat all instances of earth movement within a seven-day period as one cumulative event.

Vandalism

"Vandalism" occurs when a person causes damage on purpose with malicious intent. Basic and intermediate kinds of commercial property insurance do not cover theft committed by vandals, but they often will cover repairs when thieves enter the premises by damaging the building.

Sprinkler Leakage

Though most water damage will not be covered without flood insurance, businesses can use their regular property insurance to cover leakage of automatic sprinkler systems. The reason for this flexibility is simple: By agreeing to cover sprinkler leakage, insurers hope sprinkler systems will be installed in buildings to prevent fires.

Excluded Perils

Even insurers offering all-risk commercial property insurance will exclude some perils from their policies. The next several sections address those commonly excluded risks. Businesses concerned about excluded losses might want to purchase another type of insurance.

Water Damage

Other than sprinkler leakage, commercial property insurance is usually not designed to cover water damage. This includes losses linked to any of the following causes:

- Floods.
- Waves.
- Mudslides.
- Seepage.
- Sewer backups.

Fungus, Rot and Bacteria

Basic kinds of commercial property insurance do not cover losses related to fungus, rot or bacteria unless the fungus, rot or bacteria is caused by a covered peril. There is no special limit of liability when fungus, rot or bacteria is caused by fire or lightning. When fungus, bacteria or rot are caused by other covered perils, the insurer's limit of liability is no more than $15,000. Insurance money can be used to remove fungus, rot or bacteria, tear a building apart in order to remove those things, or conduct tests to ensure that the removal of those things has been successful.

No matter which covered peril actually causes fungus, rot or bacteria, covered businesses must do what they can to prevent its further spread. If a business does not take reasonable steps to keep fungus, rot or bacteria under control, the insurance company can deny the claim.

Earth Movement

Significant kinds of earth movement can include earthquakes, landslides, volcanic eruptions and sinking. Separate insurance is necessary if a business is concerned about earth movement. However, a business can choose to insure against sinkhole collapse and volcanic action. (Details regarding those two perils appeared in previous sections of this material.) Fire damage remains covered even if the fire is caused by earth movement.

Pollutants

Standard kinds of commercial property insurance do not cover pollution losses, other than the cost of cleanup. Furthermore, the cleanup is only covered when it results from a covered peril. Some substances that might qualify as pollutants are listed below:

- Smoke.
- Soot.
- Fumes.
- Acids.
- Chemicals.
- Waste (including waste being held for recycling).

The most the insurer will pay for cleanup of pollutants is $10,000 per year. This is additional insurance and has no impact on the insurer's other limits of liability. To have a claim for cleanup covered, the business must report any cleanup expenses to the insurer within 180 days of the triggering loss.

Nuclear Reactions and Radiation

Damage done by any kind of nuclear reaction or nuclear radiation is excluded. This exclusion still allows businesses to be reimbursed for fire losses when a nuclear reaction causes a blaze.

War

Commercial property insurance generally does not cover damage caused by war or military action. This exclusion applies during declared war, undeclared war, civil war and rebellion.

The Terrorism Risk Insurance Act of 2002 (commonly known as "TRIA") requires that insurance companies offer terrorism coverage to their commercial policyholders. This coverage is available for an additional cost. By signing the appropriate forms, businesses can decline this insurance.

Power Failures and Surges

Businesses receive no insurance benefits when a power failure can be traced back to problems at a utility company. There is also no coverage when artificial current does damage to personal property.

In general, some coverage remains intact when a power failure or power surge causes damage from a covered peril. In other words, if a business experiences a power surge, computers

damaged by the surge will not be covered. But if the surge were to cause a fire, the business would still be covered for fire losses.

Theft

Losses from theft can often only be covered through all-risk insurance or crime insurance. If a business rejects both of those options and a burglary occurs, the insurer might only pay for repairs to the building. Replacing any stolen items will probably be the business's responsibility.

Additional Benefits of the Building and Personal Property Coverage Form

The Building and Personal Property Coverage Form has a few other uses for businesses besides insuring what they own. The next two sections explain these additional benefits.

Debris Removal

If a covered peril produces debris of covered property at the business premises, the insurance company will pay to have the debris removed. This provision in the policy does not cover the removal of pollutants, and it does not cover debris removal when damage is caused by something other than a covered peril.

The amount of money available for debris removal will depend on the size of the loss and the insurer's limit of liability for the damaged property. In general, until the insurer's limit of liability for the property has been reached, a business may file a claim for debris removal equal to as much as 25 percent of the policy's deductible plus the covered portion of the loss that created the debris.

Suppose a windstorm has created damage and debris at a hat store named Jim's Brims. The owner, Jim, has insurance with a $500 deductible. Jim's covered, non-debris losses amount to $49,500. By adding his deductible to his covered non-debris losses ($500 + $49,500) and multiplying the sum by 25 percent, we can see that Jim's insurance will pay up to $12,500 to remove the debris.

In rare catastrophic situations, businesses may be eligible to receive up to an additional $25,000 for debris removal. Eligibility for these additional benefits depends on some relatively complex math, which we will not address here.

Fire Department Charges

If a business is charged for assistance from the fire department, the insurance company will pick up at least a portion of the cost. This is extra insurance equal to $1,000. There is no deductible involved.

This insurance can only be used when the fire department was called to help prevent a covered cause of loss. In other words, a business is covered when it calls the department to help put out a fire. A business would probably not be covered when it calls the department to help get an animal out of a tree.

Barriers to Full Coverage

Even when covered property is damaged by a covered peril, full coverage of the loss is still unlikely. There are several reasons why this is true. At this point, we'll examine the assorted barriers that can reduce the size of an insurance settlement.

Deductibles

The policy's "deductible" is arguably the simplest and most obvious reason why legitimate claims aren't paid in full. The deductible is the dollar amount the business must pay out of pocket before a loss can be covered by the insurance company. Usually found on the policy's declarations page, the deductible can often be as low as $250 or as high as the insured wants it to be. Generally, the higher the deductible, the lower the premiums.

As an example, let's assume a business has a commercial property policy that insures personal property for $50,000 and has a $500 deductible. A fire occurs, and damages to personal property are calculated at $50,100. In this case, the insurance company would deduct $500 from $50,100 and pay the business $49,600 for its losses.

If a loss occurs at multiple buildings that are covered by the same policy, the deductible usually only applies once. So if two buildings are insured by a policy with a $500 deductible and both are damaged at the same time, the deductible will still be $500, not $1,000.

Coinsurance

Earlier sections of this course mentioned "coinsurance requirements." A coinsurance requirement usually states that if property is not covered up to a certain percentage of its actual cash value (or, in some cases, its replacement cost), the insurance company will not fully compensate the business for a loss. Instead, the insurer will pay a prorated amount based on how close the business was to meeting its coinsurance requirement.

Even for insurance veterans, coinsurance requirements can be confusing. Let's look at a few examples of how the requirements might affect a business. In all examples, let's assume there is an 80 percent coinsurance requirement:

- A business owner purchased insurance that covers his property for up to $80,000. After a fire, it was determined that his property was actually worth $100,000. Since the policy limit ($80,000) was equal to 80 percent of the property's value ($100,000 × 80% = $80,000), the owner met his coinsurance requirement and his entire claim will be paid.
- Another business owner purchased insurance in the amount of $90,000. After a windstorm damaged the business's roof, it was determined that the value of covered property was actually $100,000. Since the amount of coverage ($90,000) was greater than 80 percent of the property's value ($100,000 × 80% = $80,000), the owner met her coinsurance requirement and had her claim paid.
- A third business owner purchased insurance in the amount of $60,000. After a major hailstorm, it was determined that the value of his property was $100,000. Since the amount of insurance ($60,000) was less than 80 percent of the property's value ($100,000 × 80% = $80,000), the business did not meet its coinsurance requirement and was only covered for a portion of its losses.

Prorated Settlements

When a business fails to satisfy a coinsurance requirement, an insurance professional can help calculate the covered portion of a loss. The first step is to determine the size, in dollars, of the coinsurance requirement. This is accomplished by multiplying the coinsurance requirement by the property's value at claim time. For a business with a $60,000 policy, an 80 percent coinsurance requirement and property worth $100,000, we would multiply 80 percent by $100,000 and get a result of $80,000.

In the next step, we need to divide the amount of purchased insurance by the size of the coinsurance requirement in dollars. For the business mentioned in the previous paragraph, we would divide $60,000 by $80,000 and get a result of 0.75. This means the business would be covered for no more than 75 percent of a loss.

Now all we have to do is multiply our answer from the previous step by the actual loss. Suppose a hailstorm caused $40,000 of damage to the business's building. In this case, the insurance company would multiply $40,000 by 75 percent and get a result of $30,000. Leaving deductibles out of the equation, this is the amount the business would receive from its insurer. The remaining $10,000 would be considered an uninsured loss.

The preceding steps can be combined to form the following equation:

- Pro-rated settlement = [Coverage limit ÷ (80 percent × property value at claim time)] × actual loss – deductible.

Coinsurance and Extended Coverage

As if the possibility of a partially denied claim wasn't enough, there are plenty of other reasons why a business would at least consider accepting a coinsurance requirement of at least 80 percent. If the coinsurance percentage on the declarations page is less than 80 percent, there will be no coverage for the following kinds of property:

- Newly constructed property.
- Newly acquired property.
- Personal effects and property of others (the insurance with the $2,500 limit).
- Valuable papers and records.
- Off-premises property.
- Outdoor property.
- Trailers.

Agreed Value

Insurance companies will typically waive their coinsurance requirements if a business chooses the "agreed-value option." When the agreed-value option is selected, the insurance company considers the property owned by the business before issuing a policy and arrives at a seemingly suitable dollar limit for the business. This limit is known as the "agreed value."

The business can then choose the agreed value or any other value as the policy's dollar limit. If the business opts for the agreed value or a higher number, the insurer will pay 100 percent of claims up to the policy's dollar limit. If the business opts for a dollar limit below the agreed value, the covered portion of all claims will be determined by dividing the policy's dollar limit by the agreed value.

Like coinsurance, the agreed-value option can probably be best understood by looking at a few examples. First, let's imagine an insurance company has evaluated a business's property and arrived at an agreed value of $100,000. If the business decides to insure its property for at least $100,000, it will be covered for 100 percent of losses up to $100,000 after satisfying any deductible.

Now imagine the same business has decided to insure its property for $80,000 instead of the agreed value of $100,000. Since the business is only purchasing insurance equal to 80 percent of the agreed value, it will only be covered for 80 percent of any losses.

The agreed value will only remain in effect until a specific date, which may or may not coincide with the end of the policy period. After this date (unless the insurer is contacted), losses will be subject to the coinsurance requirements.

Vacancy

The insurance company can sometimes deny an otherwise valid claim if the business's building had been vacant for an extended period at the time of the loss.

The vacancy clause doesn't impact building owners and tenants in the same way. In the case of an insured tenant, the vacancy clause can be enforced only when the tenant's portion of a building does not contain enough property for a tenant to conduct normal business operations. In the case of an insured building owner, it can be enforced when 70 percent or more of the entire building is neither rented to tenants nor used by the owner to conduct regular business. Buildings are not vacant if they are under construction or being renovated.

The vacancy clause is also applied differently depending on the cause of a loss. When a loss is caused by vandalism, theft, water damage or broken glass, the insurance company can deny coverage entirely if the building was vacant for more than 60 consecutive days. For all other perils, a vacancy period beyond 60 days will decrease the insured portion of a loss by 15 percent.

Ordinances and Building Codes

Local building and fire codes are often updated to make buildings safer and more energy-efficient, but existing structures are often exempt from the new requirements. When a building that had been exempt from the new requirements is destroyed, any replacement building must be built in full compliance with current law.

When buildings are destroyed relatively soon after they have been built, owners are not likely to be burdened by the changes in building ordinances. Any changes that might have been made to local codes since the original building's construction are likely to be few in number, and the cost to construct a new building will probably not be far away from the destroyed building's insured value. But if the destroyed building was several years old, the owner might need to comply with many changes to the codes and could be significantly underinsured.

The extra cost of complying with ordinances and building codes can be covered if the business has insured its building at replacement cost. The most the insurer will pay for these additional construction expenses is $10,000 or 5 percent of the building's insured value, whichever is lower.

Getting Through the Settlement Process

A significant loss of property can be a stressful experience. Stress and unpleasantness can be reduced if the insured has a good idea of what to expect after a loss occurs and during the settlement process.

Duties After a Loss

Assuming the insured's personal safety is not at risk, a business's first priority after a loss should be to keep damage under control. For example, if a windstorm has created openings in a roof, the business should take reasonable steps to protect interior property. This might mean putting a tarp over the roof, or it might involve moving interior property to another location. If the property is moved, it will remain covered while at the offsite

location for 30 days, sometimes against nearly any peril that causes a loss.

The business should document any costs that it incurs from managing the damage. The insurer may take these expenses into account when calculating an appropriate settlement. If a business does not take reasonable steps to reduce the scope of a loss, the insurer might have the right to deny claims.

Once steps have been taken to minimize the loss, the business should start contacting people about the occurrence. If there is evidence of criminal wrongdoing, such as vandalism, the business's first phone call should be to the police department. If there is no evidence of wrongdoing, that first call can go to the insurance company or one of its representatives. Though the exact details are not necessary for the initial phone call, the business should provide the following information to the carrier in a timely manner:

- The magnitude of the damage or loss.
- The property that was damaged or lost.
- The location where the damage or loss occurred.
- The time when the damage or loss occurred.
- The cause of the damage or loss.

After being made aware of the loss, the insurer will probably ask the business to complete a "proof of loss form." This form must be completed, signed and returned to the insurer within 60 days of the carrier's request, although state law might call for a looser deadline. The insurer then usually has 30 days to respond with a proposed settlement.

Insurer Access to Company Records

Despite all the claims made for losses by honest businesses, instances of fraud still occur. To help itself fight this problem, the insurance company is allowed to access and make copies of the business's records.

The policyholder must cooperate in all reasonable ways while the insurer is investigating a claim. In some cases, the policyholder might have to answer the insurer's questions under oath and in writing.

Insurance Inspections

The insurance company is allowed to inspect damaged property to determine the scope of a loss. Building owners should understand that an insurer's inspection is for coverage purposes only. It is not meant to be a safety inspection. The insurer isn't responsible for the safety of a business's customers or employees at the building, and it isn't responsible for checking to see if everything is compliant with local building codes and ordinances.

Appraisals and Legal Action

If there is a disagreement regarding a loss, the business or the insurer can demand an appraisal. Each side of the dispute will hire its own appraiser. If the appraisers cannot come to an agreement, the case can be sent to an arbitrator.

Coverage for Mortgage Lenders

Mortgage holders, including trustees, can be compensated in a manner that reflects their ownership interest in a damaged building. In order to be paid by the insurer, the mortgage holder must be listed appropriately on the policy's declarations page. The mortgage holder is entitled to compensation even if a loss occurs while it is in the process of foreclosing on the covered property.

If an action or inaction by the policyholder causes the insurer to deny a claim, the mortgage holder can still get its share of insurance money. To receive compensation after a claim has been denied, the mortgage holder should take all of the following actions:

- Pay the insurance premiums if the policyholder has not done so.
- Submit a proof of loss form within 60 days of a request if the policyholder has not done so.
- Disclose all relevant risk factors related to the property if the policyholder has not done so.

Recovered Property

As unlikely as it may seem, there really are times when lost property is recovered after an insurance settlement has been finalized. When this happens, the insurer and the recipient of insurance benefits are usually obligated to contact each other. The insured can then choose one of two options: Either the insured can return the insurance money and retain ownership of the recovered property, or the insured can keep the money and pass ownership of the property along to the insurance company. These options are usually spelled out in the policy's "recovered property" clause.

Conclusion

In printed form, a commercial property policy can amount to less than 30 pages. But each of those pages contains a lot of important information. By applying their knowledge of risks to a business's specific situation, insurance sales professionals are more likely to keep policyholders satisfied and well-protected.

CHAPTER 2: PLANNING FOR LONG-TERM CARE

Introduction

Advances in medical science are allowing Americans to live longer than ever before. However, the seemingly fortunate increase in life expectancy raises questions about an older person's continued qualify of life. While people of advanced ages can certainly find happiness and make priceless contributions to the lives of others, each passing year makes them more likely to need assistance with basic daily activities. Dealing with this need for help is often a courageous, exhausting and expensive task for both the individual and his or her family members.

The multi-faceted challenges of needing "long-term care," which can generally be defined as non-medical care that a person requires for at least 90 days, are probably already somewhat understood by most adults. Even if they haven't been directly responsible for ensuring proper care for an elderly parent, they've almost certainly observed the impact of this responsibility on other family members, co-workers and friends. The solution to long-term care is often far from obvious, and our other obligations (to our jobs, our family and ourselves) are unfortunately not likely to stop while we try to find it.

To a certain extent, practical solutions related to long-term care have been complicated by changes in society. These changes have often been necessary and even positive in some respects, but they have certainly given us more to think about when a loved one needs some extra help. For example, consider the following societal changes from the past 50 years or so:

- Fewer households feature a stay-at-home adult. This has made it less likely that an elderly person who needs

long-term care will merely move from his or her own home to a younger relative's home.

- Adult children often live in different geographic areas than their parents. If adult children don't live reasonably close to their adult parents, care for the parent can be more difficult to coordinate. It may also be harder to judge whether an elderly parent can still live independently or requires some assistance with daily activities.
- Parents are having fewer children. As a result, the responsibility for a parent's long-term care is less likely to be spread out in manageable portions among several family members.
- Adults are waiting longer to marry and to have children. This has created a "sandwich generation" of people who are caring for elderly parents while also continuing to provide financial support to their own kids.

The federal government estimates that approximately 70 percent of people who reach age 65 will eventually need some kind of long-term care. Among that large majority of seniors, approximately 20 percent will need long-term care for at least five years.

Despite those striking numbers, they don't necessarily prompt more people to plan around the need for long-term care. Indeed, the statistics can have the exact opposite effect because they can provoke so much fear. The possibility of needing long-term care inevitably makes us think of unpleasant scenarios involving our physical deterioration or even incapacitation. Given the choice to either address those anxieties or think about something else, who among us wouldn't opt instinctively for the latter?

The good news is that medical providers, insurance professionals and advocates for senior citizens are working to change some of the stereotypes surrounding long-term care. In the past, long-term care was often viewed as something that was given only to residents of nursing homes. Today, it is actively promoted as something that might be provided in private homes or in other settings that preserve as much independence for the recipient as possible. And while products like long-term care insurance might end up being extremely important for people who eventually require constant care, they can also be utilized by people who only need help with a few activities, such as getting dressed or taking a shower.

The prospect of needing long-term care isn't going to please anyone, but those who need it don't have to be stripped of their dignity and happiness.

The Purpose of Long-Term Care Insurance

Long-term care insurance helps cover the costs of skilled, intermediate and custodial care that is likely to be needed by an individual for at least 90 days.

Perhaps the best way to define long-term care insurance is to explain what it is not. For example, long-term care insurance is not insurance for medical treatment that is provided in hospitals or physicians' offices. Neither is it short-term nursing care for someone who is temporarily disabled and is likely to recover in a few weeks.

Instead, long-term care insurance might be used to pay someone who will visit an elderly or disabled person a few times a week for six months in order to help the person bathe and get dressed. Or it might be used for several years in order to pay for the daily help that is available at an assisted-living facility or nursing home.

Though long-term care insurance was technically sold as early as the 1970s, it took another 20 years or so for average consumers to take notice. By the 1990s, many financial professionals assumed that the looming retirement of the Baby Boomer generation would result in a hugely profitable market for long-term care insurance. Those expectations were spoiled by a variety of factors (including a perceived lack of affordability), but that hasn't stopped both the private and public sectors from encouraging adults to confront their possible need for good coverage. By 2012, according to the American Association for Long-Term Care insurance, more than 8 million Americans were protected by long-term care insurance products.

Levels of Long-Term Care

In general, there are three levels of long-term care, with each level representing a different degree of severity and required medical expertise. The three levels are listed below:

- Skilled care.
- Intermediate care.
- Custodial care.

The differences in each level of care can be important when evaluating a person's health situation and attempting to formulate an appropriate insurance plan for that individual.

Many objections that are raised by consumers in regard to long-term care insurance relate to Medicare, Medicaid and private insurance programs that are allegedly already in place to fund long-term care services. However, these programs typically treat each level of care differently and are therefore less of a safety net than many insurance prospects believe. For example, programs like Medicare might pay for a relatively large amount of skilled care under certain circumstances but be far less generous when asked to pay for custodial care. With the right policy in place, long-term care insurance can minimize this kind of gap.

Skilled Care

"Skilled care," is care that is prescribed by a physician and available (although not necessarily used) on a 24-hour basis. It might include various kinds of physical or speech therapy as well as the changing of dressings and bandages. Since it is available around-the-clock, most recipients of skilled care receive it in a hospital or nursing home.

Many states prohibit the sale of long-term care insurance that only covers skilled care. Similarly, some states have made it illegal to only cover lower levels of care if the insured person has already needed skilled care. This is a major difference between private long-term care insurance (which is usually meant to cover all three levels of long-term care) and programs like Medicare (which typically only cover long-term care if the person requires skilled care).

Intermediate Care

In regard to long-term care, "intermediate care" is medically prescribed care that is provided every day but is not available on a 24-hour basis. For example, an assisted-living facility might provide intermediate care from a physical therapist who works onsite for a few hours each day but is not available at any time.

Some content experts have a different definition of "intermediate care" and use this term to mean rehabilitative care that won't be needed on an indefinite schedule (such as care for a nursing-home resident who will eventually move back to a private residence).

This difference in definitions is one of at least a few reasons why the distinctions between skilled and intermediate care have become significantly less important over the past few decades. Although you might not encounter the term "intermediate care" very often, you should be careful to understand its meaning (and the potential consequences for policyholders) when it appears.

Custodial Care

"Custodial care" is the lowest level of long-term care and does not need to be supervised or performed by a medical professional. It typically involves helping someone with their basic hygiene or with housekeeping responsibilities. For example, someone who provides custodial care might help people perform the following tasks:

- Eating.
- Bathing.
- Dressing.
- Using the restroom.
- Cleaning.
- Cooking.
- Paying bills.
- Making phone calls.
- Standing up or sitting down.

Unless long-term care is needed as the result of a sudden illness or serious accident, custodial care is usually the first type of long-term care that someone will receive. Then, following an extended period of time, the person receiving custodial care will transition to needing intermediate or skilled care.

Early long-term care insurance policies were often impractical because they ignored this typical progression and would only cover custodial care if the insured person received skilled care first. Regulators responded to this problem by requiring most long-term care policies to start paying benefits to policyholders when people can no longer perform a certain number of "activities of daily living" (ADLs). Long-term care insurance contracts typically define "activities of daily living" in ways that include the following tasks:

- Eating.
- Bathing.
- Dressing.
- Transferring (such as the ability to move in and out of beds or chairs).
- Continence (for people who cannot control their bladder or bowel muscles).
- Toileting (for people who still have control over their bladder and bowel muscles but need help using a restroom).

You will learn more about activities of daily living later in this course. For now, just be aware that even though help with ADLs might be provided by non-medical professionals, most insurers won't honor long-term care claims unless someone's inability to perform these activities has been certified by a physician. Similarly, even though family members might be capable of helping with activities of daily living, some insurance companies will only cover care that has been provided by a specially licensed person or specially licensed business entity.

Common LTC Myths

Misinformation is at least partially responsible for the underwhelming amount of long-term care insurance sales in the United States. When presented with the possibility of needing this type of insurance, many prospects deflect the issue by assuming their long-term care needs can easily be addressed through other means.

Let's look at some of the most common excuses people make for not purchasing long-term care insurance and examine the level of truth in each of those excuses.

Common reasons why people claim not to be interested in long-term care insurance are listed below:

- **"I'm already covered by regular health insurance:"** Major medical insurance might be adequate to pay for skilled care, but it usually covers little to none of the custodial care that many people need.
- **"I'm already covered by Medicare:"** Medicare might pay for a limited amount of skilled care and even minor amounts of custodial care. However, the program only pays medical bills for a certain number of days and is not entirely suitable for individuals who need long-term care for more than a few months. Also, payment for custodial care might only be possible if a patient first receives skilled care.
- **"If I ever need long-term care, Medicaid will pay my bills:"** Indeed, Medicaid pays for a very significant amount of long-term care services provided in the United States. But in order to qualify for this Medicaid assistance, individuals often must first get rid of—or "spend down"—most of their assets. This and other eligibility requirements are necessary in order to ensure that Medicaid remains a need-based program intended for the poor. And since many assisted-living communities and nursing homes do not accept Medicaid payments, patients enrolled in the program might have a limited number of options regarding where they can live or which medical providers they can use. (Be very careful not to confuse Medicaid and Medicare. Remember, Medicaid will often pay for long-term care but is reserved for the poor. Conversely, Medicare is available to practically anyone of a certain age but doesn't pay for much long-term care.)
- **"The problems associated with long-term care will eventually become too big for the government to ignore. There's likely to be some kind of long-term care insurance program for all Americans at some point, so I don't need to buy insurance for myself:"** Indeed, some legislators have attempted to implement federal long-term care insurance programs. But proposed solutions related to long-term care that would help all Americans (including the wealthy and the middle class) have a history of being dead on arrival. Instead of focusing on creating a government program for long-term care, most legislators have tried to create incentives for people to purchase private long-term care insurance.
- **"I don't need to worry about long-term care insurance until I'm much, much older:"** Long-term care insurance isn't something that is used exclusively by older policyholders. The need for long-term care can arise at practically any time. In fact, according to the National Care Planning Council, roughly 40 percent of long-term care recipients are under the age of 65. (Presumably, many of these younger people are recovering from an accident and will need care for several months as opposed to several years). Although there are reasonable debates about the best age to purchase long-term care insurance, it is generally true that consumers who wait too long will be stuck paying

higher premiums or might not be able to obtain coverage at all.

- **"If I ever need care, my family will look after me:"** We've already highlighted some of the societal changes that have made care from family members less likely and harder to coordinate. But even if issues like geography and time are not significant burdens for well-meaning family members, those family members might lack the patience or physical strength to help with all kinds of necessary care. And in some cases, parents who have a lot of pride or are self-conscious about needing help with sensitive tasks (such as toileting or bathing) might prefer to receive assistance from a paid professional instead of from a close relative.
- **"If I buy long-term care insurance, there's no guarantee that I'll actually ever need to use it:"** There's some potential truth to this. However, the same statement can be made about several other kinds of insurance that consumers deem important. For example, most homeowners will never experience an event that will destroy their entire home, but this hasn't stopped them from insuring their homes up to its replacement value. Unlike other kinds of financial products that contain guarantees and can actually grow our portfolios, long-term care insurance can be viewed more appropriately as something we purchase in exchange for greater peace of mind.
- **"It's too expensive:"** This can be a valid statement for some prospects and an invalid one for others. Much depends on the person's specific financial situation, insurance-related objectives, age and health. Consumers who buy from the right company at the right time can get decent coverage at a relatively affordable price. But since there might be a limited window of opportunity for getting a great deal on long-term care insurance, people who have an interest in this coverage should discuss it with an experienced insurance professional as soon as possible.

The Importance of LTC Planning

Regardless of whether insurance is really the answer to someone's problems, people who want to preserve as many choices and maintain as much control over their own long-term care need to start thinking about the issue long before care is ever required. In most cases, this is an effort that should include both the person who might eventually need care and his or her close family members. Topics for discussion should (at the very least) include the following questions:

- Is long-term care expected to be provided by a family member, a hired professional or both?
- If care is expected to be provided by a family member, is the family member willing and able to accept all of the responsibilities of long-term care?
- If care is expected to be provided by a hired professional, does the recipient expect to be living in his or her private residence or in a community-like setting (such as an assisted-living facility)?
- In the event that care is needed in a community-like setting, are there specific facilities where the person would prefer to reside (such as a local facility already known to the person or any facility run by members of the person's faith group)?
- Is the person likely to qualify for Medicaid fairly quickly, or will he or she need to "spend down" a significant amount of personal assets first?
- Is the person concerned about leaving a significant amount of assets untouched for a spouse, family member or charity, or is the person willing to use practically all of his or her savings to fund long-term care?

Answers to those questions can play a key role in determining whether long-term care insurance should be considered and to what extent. In general, the less a person cares about qualifying for Medicaid and/or receiving care in a specific facility, the less he or she is likely to be interested in long-term care insurance. But if someone wants to avoid Medicaid for as long as possible or is adamant about wanting to receive care in a specific setting, insurance can bring those goals closer to a reality.

Care Options

Unless someone is willing to pay a tremendous amount of money out of their own pocket over an extended period of time, insurance is arguably the best tool for keeping long-term care options open. Although there are certainly many places where people without long-term care insurance receive excellent attention and services, not all of them are affordable, and not all of them will accept patients or residents who are enrolled in the Medicaid program. However, practically all reputable facilities and long-term care service providers will accept payment in the form of long-term care insurance.

We will focus on the specifics of Medicaid in a later portion of this course. For now, it's important for you to understand the basic residential and institutional options for people who need long-term care. Once a prospect has decided on a preferred setting for his or her care, the plan for paying for that care can become much clearer.

Private Homes

When asked to choose between potentially receiving long-term care in their own home or in a community setting, most people would probably opt to remain in their current residence. This makes sense because home care allows people to stay in familiar, comforting surroundings and to feel like they are still relatively independent.

In fact, a significant amount of long-term care is provided in people's own homes, although it is not necessarily the kind that is covered by a typical long-term care insurance policy. According to a study referenced in 2010 in the publication Health Affairs, approximately three-fourths of home care is provided by unpaid family members at a projected unreimbursed cost of $375 billion. Those numbers have undoubtedly grown over the years with inflation.

While not exactly easy, providing long-term care at home is often manageable if the person only needs a minor amount of custodial care and already lives with a healthy adult. If the person needing care lives alone and does not want to move into an assisted-living facility or nursing home, some assistance is likely to be needed from a home health aide or other hired caregiver. Even if the person has a live-in family member to help with most tasks, a home health aide might be hired for a few hours each week in order to give the normal caregiver a rest.

Home care isn't always as practical or enjoyable as expected. A family member might be fully committed to providing care to a loved one but lack the physical strength or training necessary to perform certain tasks, such as moving the loved one in and out of chairs and beds. Meanwhile, someone who lives alone might receive adequate care from a home health aide but discover that

there isn't enough social interaction available to make life fulfilling. As an occasional alternative, a person who receives care primarily at home might be able to enhance their social life by attending adult day care services on a periodic basis. You'll learn more about these services in the next section of this course.

Family members who hope to provide long-term care to elderly or disabled relatives should be made aware of the fact that they typically won't be compensated for their work through a long-term care insurance policy. In order for the cost of a home health aide to be covered by long-term care insurance, the person providing the care usually must be specially certified or licensed. Some insurers will pay family members who have the necessary certification or license, but families and insurance professionals should examine a policy's specific requirements about this issue instead of making assumptions.

Adult Day Care/Respite Services

Adult day care is a type of long-term care service that is usually utilized by people who live with another adult who is either working or has other major responsibilities. In exchange for a daily or weekly fee, the day care provider will help groups of people with activities of daily living, feed them, engage them in social activities and, perhaps, transfer them to and from their home.

Adult day care can be a great help to caregivers who have busy lives or who simply need some time to themselves. In fact, some states require all long-term care insurance products to cover some degree of adult day care services if they also cover home care.

Adult day care and similar services that give regular caregivers an occasional break from their duties are collectively known as "respite services." Caregivers are strongly encouraged to utilize these services when they feel overburdened. Since respite services can greatly reduce stress for a live-in caregiver, it is generally believed that utilizing these services can help elderly or disabled people maintain healthy relationships with their live-in relatives. Healthy relationships can help the care recipient remain at home for a longer period of time, which is likely to reduce costs for the person's insurance company.

Assisted-Living Facilities

Assisted-living facilities are sometimes thought of as an intermediate step between needing home care and needing care in a nursing home. In general, residents maintain their independence by living in a private unit with their own bedroom, bathroom and perhaps their own kitchen. Residents who want to socialize can interact with other residents by eating in a communal dining area or by partaking in various scheduled activities.

Assisted-living facilities offer help with custodial care on a 24-hour basis, as well as possible housekeeping, cooking and laundry services. Access to skilled care, such as physical therapy, will not be available as frequently but might be obtained on a weekly or monthly basis from a visiting medical professional.

Assisted-living facilities can provide a good balance of freedom and socialization, but people who intend on living in them should confirm that their preferred facility will indeed accept the resident's likely type of payment. Practically all facilities will accept payment out of the resident's own pocket, but many facilities won't accept payment from Medicaid. Long-term care insurance companies might only pay for care in assisted-living facilities where there are a certain number of beds (generally the more, the better) and that are properly licensed or certified by the state.

Nursing Homes

Nursing homes provide both custodial and skilled care on a 24-hour basis. Unlike assisted-living facilities, they are generally intended for residents who aren't very independent. Due to the heightened level of care provided in nursing homes, the cost of residency is typically higher than the cost of other living arrangements. The difference in cost helps explain why, unlike residents at assisted-living facilities, people who live in nursing homes often occupy a semi-private room that is shared with a roommate. If a private room is desired, the potential resident should first conduct a thorough examination of his or her finances in order to determine affordability.

Within the context of government programs and long-term care insurance, nursing homes are sometimes referred to as "skilled nursing facilities." Medicare covers a portion of care received in a skilled nursing facility for a limited time. Medicaid and long-term care insurance are more likely to pay for care in a nursing home over longer stretches.

Continuing-Care Communities

A "continuing-care community" provides multiple levels of long-term care in the same building or same complex. For example, residents living on the facility's ground floor might live in private units and receive the kinds of care typically associated with assisted-living facilities. If and when those residents require a higher level of care (such as frequent skilled care), they might move to a higher floor in the building and become part of the facility's nursing-home wing.

The appeal of continuing-care communities is that residents can stay in the same facility for the rest of their lives even if their required level of care changes. This can ease the emotional transition from one level of care to the next because patients are already familiar with their surroundings and are likely to see many of the same neighbors or caregivers every day. These facilities are also suitable for elderly couples who want to remain in close contact with each other. For example, a couple might start living in the same room in an assisted-living section of the community and then end up living just a few floors apart as one spouse declines in health.

One large drawback to continuing-care communities is the typically large deposit that must be made in order to secure a permanent spot in the facility. Common entry fees can run anywhere from $200,000 to $300,000 or more and are often funded through the sale of a resident's private home. In the event that a resident dies soon after entering the community (or wants to move elsewhere), the deposit might only be refundable under limited circumstances. Similarly, seniors might encounter serious financial issues if their chosen continuing-care community is mismanaged and needs to close.

In addition to an initial deposit, residents at a continuing-care community will usually be charged monthly fees. Someone who pays a large deposit and eventually runs out of money might be able to fund the monthly fees through Medicaid, but this is not an option if the facility does not accept Medicaid payments.

A person might have problems joining a continuing-care community if he or she is in poor health. Not unlike an insurance company, the community must balance its risk by accepting enough healthy residents, who will help offset the higher costs of the unhealthier residents. Therefore, it is important for people

who are interested in continuing-care communities to do their research in a timely fashion and not wait to apply for residency until they need a high level of care.

Hospice Care

"Hospice care" is intended for patients who are terminally ill and have shifted their attention away from potentially curing their illness and toward managing their pain. It is available to patients who have been diagnosed with a short remaining life expectancy, such as six months or less.

Unlike the kinds of care that have already been mentioned in this course material, hospice care is often covered fairly well by Medicare, Medicaid and traditional forms of private health insurance. For this reason, we will not spend much time explaining the details of hospice care.

Common LTC Insurance Policy Provisions

The next several sections will make you aware of the common provisions, exclusions and other features of long-term care insurance policies.

Unlike many types of property and casualty insurance, there are technically no standard policy forms that are used by most long-term care insurance companies. However, standardization across various insurance carriers has become more common in recent years, perhaps because of the shrinking number of companies that are offering long-term care insurance products.

With all of this in mind, you should take the time to understand the common benefits and restrictions of long-term care insurance but also carefully read the specific policy forms that you encounter.

Benefit Triggers

Long-term care insurance policies have multiple "benefit triggers" that can make the insurance company responsible for funding the insured's care. These triggers might include the diagnosis of a particular medical condition or a demonstrated inability to perform certain daily tasks.

For insurance purposes, a triggering event must be verified by a licensed physician. The physician must then certify that the person's diagnosis or inability to perform certain activities is unlikely to change for at least 90 days. If a physician provides this certification but a patient actually improves before 90 days have passed, the patient usually won't be penalized by the insurer.

After the initial 90-day period, the patient will need to be recertified by a physician in order for insurance benefits to continue. However, if the diagnosis or inability to perform certain tasks is likely to be permanent, recertification might be required on a considerably less frequent basis, such as every six months or every year.

Activities of Daily Living

The vast majority of long-term care insurance products will go into effect if the insured is unable to perform at least two "activities of daily living," as specified in the policy. Although the inability to perform activities of daily living is not the only benefit trigger for long-term care insurance, it is the one most commonly used by policyholders who have not been diagnosed with a cognitive impairment.

Most policies in the United States define "activities of daily living" to mean at least the following tasks:

- Bathing (including the ability to wash oneself and get into and out of a tub or shower).
- Dressing (including the ability to put on clothes and equipment such as braces or artificial limbs).
- Eating (the ability to feed oneself).
- Transferring (the ability to get into and out of a bed or chair).
- Toileting (the ability to get to and from a restroom and perform tasks related to personal hygiene).
- Continence (the ability to control the bladder and bowel muscles).

Some long-term care insurance products are less restrictive and either have a longer list of activities of daily living or condition coverage on the inability to perform only one activity rather than two. Conversely, some policies in a few states might combine activities such as bathing and dressing into one, thereby making it more difficult for benefits to be triggered. However, policies that mention more than these six activities of daily living have become very rare because of tax rules that will be mentioned later in this course. Similarly, policies that combine some of these activities of daily living are prohibited in some states.

Cognitive Impairment

In the early days of long-term care insurance, some families discovered that their elderly relatives had been diagnosed with Parkinson's disease or Alzheimer's disease but still weren't qualifying for insurance benefits. Their relatives were no longer capable of being left alone for too long, but their mental illnesses hadn't yet resulted in any need for help with things like getting dressed or using the bathroom. In short, benefit triggers based entirely on the inability to perform activities of daily living were shutting out a lot of needy policyholders.

In response, regulators across the country began mandating that "cognitive impairment" be included as another possible benefit trigger for long-term care insurance. In general, a cognitive impairment is something that lessens a person's ability to reason or to remember things. Like the trigger related to activities of daily living, cognitive impairment typically must be diagnosed by a licensed physician in order for it to trigger benefits under a long-term care insurance policy.

Independent/Instrumental Activities of Daily Living

Occasionally, a long-term care insurance policy will refer to either "independent activities of daily living" or "instrumental activities of daily living." These two terms generally mean the same thing and are used in connection with activities that are a bit more advanced than the standard activities of daily living. For example, these "IADLs" might include the following tasks:

- Cooking.
- Cleaning.
- Answering the phone.
- Paying bills.
- Balancing a checkbook.

As was mentioned in an earlier section, a few long-term care insurance products make benefit eligibility simpler by using benefit triggers besides an inability to perform basic tasks like bathing, eating or dressing. In those rare cases, these IADLs might be used as possible benefit triggers as well. However, products with this kind of flexibility are rarely sold today because they are generally deemed too generous by the Internal Revenue Service and, therefore, might result in negative tax consequences for consumers.

Medical Necessity

Another rare type of benefit trigger for long-term care insurance is "medical necessity." This is a vague concept that essentially allows benefits to be triggered if a licensed physician believes long-term care is necessary. It does not require diagnosis of a cognitive impairment or an inability to perform specific activities of daily living.

Like the use of IADLs, the use of medical necessity as a benefit trigger has become very rare in long-term care insurance. In the event that it is included in a policy, the policyholder is likely to lose certain tax-related privileges.

Prior Hospitalization

Older long-term care insurance products sometimes required the insured to spend at least three days in a hospital before insurance benefits would be provided. This requirement was somewhat similar to a requirement in the Medicare program, which only covers long-term care under limited circumstances and typically includes prior hospitalization as a pre-requisite for long-term care insurance benefits. In most states, long-term care insurance products that require prior hospitalization are now prohibited.

Elimination Periods

A long-term care insurance policy's "elimination period" is essentially a deductible based on a number of days rather than a dollar amount. Even after satisfying a benefit trigger (related to activities of daily living or cognitive impairment), the insured will not have his or her care covered by insurance until the elimination period has ended.

Perhaps the best way to understand elimination periods is to look at an example. Suppose the insured has a policy with a 90-day elimination period. A few years after purchasing the policy, the insured is deemed unable to perform multiple activities of daily living. At this point, the insured will not have his or her care paid for by the insurance company. Instead, he or she will need to pay for care independently for the next 90 days. On the 91st day, the elimination period will end, and the insurance company will start paying for the insured's care.

Elimination periods can span anywhere from zero to 180 days or more. The duration will depend, to some degree, on the type of care needed and the amount of money the policyholder is paying for the insurance. For instance, a policy might have a relatively short (or even no) elimination period for certain types of care received at the insured's home but might enforce a longer elimination period if care is first provided in an assisted-living facility, continuing-care community or nursing home. Regardless of where care is rendered, a longer elimination period will usually entitle the policyholder to lower premiums.

Just as they should in regard to their auto, health or homeowners insurance deductibles, prospects for long-term care insurance should carefully choose an elimination period that won't overly strain their finances. If the elimination period is too short, the prospect might be overburdened with high premiums and might end up cancelling coverage at the wrong time in order to save money. But if the elimination period is too long, someone who needs care will need to pay a significant amount out of pocket at the same time that he or she is physically or mentally vulnerable.

Once they have chosen an appropriate elimination period for themselves, prospects should look carefully at how the insurer actually calculates each day. Many policies simply use calendar days to count down the elimination period, but others only use days on which long-term care is actually rendered. This is another case in which an example should help you understand an important distinction.

Suppose an insured has a long-term care policy with an elimination period of 90 days and has been certified to need assistance with activities of daily living. He and his family decide to hire a home health aide to help the insured with various tasks once per week. If his insurer uses calendar days to calculate the elimination period, the insurer will start paying for his care after 90 days have passed. However, if the insurer uses service days, the insurer will start paying for his care after the home health aide's 90th visit (in other words, after 90 weeks).

When policyholders or their families file complaints against long-term care insurance companies, the issue is often related to the policy's elimination period. Some consumers don't understand that this period exists at all and expect to be covered for care immediately. Others know it exists but believe it starts on the day the policy is purchased (rather than the day when a doctor certifies the need for care). A third group misunderstands the difference between an insurer that uses calendar days and one that uses service days. Since confusion about this issue is so common, producers should consider spending extra time explaining it.

Time and Dollar Limits

The maximum amount of benefits provided through a long-term care insurance product might be based on a specific dollar amount, a certain time period or both. For example, a policy that is considered "long and thin" will provide coverage for several years but will only pay for a fraction of the insured's long-term care costs over that long stretch. Conversely, a policy that is "short and fat" will only provide coverage for a brief period of time but will do so with little or no cost-sharing from the insured during that brief period.

Let's look at time limits and dollar limits in greater detail and examine how they might impact each other.

Benefit Term Limits

Once a long-term care insurance policy's elimination period has passed, its "benefit period" begins. In simplistic terms, the benefit period is the amount of time the insurance company will help fund the insured's long-term care. In reality, however, the initial length of the benefit period might become longer with time as the years go by. This lengthening of the benefit period is possible in cases where the policy also has dollar limits that have not been reached during the initial benefit period.

For example, if the policy's initial benefit period expires but the insured has received a total amount of care that is $12,000 less than the policy's dollar limit, the insured might be able to extend the benefit period for another year and receive up to $1,000 of covered care during those 12 months. (This is purely a simple example and is not intended to reflect the exact way in which unused long-term care insurance benefits might be carried over from one year to another.)

Many policyholders choose an initial benefit period of three years because this number is generally in line with the average stay in a nursing home. (Multiple sources say the average stay in a nursing home is roughly 2.5 years.) Of course, there might be valid reasons to disregard this figure and to choose a benefit period that is either shorter or longer than three years. Family life expectancies as well as gender (with women generally living

longer and therefore needing more long-term care than men) are common considerations.

Some very old policies promised to pay benefits for as long as the insured lived, but these products quickly became impractical for insurers and are generally no longer available in today's market.

Benefit Dollar Limits

Along with a specific benefit period, payment for long-term care will be capped at a certain dollar amount by the insurance company. The cap will either be based on a daily amount or a monthly amount.

In the event that an insured needs less care than the capped dollar amount, the unused portion of the dollar amount can often be applied in ways that lengthen the policy's benefit period. However, the unused portion of the dollar amount usually can't be applied in ways that increase the dollar-based cap over a short period of time. For example, the fact that someone has $12 worth of unused care at the end of a month doesn't necessarily mean he or she can go $12 beyond his or her dollar limit during the following month. Instead, the insurer will usually keep track of unused dollars over a long period of time (such as an entire year) and eventually extend the policy's benefit period based on the unused amount.

To determine the overall maximum dollar amount that will be paid by the insurer for long-term care, multiply the benefit period by the daily or monthly dollar limit. For example, if the insured starts with a three-year benefit period with a daily dollar limit of $100, the insurance company would be liable for a maximum of $109,500. ($100 multiplied by 365 days multiplied by 3.) Again, the benefit period might change if the insured needs less care than expected, but even if the benefit period is extended, the insurance company will not need to pay more than $109,500 to fund this policyholder's care.

You should now be able to see how benefit periods and dollar limits relate to how much will be covered by long-term care insurance. In order to ensure that a patient is not overburdened by unexpected uninsured costs, it is very important to consider local expenses for long-term care and not rely solely on national averages. An insured who plans to receive care in Beaufort, South Carolina, for instance, should base his or her benefit periods and dollar limits on the cost of care near that small-town community. Someone who intends on receiving care in the much more expensive area around New York City should use completely different figures that relate to the cost of care in that metropolitan area.

Individuals or couples who plan on relocating to other regions of the country in their senior years should probably research costs of care in their current community as well as their likely future community. In general, care received in densely populated cities will cost more than care in smaller rural areas.

Reimbursement Policies vs. Indemnity Policies

In regard to payment of long-term care insurance benefits, some policies are "reimbursement" policies and some are "indemnity" policies. Let's look at the differences between these two options.

Reimbursement Policies

Reimbursement policies tend to be more popular and more affordable than indemnity policies.

In order to receive payment via a reimbursement policy, the insured must first incur long-term care expenses. Then, the insurance company will pay a certain amount of those documented expenses up to the policy's daily or monthly benefit limit. Insurers might make such payments to the insured or send it directly to the entity that provided the covered care. Regardless of how this type of payment is made, it is important to remember that reimbursement policies pay an amount based on the actual cost of received care.

Indemnity Policies

An indemnity policy can pay a flat amount (up to the policy's daily or monthly limit) regardless of how much is actually spent on covered care. It is therefore theoretically possible for the insured to receive an amount greater than what he or she actually paid for his or her care. However, this has the potential to create tax problems and is also made indirectly undesirable by the fact that indemnity policies can be considerably more expensive than reimbursement policies.

In the event that the policyholder purchases an indemnity policy, the flat daily or monthly amount will only be paid in cases in which covered care was actually rendered. In other words, if the insured has an indemnity policy with a $100 daily benefit but only receives care twice a week, the insured will only pay $200 for the week. The five other days (on which no care was rendered) will not result in any daily benefit.

Exclusions

The fact that someone cannot perform activities of daily living isn't a guarantee that the person will be eligible for long-term care insurance benefits. Like practically every other kind of insurance product, long-term care insurance policies contain a list of exclusions that exempt the insurer from having to provide compensation for the insured under certain circumstances.

For example, a policy might state that no long-term care benefits will be provided for any of the following injuries or ailments:

- Injuries sustained during a war.
- Self-inflicted injuries and suicide attempts.
- Care linked to alcoholism or other drug abuse.
- Non-organic forms of mental illness, such as depression or anxiety (although some forms of mental illness, such as Alzheimer's disease, must be covered).
- Care that would otherwise be covered by a government health program or by other insurance (such as workers compensation insurance).
- Injuries sustained while engaging in criminal activity.
- Injuries sustained in a plane crash (unless the insured was a passenger in a commercial aircraft).
- Pre-existing health conditions.

The exclusion of pre-existing health conditions is arguably the most important exclusion in long-term care insurance policies. With this in mind, we will address it in its own special section.

Pre-Existing Conditions

In general, a "pre-existing condition" is a health problem that had already materialized by the time the insured completed his or her application for insurance. Specific definitions will differ from state to state. For example, some states define it to mean any health condition for which symptoms were noticed and would've prompted a reasonable person to seek treatment within six months prior to the completion of the insurance application.

States also commonly set rules for how long an insurer can exclude coverage for these health problems. In most states, insurers aren't allowed to exclude pre-existing conditions for a period longer than six months or a year. If you will be selling long-term care insurance to anyone, you should research the specific rules in your state.

Although states have rules for how long-term care insurance companies can exclude coverage of pre-existing conditions, these rules only apply in cases where an applicant is otherwise deemed insurable and is issued a long-term care insurance policy. If an applicant waits too long to purchase long-term care insurance and has developed serious health problems prior to completing an application, the insurance company can deny the application outright and is not obligated to insure the person.

The federal Patient Protection and Affordable Care Act restricted insurers from denying major medical insurance to individuals because of their health (including any pre-existing conditions). However, this law did not include similar restrictions for long-term care insurance.

Guaranteed Renewable vs. Non-Cancellable Coverage

In most states, long-term care insurance must be either "guaranteed renewable" or "non-cancellable." Though these two terms might seem similar, they are different in some very important ways.

If long-term care coverage is guaranteed renewable, the policyholder has the right to renew the coverage and keep it in force as long as premiums continue to be paid. The insurance company cannot cancel the person's coverage due to the insured's increased age or deteriorating health. The premiums for a guaranteed renewable policy can increase, but the increase must apply to all of the insurer's customers within a particular rate class. In other words, although the insurer can raise prices on a large group of policyholders (such as all policyholders who purchased coverage more than two years ago), it cannot discriminate against a specific policyholder and impose higher prices specifically on that one person.

If long-term care coverage is non-cancellable, both the coverage itself and the cost must remain the same as long as premiums continue to be paid. Unlike guaranteed renewable coverage, non-cancellable coverage cannot be subjected to price increases unless the policyholder decides to make changes to the policy and opts for better insurance.

Non-cancellable long-term care insurance was available several years ago and was typically purchased with a large, lump-sum premium. Insurance companies eventually realized they had priced these products incorrectly and have since made non-cancellable coverage very difficult to find.

Carriers and producers must be aware of the differences between guaranteed renewable and non-cancellable coverage. Using the wrong term in advertising or in conversations with consumers can create serious confusion and can lead to disciplinary actions.

Inflation Protection

Since the cost of health care is almost certain to rise over time, consumers might struggle to determine whether their benefit limits (daily, monthly or cumulative) will be enough to eventually pay for their care. Insurance companies have responded to this concern by offering various "inflation protection" riders for their long-term care products.

At the time this course was being written, the most common form of inflation protection for long-term care insurance provided a 5 percent increase in a policy's benefit limit every year. Usually, the increase is compounded, meaning the 5 percent increase for a given year will include any 5 percent increases from previous years, too. This form of compounded interest is the opposite of "simple interest." Inflation protection based on simple interest will result in lower increases in daily benefits but will generally be cheaper than protection based on compounded interest.

Other forms of inflation protection might be based on increases in an economic index—such as the Consumer Price Index—rather than on a specific, predetermined percentage. However, it should be noted that this type of index tends to look at inflation across several sectors of the economy and won't necessarily match the level of inflation in health care.

Many financial professionals advise consumers to purchase inflation protection for their long-term care insurance, especially if coverage is purchased at a relatively young age. In fact, some states require inflation protection to be included in long-term care policies unless the consumer signs a waiver and refuses the protection. But regardless of the generally positive opinions surrounding inflation protection, it is still important to conduct a needs analysis for consumers and determine whether this important feature is worth the relatively high cost.

Similarly, it is important to be clear about how inflation protection actually works and to not allow prospects to be confused by its name. Purchasing inflation protection can reduce the risk of coverage not keeping up with inflation, but it does not guarantee that a policy's benefit limit will constantly be increased at the same rate as health care costs.

Future Purchase Options

A "future purchase option" is often viewed as an alternative to inflation protection. When included in a long-term care insurance policy, this feature allows someone to purchase more insurance (such as a higher benefit limit) without needing to medically qualify for it. This can be beneficial for policyholders who bought insurance many years ago, realize they need more coverage and would otherwise not qualify for it based on their worsened health status.

While a future purchase option can solve problems related to insurability, it won't necessarily make additional coverage affordable. When the insured decides to exercise a future purchase option, the price for the additional coverage will be based on the person's age at that point (known as the person's "attained age") and not on the person's age when the initial policy was purchased (known as the person's "issue age").

Consider, for example, someone who buys a policy at age 50 and chooses to include a future purchase option. At age 75, the policyholder realizes he is close to needing long-term care and that his benefit limits won't be nearly enough to fund his expenses. If he opts to exercise the future purchase option, the cost of the additional benefits will be based on him being 75. They will not be based on his issue age (50).

Future purchase options often have limits regarding when they can be exercised. For example, the insurance company might require that the option either be exercised or forfeited by the time the insured reaches a certain age, such as 65 or 70. The option generally cannot be exercised if the insured is already in need of long-term care. In other words, if the policyholder wants to take advantage of this option, he or she must do so while still relatively healthy.

Waiver of Premium

A "waiver of premium" is an important part of a long-term care insurance policy, particularly for people who already need care. Under this provision, the insured is exempt from having to pay premiums once he or she has started to receive benefits from the insurer.

In addition to the financial help that a waiver of premium can facilitate, it provides practical relief, too. Although some individuals who need long-term care might be capable of managing their own finances, others will lack the physical or mental ability to keep track of their bills, including premium-related notices from their insurance company. The waiver makes it less likely that coverage will end when a claimant is most vulnerable.

Free-Look Periods

A "free-look period" gives policyholders a chance to review their recently purchased long-term care insurance policy and get their money back if they notice something they don't like. The deadline for returning the policy to the insurer and requesting a refund of any paid premiums is often set by state rule and might depend (to a certain degree) on the applicant's age. For example, a state might require at least a 30-day free-look period for all long-term care purchases but extend the requirement to 45, 60 or 90 days if the applicant is a senior citizen.

Care Coordination

Some insurers will pay for assistance from "care coordinators." These trained individuals do not provide skilled, intermediate or custodial care but have a thorough understanding of long-term care services in their geographic area. They can assist consumers by providing referrals to qualified local providers, and they can help insurers by making sure that long-term care services are being delivered in an efficient, cost-effective manner.

Alternative Plan of Care

A long-term care insurance policy might agree to pay for costs related to an "alternative plan of care." When present, this provision allows certain kinds of long-term care to be covered by the policy even if the policy language doesn't address them. For example, a policy issued prior to the popularity of assisted-living facilities might not specifically mention these residential options but might pay for them anyway. Similarly, a policy that doesn't mention coverage of ramps, bars and other types of home modifications for disabled people might still pay for their installation as an alternative plan of care.

Coverage of an alternative plan of care usually requires the insurer and a licensed physician to agree that the care is the most appropriate option for the insured. Usually, the insurer will defer to the physician's judgment as long as the recommended alternative plan of care is likely to save the insurer money. In most cases, the insurer will save money if the insured remains in a setting other than a nursing home for as long as possible.

Bed Reservation Benefit

A bed reservation benefit is sometimes included in a long-term care insurance policy. When available, this benefit will continue to cover payment in a nursing home even if the bed's usual occupant is temporarily residing elsewhere. The benefit might be exercised if the resident of a nursing home enters the hospital for an extended period of time or decides to go on a long trip.

Home Modification Benefit

Home modification benefits can cover the installation of wheelchair ramps and various pieces of equipment that help weak or disabled people shower, bathe or use the restroom. When they are not specifically included in a policy, these benefits might be available indirectly via an alternative plan of care. (Alternative plans of care are explained in an earlier portion of these materials.)

Geographic Limits

Applicants who are toying with the idea of living overseas should think carefully before settling on a long-term care insurance product. Most policies will pay for care anywhere in the United States but might offer no (or very few) benefits if care is needed in other countries. On occasion, the insurer will offer coverage that extends to other parts of North America (such as Canada or Mexico).

Even if a policy will remain in force across state or even national lines, geographic location needs to be part of a long-term care insurance prospect's decision. It will be very difficult (if not impossible) to select an appropriate benefit limit if the potential policyholder has no knowledge of local health care costs.

Cancellations and Non-Renewals

For various reasons, a long-term care insurance policy might be cancelled or not renewed. Non-renewal occurs when either the insurance company or the policyholder decides to stop coverage at the end of the policy period (such as at the policy's annual anniversary date). Cancellation, on the other hand, might occur at other times as long as proper notice is provided and other rules are followed.

Policyholders might choose to cancel or not renew their coverage because premiums have become too high. In this case, a state might require that the insurer offer to keep a smaller amount of coverage in place in exchange for lower premiums.

On occasion, insurance will be on the verge of cancellation because the policyholder merely forgot to pay the insurer on time. In addition to sending a warning to people who have missed a premium payment, notice might be given to a friend or family member. The option to alert a friend or family member is often given to applicants when the policy is issued and is meant to avoid situations in which payments are missed due to extended vacations or even the early signs of cognitive impairment.

In relatively rare cases, an insurance company can cancel someone's long-term care coverage with proper notice for reasons besides nonpayment. Grounds for cancellation typically only exist if the policyholder misrepresented facts to the insurer when applying for insurance. Depending on state law, an insurer's ability to cancel based on an applicant's misrepresentations might decrease over time. For instance, the insurer might have the ability to cancel based on an unintentional (but still important) misrepresentation if the policy has only been in force for a few months. But once the coverage has been in effect for a few years, the insurer might only be allowed to cancel if the applicant obviously engaged in an intentional type of fraud.

Reinstatement For Cognitive Impairment

You just learned about how the insured has the option of having cancellation notices sent to a friend or family member and how this can manage the possible risk of cognitive impairment. Regardless of whether the aforementioned third-party notice is desired, a policyholder who misses premium payments due to

cognitive impairment and ultimately loses coverage is typically allowed to regain the insurance within a certain timeframe. This is known as "reinstatement for cognitive impairment" and is typically possible within the first few months after long-term care coverage has lapsed.

When this option is exercised, the insurer will need to receive a letter from a licensed physician who can verify the impairment. The policyholder will need to pay all premiums that were missed or would have been due during the lapse, but the person won't be charged more or denied coverage because of any changes in his or her health. In other words, both the insurance and the price for it must remain the same, as if the lapse in coverage had never occurred.

Non-Forfeiture Options

Depending on the state where it is purchased, a long-term care insurance policy might automatically include "non-forfeiture benefits" or at least give the policyholder a chance to add them for an additional charge. Non-forfeiture benefits are provided when the policyholder has paid premiums for the insurance but decides to cancel coverage before long-term care services are ever needed. They can be particularly appealing to applicants who worry about paying for a policy that they might never actually use.

Typical non-forfeiture benefits will allow the insured to remain covered for a period of time after cancellation without having to pay any additional premiums. The length and size of the non-forfeiture benefit will be chosen either by the policyholder or the insurer. One option might be to cover the insured for the remainder of the policy's benefit period but to lower the daily benefit. Alternatively, the daily benefit might stay the same but only allow coverage to continue for a brief period of time. Or instead of receiving some kind of reduced coverage, the policyholder might simply receive a partial refund of premiums.

The size and variety of non-forfeiture benefits will depend on what a particular state requires, how much the policyholder has already paid in premiums, and how much the insured is willing to pay for the flexibility of a particular non-forfeiture option.

Covering Multiple People With LTC Insurance

So far, our focus has been on long-term care insurance intended for one person. However, some products can insure two or even more people at the same time. Let's spend a few moments learning about these options, including group plans and spousal coverage.

Group Plans

Though relatively rare, it is possible to purchase long-term care insurance as part of a group plan. Group plans involve little or no medical underwriting, making it is easy for relatively unhealthy people to join.

Unfortunately, many long-term care insurance plans in the workplace experience "adverse selection," which occurs when insurance is too commonly purchased by people who are considered "bad" risks for the insurance company. Younger and healthier employees almost always decline to join these group plans, so the insurer must price the coverage at a relatively high rate. The relatively high prices make group plans unattractive to those employees who might otherwise be interested in some form of long-term care insurance. Furthermore, hardly any employers supplement the cost of group plans by paying a portion of the premium. (This is true even though employer contributions to group long-term care insurance plans might be tax-deductible for the employer.)

Group long-term care insurance plans might entice participation from employees who are interested in some coverage and don't have the time to shop for it. However, many potential participants in group plans are likely to qualify for an individual policy that is more customized to their needs at (perhaps) a more affordable price. Employees who are presented with offers to join a group plan might want to explore all of their available options, including those in the individual market.

Spousal Coverage

Spouses who are interested in obtaining long-term care insurance have the option of purchasing a completely separate policy for each spouse or purchasing a product that allows for "shared care." If a policy allows for shared care, benefit periods and benefit limits can be transferred from one spouse to another on an as-needed basis. This is particularly helpful in cases where one spouse eventually needs care but the other is likely to live a longer, largely independent life.

In cases where shared care is possible, the insurer might still put limits on the amount of benefits that can be transferred from one spouse to the other. For example, an insurer might prohibit any more sharing of care if the spouse giving up his or her benefits would be left with less than three years of coverage.

LTC Producer Licensing and Training

Individuals who wish to sell long-term care insurance must first be properly licensed and complete any required coursework.

A producer who wants to sell long-term care insurance must already be licensed to sell accident and health insurance. Then, the producer typically must complete a special training course about long-term care. Note that the requirements for this course are set not only by the state's licensing division but also (in some cases) by the insurance company that the producer plans to represent. For example, a state regulator might only require that producers take a long-term care insurance course that is at least a certain length. However, a particular insurance company might require all of its agents to complete a specific course from a specific education provider. So it's possible (but not guaranteed) that a producer who represents multiple insurance companies might need to satisfy the coursework requirement multiple times by taking multiple courses.

Many states require producers to complete additional long-term care insurance training on a regular basis. In most cases, this continued training will be tied to a producer's continuing education requirements as part of the license renewal process. As is the case with the initial training requirement, each insurance company might have its own rules regarding which long-term care courses must be completed.

Please note that although the course you are reading has been approved for insurance continuing education credit, it is not intended to satisfy the specific long-term care insurance training requirements mentioned above.

Underwriting and Pricing of LTC Insurance

Affordable long-term care insurance isn't available to everyone who wants it. Insurance companies absorb significant risks when they issue a long-term care policy, so each applicant for coverage is likely to be evaluated carefully.

Underwriters of long-term care insurance consider the information provided on a person's application and are also likely to delve further into the applicant's medical history. When evaluating an applicant's health, the insurer might request access to files from the person's physician as well as data from an industry database called the "Medical Information Bureau."

Depending on the information on the application, the insurer might also require the person to undergo either a paramedical exam or a brief phone interview. Paramedical exams and interviews are especially common for older applicants and are generally intended to help the insurer determine early signs of cognitive impairment. As part of this process, some insurers test the applicant's memory and ask the person to solve basic math problems.

Morbidity Risk

Although long-term care insurance is sold by many life insurance companies, underwriting guidelines for long-term care coverage are not identical to underwriting guidelines for life insurance. Whereas life insurers are generally concerned about "mortality risk" and focus on a person's life expectancy, long-term care insurers are generally concerned about "morbidity risk" and want to know how long a person is likely to have a debilitating health condition.

Due to the differences between mortality risk and morbidity risk, it is possible for an applicant to be eligible for affordable life insurance but not affordable long-term care insurance and vice versa. Consider, for example, someone whose family history suggests a long life expectancy but the possibility of eventual Alzheimer's disease. In this case, the applicant might live long enough (and pay enough in premiums) to be considered a good risk for a life insurance company but is less likely to remain cognitively healthy and be considered a good risk for a long-term care insurance company.

Despite the differences between morbidity risk and mortality risk, long-term care insurers and life insurers both place some significance on an applicant's age. Since morbidity risk tends to increase as people grow older, applicants will pay higher premiums the longer they wait to sign up for coverage. This doesn't necessarily mean a young person should purchase long-term care insurance as soon as possible, but it does create a challenge for healthy consumers who believe long-term care insurance is a valuable product. If they buy long-term care insurance too soon, they might end up spending a significant piece of their income on insurance that they're unlikely to use until several decades later. On the other hand, if someone puts off the decision to purchase long-term care insurance for too long, the premiums might be prohibitively high or the insurer might deny the person's application outright. The best time to purchase insurance is right before you need it, yet none of us knows exactly when that will be.

Unfortunately, many people with serious health conditions have already waited too long to purchase long-term care insurance. An insurance company is likely to decline an application for long-term care insurance if the applicant has been diagnosed with the following ailments:

- AIDS.
- Cancer.
- Multiple sclerosis.
- Parkinson's disease.
- Alzheimer's disease.
- Stroke.
- Diabetes.
- Extreme obesity.

Admittedly, not all insurance carriers view all applicants in the same way. Someone who was diagnosed with skin cancer but went into remission five years ago might be denied a policy from one insurer but qualify for coverage from a different company. However, being denied insurance by one insurance company is often a warning sign or "red flag" to other insurers. In order to steer applicants to the most appropriate carrier, producers should make an effort to learn the underwriting standards of each insurer they represent.

Issue Age vs. Attained Age

The impact of age on premiums for long-term care insurance will depend on whether the cost of coverage is based on the insured's "attained age" or "issue age."

If premiums are based on the insured's attained age, they are nearly guaranteed to increase on a regular basis as the insured grows older. Increases in cost might occur on an annual basis or on some other regular schedule. However, some states put caps on premiums for issue-age coverage and don't allow insurers to increase costs based purely on age after the insured reaches a certain birthday (such as 65).

Most long-term care insurance products sold today are priced on the basis of the insured's issue age. The insured's issue age is his or her age at the time when coverage was originally purchased. In practice, this can lock the size of premiums for an extended period of time and provide more cost-stability for the insured than an attained-age policy. However, someone who purchases coverage based on his or her issue age isn't fully shielded from future premium increases. Unless the coverage is "non-cancellable" (as opposed to guaranteed renewable), the insurer will retain the option to increase premiums for entire classes of policyholders if business ends up being less profitable than expected. More details about non-cancellable and guaranteed-renewable coverage appear in an earlier section of this course.

As was mentioned previously, it is possible to wait too long to purchase long-term care insurance. This is true even if the applicant is relatively healthy and is only considered a high risk due to his or her age. Most insurers have a cutoff point for issue ages, meaning they won't accept applicants who have lived beyond a certain number of years. Maximum issue ages might fall anywhere from 75 to 85 years old but are likely to differ from carrier to carrier.

Rate Increases

When shopping for the most affordable long-term care insurance policy available, the buyer might be tempted to merely go with the carrier offering the lowest price. Though current prices for coverage are a wise place to begin the shopping process, the low prices offered today are not guarantees of low prices tomorrow. Consumers and insurance producers should consider whether further research is required to determine the likelihood of stable pricing across several policy years. Here are some questions to consider when evaluating a quoted price:

- Does the carrier have a history of rate increases?
- Is the company new to the market and pricing its products in ways that are seemingly unrealistic?
- When a carrier has initiated a rate increase, has the increase usually been applied only to new policyholders or spread across the insurer's entire clientele?

Taking a long-term approach to affordability is particularly important for long-term care insurance applicants because of the market's frequent instability. When the insurance first became popular, carriers wrongly assumed many policyholders would eventually let their insurance lapse and never force an insurer to pay any claims. They also misjudged the overall future of the global economy and assumed they would be able to earn much more income from invested premiums than what was ultimately possible.

As a result, many insurers realized they could no longer price long-term care insurance confidently and stopped selling it. The companies that remained were sometimes forced to impose rate hikes on existing customers in order to remain solvent and achieve a relative degree of financial health. The older a policy was, the more likely it was to experience an increase in cost. Rate increases in the neighborhood of 40 percent to even 90 percent over a period of time weren't uncommon and were bad news for many senior citizens on fixed incomes.

In order to lessen the impact of possible price increases, many states have rules regarding disclosure of rates and the steps people can take to cope with the extra costs. For example, pending rate increases might need to be reported to policyholders several weeks in advance of their effective date. Also, an insured who is confronted with a rate increase might be entitled to a revised policy that reduces some benefits but allows the person to keep some insurance in force at the same, usual price.

Single-Premium Plans

A few older long-term care insurance products allowed consumers to purchase them with a single premium. For the reasons mentioned earlier in this material (including misjudged lapse rates and unexpectedly low investment returns), these products rarely turned a profit for insurance companies and are almost never sold anymore. Instead, most long-term care insurance is funded through monthly or annual premiums that must be paid until the insured qualifies for long-term care services.

Should Everyone Buy LTC Insurance?

Planning for potential long-term care is something that hardly anyone should ignore. But the importance of long-term care planning shouldn't be confused with the importance of long-term care insurance. Insurance can play an immensely important role in long-term planning, but it isn't the obvious answer for all or even most people.

This doesn't mean producers should dismiss long-term care insurance as an option or feel guilty about selling it. It merely means they should carefully examine each prospect's unique situation and not view the product as a one-size-fits-all form of protection. If an insurance professional is open and honest when a product isn't especially suitable for someone, the professional's recommendations to purchase other products are likely to carry more weight.

The truth of the matter is that long-term care insurance isn't suitable for everyone. However, consumers and their financial advisers might struggle with the concept of suitability because there are no clear rules about who should purchase coverage and who should either save their money or spend it on other things. An online search will likely reveal several conflicting pieces of advice that are tied to specific dollar amounts. For example, some alleged experts suggest consumers purchase long-term care insurance if their personal assets are worth at least $200,000. Others might make a distinction between liquid assets (such as savings accounts) and illiquid assets (such as a home) and say that adults with illiquid assets of at least $50,000, $100,000 or maybe as much as $300,000 should consider a long-term care policy.

One potential problem with these types of broad recommendations is that they don't consider the differing costs of care across various parts of the country. They also pay little attention to a prospect's current income and the person's other financial goals and obligations. In all likelihood, care in a New York City nursing home is likely to cost a different amount than care in a rural setting. Furthermore, a middle-aged parent with a mortgage and no disability insurance or life insurance might want to make other kinds of coverage a higher priority than a long-term care policy.

Although making blanket statements about the value of assets and the appropriateness of long-term care insurance can be tricky (or even unadvisable), two common pieces of advice are too widely accepted to ignore:

- People who are likely to qualify for Medicaid either before or within a few months of needing long-term care services generally aren't good candidates for long-term care insurance. Presumably, the value of their assets won't justify the premiums paid for a good policy.
- People who are very wealthy and have a significant amount of money in liquid assets might not be good candidates for long-term care insurance because they might be able to pay for their care out of their own pockets.

Despite those two widely accepted pieces of advice, there will almost certainly be exceptions to them. For example, perhaps someone with a small amount of assets would otherwise qualify for Medicaid but is adamant about staying in a specific long-term care facility that does not accept Medicaid payments. Or maybe a very wealthy person has a very large family or children with special needs and therefore lacks as much financial flexibility as we'd expect. In both cases, it might be wise to consider long-term care insurance.

Performing a Basic Needs Analysis

Making insurance recommendations that are suitable for a prospect isn't just a matter of good, ethical business. Many states have made suitability a compliance issue, too, and have developed lists of factors that must be considered before encouraging someone to purchase long-term care insurance. Specific factors to consider tend to differ from state to state but are still likely to include answers to the following questions:

- Why is the person interested in long-term care insurance, and will this product help the person achieve his or her goals?
- Will the person be able to afford the amount of recommended coverage (both in the present and in the future)?
- Does the person already have other insurance or other legitimate means of paying for long-term care services?

Alternatives to Long-Term Care Insurance

When planning for the potential of needing long-term care services, people need to carefully explore all of their available options. This is important not only because of the few disadvantages of long-term care insurance (such as cost) but because these options are often misunderstood by the public and

leave many prospects with the incorrect belief that an insurance-focused long-term care plan isn't right for them.

The next several sections will summarize many of the possible products and programs that might be used as alternatives or supplements to long-term care insurance. Just as we have attempted to be transparent about the plusses and minuses of long-term care insurance, we will address each option's strengths and weaknesses. Perhaps most importantly, we will attempt to clarify some of the myths or half-truths that might be having an unfair influence on potential insurance buyers.

Medicare

Medicare is the popular federal insurance program intended mainly for Americans who are at least 65 years old. Practically every legal resident of the United States who has reached his or her 65th birthday is either eligible for some level of free Medicare coverage or can at least join the program by paying premiums. The program also is available to Americans of any age if they have certain disabilities or illnesses. Unlike the similarly named "Medicaid" program, Medicare is not a need-based program and is open to Americans regardless of whether they are rich, poor or members of the middle class.

Medicare Part A

There are several different parts to the Medicare program, each with its own eligibility requirements and list of benefits. In general, each part is known by a particular letter of the alphabet. The part that is most relevant to a discussion about long-term care services is "Part A."

In addition to paying for care received in hospitals, Medicare Part A can be utilized to pay for brief confinement in a "skilled nursing facility" or nursing home. In order for a stay in a nursing home to be covered by Medicare, a Medicare recipient must need skilled care and must have moved into the nursing home after at least three days of hospitalization. Assuming those two requirements have been met, Medicare Part A will pay for practically all of a nursing-home stay that lasts up to 20 days and will cover smaller amounts of nursing-home bills up to the patient's 100th day of confinement. Someone who needs to stay in a nursing home for more than 100 days will not have his or her care covered by Medicare anymore.

These restrictions make Medicare an inadequate alternative to long-term care insurance for the following reasons:

- Most people who need long-term care mainly need help with custodial care (such as eating, bathing, dressing and toileting) and will usually need this assistance for several years before needing the skilled care covered under Medicare Part A. Long-term care insurance will cover custodial care once a policy's elimination period has ended.
- Many people need long-term care because of the gradual aging process and not because of a serious illness or injury. However, Medicare will only pay for nursing-home care if the person has first been hospitalized for at least three days. Long-term care insurance generally doesn't require prior hospitalization in order for benefits to begin.
- Medicare stops paying for nursing-home care after 100 days, but care might be required for a much longer period of time. Long-term care insurance can help pay for care that lasts several months or years.
- The Medicare benefits mentioned here apply only to skilled nursing facilities and not to assisted-living facilities or home care. Long-term care insurance can be used to pay for care provided in a variety of different settings, including nursing homes, assisted-living facilities, private homes or continuing care communities.

Medigap Plans

Millions of senior citizens purchase private insurance products called "Medigap policies" or "Medicare supplements" in order to fill in some of the holes in the popular Medicare program. These supplemental policies can reduce cost-sharing for Medicare recipients by covering Medicare deductibles, copayments and co-insurance fees.

Medigap policies generally do not pay for categories of care that aren't already covered in some form by the Medicare program, and they don't change Medicare eligibility rules. This includes the rules about skilled care, custodial care and prior hospitalization. So if someone is ineligible for long-term care coverage through the Medicare program, a Medigap policy is almost certainly not going to solve the problem.

Medicaid

Medicaid (as opposed to Medicare) is a health care program intended for people with few or no assets. Costs under the program are shared by the federal government and the individual states. In exchange for paying some of Medicaid's bills for the states, the federal government sets minimum standards for the program. States can then implement the program in their own ways as long as the federal standards are met. For example, the federal government requires all state Medicaid programs to pay for certain forms of long-term care provided in nursing homes but allows states to exclude coverage of home care.

Believe it or not, most long-term care that is provided in the United States is paid for by Medicaid. However, this doesn't mean reliance on Medicaid should be everyone's solution to their long-term care needs.

In order to qualify for the plan in the first place, individuals must satisfy some strict requirements that are likely to impact their financial future. They are also likely to lose some of the choices available to people who either have long-term care insurance or are paying for services out of their own pocket. Still, since so many people already receive long-term care through Medicaid, it isn't easy to dismiss the program's usefulness.

Medicaid Income Requirements

Medicaid is a need-based program, meaning it is intended only for people who truly cannot afford services on their own. In order to qualify for help through the Medicaid program, a person must satisfy certain requirements related to income and financial assets.

The specific income-related requirements for Medicaid eligibility will depend on state rules. Some states have a "hard" income cap that forbids anyone from receiving Medicaid assistance if he or she has a monthly income above a set amount, such as $2,000. However, in a majority of states, seniors with higher incomes can qualify for long-term care via Medicaid if they "spend down" their excess income by paying for some medical services out of their own pocket.

When evaluating a senior's income, the state's Medicaid program will usually consider the following sources:

- Social Security benefits and other retirement income.
- Pension benefits.

- Veteran's benefits.
- Disability benefits.
- Salaries or wages.
- Interest income.

In general, food stamps and federal housing assistance are not counted as income for the purposes of eligibility.

Be aware that meeting an income limit is merely one step in qualifying for long-term care services from Medicaid. Even people with low incomes (such as less than $2,000 per month) or who "spend down" their excess income will typically need to satisfy additional requirements and will not be allowed to spend all of their money as they please. This point is explained in more detail in the next section.

How Much Income Can Medicaid Recipients Keep?

Regardless of how much money they technically earn, seniors whose long-term care is funded by Medicaid will only be allowed to keep a small amount of their income. All but a small piece of it must be used to pay a portion of the person's medical bills. The amount that can be used for non-medical purposes is the senior's "personal allowance" and is intended to cover personal items, phone bills and insurance premiums.

The exact size of the personal allowance will differ from state to state and might depend on whether long-term care services are being provided in a nursing home, a continuing-care community or a private residence. Though states are not required to pay for long-term care in settings other than nursing homes, those that will pay for home care will often allow for higher personal allowances. In these states, it is assumed that someone in a nursing home will not need to pay separately for necessities like food, heat and electricity, whereas someone who lives in a private home might still need to fund those expenses on his or her own.

Medicaid Asset Requirements

Even if they have low incomes, seniors who want to qualify for long-term care services via Medicaid cannot have a significant amount of financial assets. This requirement, paired with those related to income, are intended to ensure that Medicaid remains a need-based program and is not used by people who might otherwise be capable of paying for their own medical care.

Like the income requirements for Medicaid, the threshold for financial assets can differ from state to state. Seniors wanting long-term care services through the Medicaid program are generally not allowed to have assets worth more than a few thousand dollars. This includes, but is not limited to, the following types of assets:

- Checking and savings accounts.
- Stocks, bonds or shares of mutual funds.
- Certificates of deposit.
- Real estate (with the possible exception of the person's primary residence).
- Automobiles (other than one vehicle driven by the person or used to transport the person).

Some types of assets are exempt from Medicaid's rules and can be kept even if the senior has other assets worth up to a few thousand dollars. For example, the following items are generally not included when determining whether someone has too many assets for Medicaid purposes:

- The person's primary residence.
- The person's primary automobile.
- Clothing, jewelry and other personal or household items.
- Pre-paid funeral plans.
- Small life insurance policies (usually worth no more than a combined $1,500).
- A small amount of cash intended for burial and other final expenses.

Understanding the Exemption for Primary Residences

The exemption for a person's primary residence is very important and deserves special attention here. Although the person's primary residence can be excluded from Medicaid's asset-related calculations, this exemption might not apply if the senior is already in a long-term care facility, does not have a spouse or dependents, and is unlikely to ever leave the facility.

The exemption for a person's primary residence might also be unavailable if the senior has a large amount of equity in his or her home. To determine the amount of equity in a home, subtract the balance of any remaining mortgage loans from the home's fair market value.

The exact cutoff point for the residence exemption (based on the amount of equity in the home) tends to change from year to year and varies among the states. Each state has the option of using either the lower or higher of the two numbers. It is common for a state's choice to be based on local property values. States with higher property values tend to use the higher number, while states with lower property values tend to use the smaller one.

When considering how the residence exemption might impact a potential Medicaid applicant, it is important to understand how the home is currently owned and who currently lives there. The limits on home equity only apply to the person applying for or receiving Medicaid assistance. Therefore, if a home is owned by multiple people and only one of them is applying for Medicaid, a residence worth a lot of money might still qualify for an exemption.

As an example, consider a home that is owned outright by two unmarried people, one of whom is applying for Medicaid. The owners live in a state where Medicaid's residence exemption doesn't apply if home equity is more than $600,000. The owners collectively have home equity of $700,000. But because they own their home jointly (with $350,000 of equity per owner), the Medicaid applicant might be eligible for benefits without selling his or her home.

Even in cases where a Medicaid applicant owns his or her home independently, the limits on home equity can be waived in either of the following scenarios:

- The applicant's spouse lives at the property.
- The applicant's dependent (such as an adult child with special needs or a son or daughter who is a minor) lives at the property.

Medicaid Spousal Impoverishment Rights

Many married people are interested in long-term care insurance because they worry about how Medicaid's eligibility rules might impact their spouse. Since Medicaid puts limits on a person's income and assets, there is the concern that the healthy half of a couple will need to make tremendous financial sacrifices in order to help an unhealthy spouse qualify for the need-based program.

In fact, previous decades included cases in which some healthy spouses decided to divorce their unhealthy spouses in order to satisfy Medicaid's requirements and not put themselves in

poverty. Such cases resulted in the passage of "spousal impoverishment laws," which allow the non-Medicaid spouse (known as the "community spouse") to keep a certain amount of the couple's assets and income.

Income and Non-Medicaid Spouses

In general, income received solely in the community spouse's name for his or her own benefit can be kept by the community spouse and won't impact the other spouse's Medicaid eligibility.

If the community spouse has no independent income or only earns a small amount, the community spouse might be able to keep a portion of the unhealthy spouse's income. The amount of allowed income from the unhealthy spouse might be capped at a certain amount, such as $3,000 per month.

Assets and Non-Medicaid Spouses

When a married person applies for Medicaid, the government will consider the combined assets of both spouses. Then, the amount of assets that can be kept by the community spouse will be based on state rules.

In most states, the community spouse will be allowed to keep half of the combined assets but will not be allowed to keep more than a certain dollar amount. (The exact amount can change from year to year.) In other states, the community spouse will be allowed to keep 100 percent of the combined assets but will not be allowed to keep more than a certain dollar amount. (The exact amount can change from year to year.)

States that generally have a 50-percent rule might allow a community spouse to keep 100 percent of combined assets if those combined assets are lower than a certain dollar amount. (The exact amount can change from year to year.)

Also, as was mentioned previously, a Medicaid applicant's home is excluded from the program's rules regarding assets if the community spouse lives there.

Medicaid Planning and Look-Back Periods

If they believe Medicaid is likely to be their best option for long-term care services, some seniors might attempt to structure their finances in ways that make it easier to qualify for the need-based program. This process is known as "Medicaid planning."

One popular goal of Medicaid planning is to transfer financial assets to family members, charities or trusts so that they don't actually need to be spent on medical services. This is a controversial practice because it can result in people qualifying for the need-based Medicaid program without fully forfeiting their money or other things of value. On the other hand, many people don't see a problem with Medicaid planning as long as they aren't directly violating any laws and are simply taking advantage of loopholes in the eligibility rules.

In order to police certain types of Medicaid planning, the government requires Medicaid applicants to disclose practically any transfer of assets that were made in the preceding five years. The five-year timeframe is known as the "look-back period." If an asset was transferred during the look-back period for less than its fair market value, the applicant will be penalized.

To determine the penalty for an inappropriate transfer of assets, the government will start by determining the asset's fair market value. For the sake of an example, let's assume an inappropriate transfer involved an asset worth $10,000.

Next, the amount actually received in exchange for the asset (if any) will be subtracted from the fair market value. Going back to our example, imagine that the $10,000 asset was transferred to the Medicaid applicant's son in exchange for only $1,000. This means an inappropriate transfer of $9,000 occurred.

Now, we need to divide the amount of the inappropriate transfer by the average monthly cost of long-term care services in the Medicaid applicant's community. Assuming a local monthly cost of $3,000, we'd divide $9,000 by $3,000 and get a quotient of 3.

The quotient, measured in months, is the amount of time the Medicaid applicant will be forced to still pay out of pocket for long-term care services until Medicaid benefits will begin. So in our example, even if the applicant seems to have otherwise satisfied all of Medicaid's eligibility requirements, he or she won't be covered by the program until another three months have passed.

Exceptions to the Transfer Rules

Some kinds of transfers, such as certain transfers between spouses or dependents, can be made even if they occur less than five years before someone applies for Medicaid. For example, transfers of home equity might be possible if they are made to the following individuals:

- A spouse.
- A child who is under 21 years old.
- A blind or disabled son or daughter, regardless of age.
- A brother or sister who already owns part of the home and lived in it for at least one year before the person applied for Medicaid.
- A son or daughter who cared for the person and lived in the home for at least two years before the person applied for Medicaid.

Estate Recovery

Even if someone is allowed to keep certain assets and still remain eligible for Medicaid, states might have the right to access or sell those assets after the person dies. This process is called "estate recovery" and is designed to repay the state and federal governments for the amount that was spent on the person's long-term care services.

Estate recovery is a highly controversial issue because it can prevent family members or other survivors of a deceased Medicaid recipient from inheriting the person's money or other property. It's also a very complicated issue due to the different ways each state exercises its estate-recovery powers.

States have had the ability to engage in certain types of estate recovery ever since the beginning of the Medicaid program. However, going after a deceased Medicaid recipient's estate was optional and was often deemed overly complicated or at least too politically unpopular. For decades, most states only engaged in estate recovery in rare cases.

In the early 1990s, Congress determined that estate recovery was beneficial to Medicaid's long-term stability. Based on this premise, laws were passed that made estate recovery mandatory under certain circumstances. Under federal law, states are generally required to engage in estate recovery when a Medicaid recipient dies and received long-term care services through the need-based program. Although federal law only requires that states attempt to recoup the amount paid by Medicaid for long-term care services, states are allowed to recoup the cost of other Medicaid services (such as hospital bills or physician charges) if they choose.

Although estate recovery can be a scary consequence for Medicaid recipients, there are several limits on how and when it

can be done. For example, despite Medicaid being available to many different types of low-income people, estate recovery is only allowed in regard to the following classes of Medicaid recipients:

- People who received financial assistance from Medicaid at or after age 55.
- People who received long-term care services in an institutional setting (such as a nursing home) at any age through the Medicaid program.

The federal requirement that states engage in estate recovery applies to a Medicaid recipient's probate-eligible assets. Assets that are exempt from the probate process are exempt from the federal estate recovery rules and will only be subject to estate recovery if a state chooses this option. In practical terms, this means the following types of assets might be exempt from estate recovery:

- Life insurance owned by the Medicaid recipient (unless the person's estate is the beneficiary).
- Retirement accounts owned by the Medicaid recipient (unless the person's estate is the beneficiary).
- Certain kinds of property owned together by a Medicaid recipient and a spouse. (This exemption might vary depending on the state and the type of property.)
- Certain kinds of property held in a trust.

Even if an estate has assets that would ordinarily be subjected to estate recovery, federal law requires that estate recovery be delayed in any of the following circumstances:

- The spouse of the Medicaid recipient is still alive.
- A son or daughter of the Medicaid recipient is still a minor.
- A blind or disabled son or daughter of the Medicaid recipient is still alive (regardless of age).
- Estate recovery would cause undue hardship. (Specifics regarding undue hardships are left up to the individual states.)

Estate recovery must also be delayed under the following circumstances if it involves the potential sale of the Medicaid recipient's home:

- The recipient's sibling owns part of the home, helped care for the recipient for at least one year before the recipient's entry into a nursing home and has lived in the home ever since.
- The recipient's adult child helped care for the recipient for at least two years before the recipient's entry into a nursing home and has lived there ever since.

Although federal law mandates these delays in estate recovery, many states treat a required delay as something permanent. For example, let's assume a Medicaid recipient received long-term care services and would ordinarily have his remaining assets subjected to estate recovery. However, because his wife is still alive, the state is required to delay the estate recovery process until she dies. Even when the wife passes away, the state might choose to ignore its right to estate recovery because of the administrative costs associated with re-examining the family's remaining assets.

The same might be true if, for example, a mandatory delay is due to the Medicaid recipient having a surviving son or daughter who is a minor. Even when the son or daughter becomes an adult, the state might choose not to pursue the deceased Medicaid recipient's assets because of the administrative burden. In general, states do not need to engage in estate recovery if doing so is likely to be unprofitable or not worth the effort.

Liens on Private Homes

In order to facilitate eventual estate recovery, the state can put a lien on a Medicaid recipient's private home. A lien gives the state certain rights in connection with the property, such as the right to share in the proceeds from an eventual sale, but it doesn't necessarily result in the home being sold against the owner's will.

The state can put a lien on a Medicaid recipient's home even while the person is still alive but only if he or she is receiving an institutional form of long-term care (such as care in a nursing home) and is not expected to ever return home. In fact, if the person is first deemed unlikely to ever return home but eventually recovers and is able to move back to his or her private residence, the state must remove its lien.

A state cannot put a lien on a Medicaid recipient's home while any of the following individuals is residing there:

- The Medicaid recipient.
- The Medicaid recipient's spouse.
- The Medicaid recipient's son or daughter (if the son or daughter is blind, disabled or a minor).
- The Medicaid recipient's sibling. (This might depend on how long the sibling has lived at the property and whether he or she was involved in providing at-home care for the Medicaid recipient.)

A Disclaimer Regarding Medicaid Information

If the information provided here about Medicaid eligibility, estate recovery and the imposition of liens on property seems very confusing to you, you are not alone. It is important that long-term care insurance producers understand the general concepts of Medicaid and estate recovery, but the specific rules and laws related to these topics are very complex and are made even more intimidating by a lack of consistency across all parts of the Medicaid program.

For example, although we are focusing here on Medicaid and long-term care services, many people use Medicaid for other purposes, such as for help with hospitalization costs and doctor visits. The rules for people who want Medicaid for these other purposes tend to be different than the rules for people who merely need long-term care. In addition, each state has flexibility in regard to Medicaid eligibility and estate recovery rules.

For specific guidance about Medicaid eligibility and estate recovery, consumers and even insurance professionals should rely on local experts, such as elder-law attorneys in their community.

Medicaid vs. Private Pay

So far, our examination of Medicaid has centered on eligibility requirements and an applicant's likely desire to keep as much of his or her assets as possible. But for some people, particularly in their later years, asset protection isn't such a major concern.

Senior citizens who are single and either don't have any family or have relatives who don't rely on them for financial assistance might determine that spending down his or her assets in order to qualify for Medicaid isn't such a big deal. To paraphrase a common saying, "You can't take your money to the grave." So why not spend it on long-term care?

For families who aren't concerned about avoiding Medicaid for financial reasons, the choice between relying on Medicaid or

purchasing long-term care insurance might relate more to the perceived differences in the quality of care. Some advocates of long-term care insurance warn their prospects that not having long-term care insurance will increase the likelihood of receiving substandard care in state-run nursing facilities where staff members are incompetent and inattentive.

Despite occasional stories about mistreatment of patients in nursing homes, this particular method of encouraging long-term care insurance sales is arguably close to being a scare tactic. Medicaid, after all, pays for more long-term care services than any other source in the United States (including long-term care insurance companies). The suggestion that a Medicaid recipient is likely to receive inadequate care not only ignores the vast majority of cases in which Medicaid patients are monitored by dedicated caregivers but also omits the fact that elder abuse is more common in private homes than in nursing facilities.

What's true, however, is that many excellent long-term care facilities either do not accept payments from Medicaid or will only do so if the resident in question is receiving Medicaid after an extended period of paying out of pocket. The decision to not accept Medicaid payments is generally tied to the formulas that the government uses to compensate skilled nursing facilities. Even if a facility agrees to accept Medicaid payments, the formula used to calculate the payment might be significantly less than what the facility would normally charge. Unless significant amounts of funding are made available from other sources, facilities that rely almost exclusively on Medicaid payments tend to have a hard time making a profit.

Due to many facilities' decision to limit the number of Medicaid recipients they will accept, it is generally fair to say that being on Medicaid can limit a person's options for long-term care services. A senior who is insistent on eventually receiving care in a particular facility might find that the facility does not accept Medicaid recipients. Similarly, a senior might discover that while Medicaid will pay for care in a nursing home, the program might not pay for a private room or for services provided in assisted-living facilities.

If long-term care planning is conducted at a fairly early stage, the people who are likely to eventually need care might want to conduct research about various facilities in their area. Among other things, answers to the following questions can be very important:

- Does the facility accept new residents who are having their long-term care funded through Medicaid?
- If a resident starts living at the facility and initially pays out of pocket, will the resident be allowed to stay in the facility if his or her assets are ever depleted and the person becomes eligible for Medicaid?
- If the facility allows private-paying residents to eventually pay for their care via Medicaid, will the shift to Medicaid result in any changes for the resident (such as relocation to a non-private room)?

Long-term care insurance is viewed favorably by assisted-living facilities, nursing homes and continuing-care communities. In cases where space in a preferred facility is limited and/or only available to people who aren't receiving Medicaid assistance, a good long-term care insurance policy can make the admission process fairly simple.

Disability Insurance

The general consensus among long-term care insurance professionals is that coverage should be purchased several years before a person's health starts to decline. Buying at a relatively young age makes it easier to qualify for good coverage at lower prices.

Though it might seem reasonable, the recommendation to purchase long-term care insurance at a young age might not make as much practical sense if the prospect is woefully underinsured in other areas, including in regard to disability insurance.

Disability insurance is designed to replace most of a working person's income if the person is unable to perform his or her job duties because of an illness or injury. Though benefits are triggered by some kind of medical evaluation, money received from a disability insurer can be used in practically any way the recipient sees fit and doesn't need to be used to pay for medical costs. Furthermore, benefit triggers are based on an inability to work rather than on an inability to perform activities of daily living. In effect, this means disability insurance benefits tend to be easier to obtain and more flexible than the benefits provided by long-term care insurance.

Working people who are in good health might be able to qualify for a decent disability insurance product until they near their retirement. If long-term care services are required during middle-age, this disability insurance might be used to pay for those services and any other assistance that the person requires. But since practically no disability insurance products will provide benefits to someone older than 65, coverage for long-term care in a person's later years will need to be found elsewhere. Long-term care insurance can serve this purpose and can cover the insured beyond age 65.

Cash-Value Life Insurance

Some types of life insurance can be used to indirectly pay for long-term care insurance premiums or for long-term care services. Types of life insurance known as "cash-value life insurance" can be purchased with the intent of providing a death benefit for a loved one but can also be surrendered prematurely for a lump sum. This kind of insurance might also offer loan provisions that let the policyholder borrow against the policy's cash value and use the borrowed funds to either pay for long-term care or fund a long-term care insurance policy.

Be aware that not all types of life insurance are cash-value products and, therefore, don't all contain loan provisions or allow policyholders to surrender their policy in exchange for cash. For example, term life insurance is a common life insurance product with no cash value.

Despite the possible use of cash-value life insurance in long-term care planning, it is very rare for someone to purchase this kind of policy with the full intent of cashing it in or borrowing money against it. If this kind of product is used at all in long-term care planning, it is generally reserved for cases in which the policyholder purchased it years ago to fill a life insurance need that no longer exists.

In most cases, life insurance products—including cash-value life insurance—should be purchased in order to provide financial protection against premature death. If there is a need to insure for long-term care but no need for a death benefit, life insurance is usually not a suitable product.

Accelerated Death Benefits

Applicants for life insurance can sometimes pay an additional amount in exchange for potential "accelerated death benefits." When purchased, these optional benefits allow the insured to

access a portion of the policy's death benefit in order to pay for medical care and other private expenses. When the insured person dies, the death benefit paid to the policy's beneficiary will be reduced by the amount already paid as accelerated death benefits.

One potential drawback to accelerated death benefits is that they might only be accessible to people who have been certified as "terminally ill." In insurance terms, this often means the person's remaining life expectancy is believed to be no longer than two years. Though accelerated death benefits could technically be used to pay for long-term care services for a terminally ill person, they are unlikely to provide much help to seniors who aren't terminally ill.

Viatical Settlements

A viatical settlement is a financial transaction in which the owner of a life insurance policy sells the policy (including the right to receive death benefits) to someone else in exchange for a large lump sum. In general, viatical settlements are for insured people who are terminally ill with less than two years to live.

A viatical settlement might be suitable if a terminally ill person doesn't have long-term care insurance, doesn't have dependents who are relying on a death benefit and is fairly certain to need custodial care for less than two years. Compared to surrendering a life insurance policy for its cash value or utilizing a life insurance policy's accelerated death benefits, a viatical settlement will usually result in more money going to the insured.

Life Settlements

A "life settlement" is almost exactly the same as a viatical settlement, except that life settlements are for senior citizens who are not terminally ill. Because an insured who seeks a life settlement is likely to live longer than a terminally ill person (and require investors to pay a longer stream of premiums in order to keep life insurance coverage in force), life settlements result in less money for the insured than viatical settlements. However, they typically still allow the insured to receive more money compared to surrendering a cash-value life insurance policy to the insurance company.

Annuities

Annuities allow people to give large sums of money to insurance companies in exchange for a long-term stream of income at a later date. For example, an individual might purchase an annuity with a lump sum of $100,000 and then be entitled to receive $1,000 per month from the insurer for the rest of his or her life.

If an annuity owner requires long-term care services, the person might consider cashing in the annuity for a lump sum. If the annuity has been in place for several years, the owner might be able to receive a lump sum from the insurer without being subjected to financial penalties. However, most annuities impose "surrender charges" if money from an annuity is withdrawn earlier than expected. Even if an annuity can be cashed in without the threat of surrender charges, the federal government might tax the money received from the annuity as income. Withdrawals from annuities before the owner's 60th birthday might also be reduced by a federal tax penalty.

Annuity owners who need long-term care services might be able to withdraw money from their annuity without having to worry about surrender charges or tax penalties. To determine whether a surrender charge will be enforced by the insurance company, the producer must carefully review the annuity contract and any relevant policy riders. To determine whether IRS penalties and the taxation of annuity income can be avoided, the insurance producer might want to consult a tax professional.

Reverse Mortgages

A "reverse mortgage" allows a homeowner to receive income from a lender in exchange for the equity in his or her home. In general, a homeowner with a reverse mortgage receives either a large lump sum or a series of regular payments from the lender until the property is no longer the person's principal residence. When the property is no longer the homeowner's principal residence, the home can be sold, and the lender will be entitled to a large portion of the proceeds.

Reverse mortgages can be beneficial for senior citizens who are considered "house rich but cash poor." Money received from a reverse mortgage can be used by the homeowner for practically any purpose, including for long-term care insurance premiums.

Though reverse mortgages might be used to purchase a fairly expensive long-term care insurance product, these mortgages might not be as helpful in regard to paying directly for long-term care services. Since payments from the lender often can stop when the home is no longer the senior's primary residence, a reverse mortgage might not be helpful if the senior ever needs to be transferred to a nursing home. Similarly, by transferring property rights to a lender in exchange for payments, the senior won't necessarily be able to use the sale of the property to finance a stay in an assisted-living facility, continuing-care community or other setting that requires a large deposit.

For more about reverse mortgages, consult a loan officer, loan originator or other mortgage professional.

Government Encouragement of Long-Term Care Insurance

Many consumers resist suggestions to purchase long-term care insurance because they believe the federal government will eventually develop its own long-term care insurance program. This assumption makes some sense when you consider the number of people—particularly Baby Boomers—who will eventually require care. Presumably, if millions of voters are likely to have concerns about receiving adequate long-term care services, elected officials would benefit by attempting to address the issue.

Yet the federal government has generally shied away from implementing major entitlement programs focused on long-term care services. Some people question whether government can deliver or manage long-term care services efficiently. Others are concerned that even a well-run government program for long-term care will strain the country's finances.

Regardless of whether you agree or disagree with those concerns, they have been largely responsible for the types of federal responses to the issue of long-term care over the past several decades. In general, these responses have centered on encouraging consumers to purchase private long-term care insurance. The hope is that this encouragement will ultimately result in good care for the elderly while also reducing financial stress on Medicaid.

LTC Insurance For Federal Employees

The Long-Term Care Security Act led to the implementation of a long-term care insurance plan for federal employees and their spouses. The group plan involves no premium contributions from

the federal government. Employees pay their own premiums, and enrollment in the plan is optional.

When the Long-Term Care Security Act was passed, some legislators hoped the federal plan would raise awareness of long-term care insurance and result in more insurance sales in the individual market. So far, the federal plan hasn't had this type of impact. According to a 2006 report from the Government Accountability Office (issued roughly five years after the plan's debut), only 5 percent of eligible employees had signed up for the plan.

The CLASS Act

In 2010, Congress passed the Affordable Care Act, which resulted in significant changes to health insurance across the country. Although the majority of the debate surrounding this legislation had nothing to do with long-term care services, the law actually called for the implementation of a federal long-term care insurance program called "CLASS."

Under the CLASS program, citizens and legal residents who were 18 or older were supposed to be eligible for daily benefits of $50 or more when they became cognitively impaired or could no longer perform multiple activities of daily living. Program participants would've needed to have paid into the program for roughly five years before being eligible for benefits. Premiums were supposed to have been approximately the same for all participants regardless of a person's health status.

In contrast to the partisan battles surrounding the rest of the Affordable Care Act, experts on both side of the political spectrum looked closer at the details and quickly determined that the CLASS program was unworkable. Since participation was voluntary and because premiums couldn't be higher for people who were already in poor health, it was widely assumed that the program would be overused by high-risk enrollees and would be unattractive to younger, healthier people. This problem, generally known in insurance as "adverse selection," could have led to high premiums for everyone. As a result, the pieces of federal law that called for implementation of the CLASS program were repealed in early 2013.

LTC Partnership Programs

In the first few years of the 21st century, four states (California, Indiana, Connecticut and New York) received funding to implement a "long-term care partnership program." Partnership programs allow people to qualify for long-term care services under Medicaid without having to surrender or "spend down" most of their assets. In exchange for being allowed to keep more of their money, participants in partnership programs must purchase a particular type of long-term care insurance. In 2006, Congress passed laws to expand partnership programs into other states.

Long-term care partnership programs differ by state. Many states have "dollar-for-dollar" programs, in which the amount of assets that can be shielded from Medicaid will be based on the amount of long-term care insurance that the Medicaid applicant has purchased. In a simple example, consider someone who has purchased a partnership policy with a $100 daily benefit and a two-year benefit period. By multiplying the daily benefit by the benefit period, we arrive at a policy worth $73,000. So if a state has a dollar-for-dollar partnership program, the policyholder in our example might be allowed to keep an additional $73,000 in assets and still qualify for Medicaid if the policy's benefits run out. A few states might structure their partnership programs differently and allow participants to keep assets worth more or less than their policy's value.

Even if they live in a state with a partnership program, consumers who want to participate shouldn't assume that just any long-term care insurance product will satisfy the program's requirements. Requirements for partnership policies, while often similar across the country, can differ among the various states. For example, a state might have its own rules about whether a policy must include inflation protection and whether it must be a "tax-qualified" policy under IRS rules. (You'll read about the differences between tax-qualified policies and non-tax-qualified policies in the next few sections.)

The differences in state requirements for Medicaid and partnership programs have created uncertainty regarding policyholders who buy a partnership policy in one state but eventually move elsewhere. In most cases, the insurance provided by partnership policies is likely to still work upon the policyholder's move, but the ability to shield assets from Medicaid might be put in jeopardy. Reciprocity among the states has improved since the expansion of partnership programs in recent years, but it is still an important issue to consider before purchasing a partnership policy.

The effectiveness of partnership programs was unclear at the time this course was being written. A 2007 study conducted by the Government Accountability Office looked at enrollments in the four original partnership programs and questioned whether the programs would ultimately result in savings for Medicaid. The goal of partnership programs has always been to encourage more purchases of long-term care insurance, but the study estimated that roughly 80 percent of partnership policies were bought by people who probably would've purchased long-term care insurance anyway. Although the remaining 20 percent were unlikely to have purchased a non-partnership policy, it was unclear whether those 20 percent would've mainly paid out of pocket for long-term care without a partnership policy or whether they would have been relying on Medicaid.

The U.S. Department of Health and Human Services has been more optimistic about partnership plans and has hypothesized that the plans might make Medicaid applicants less inclined to hide assets and engage in the kind of Medicaid planning that allows wealthier people to qualify for the need-based program.

Tax Treatment of LTC Insurance

Many instances of government support for long-term care insurance have been indicated by changes in tax law. For example, in 1996, the federal government made it possible for long-term care insurance policyholders to deduct a portion of their premiums from their taxable income. Be aware that there might be limits to this tax deduction depending on the policyholder's age and the size of the premiums. Also, this deduction for long-term care insurance premiums is only available to taxpayers who itemize on their returns rather than taking the standard income-tax deduction.

Regardless of the deductibility of premiums, the benefits received from long-term care insurance are usually tax-free to the recipient and are, therefore, not treated as income. This general rule applies to reimbursement policies, which only provide benefits based on the actual cost of care received by the insured. By contrast, an indemnity policy might pay a flat amount to the policyholder regardless of whether the cost of long-term care has met or exceeded the flat amount. Insurance benefits that exceed

the actual cost of care are likely to be treated as taxable income to the recipient.

The tax benefits mentioned in this section are generally reserved for "tax-qualified" policies. These policies must include certain provisions and limits set by federal law. Although nearly all long-term care insurance policies in today's market are tax-qualified, some older policies that don't satisfy these requirements are still in force.

Tax-Qualified vs. Non-Tax-Qualified

In exchange for the positive tax features mentioned in the previous section, owners of tax-qualified long-term care insurance policies might face stricter rules for benefit eligibility than owners of the few remaining non-tax-qualified policies. Differences between tax-qualified policies and non-tax-qualified policies are summarized below:

- Tax-qualified policies cannot provide any long-term care benefits unless the insured is either cognitively impaired or unable to perform at least two activities of daily living (eating, bathing, continence, transferring, dressing or toileting). By contrast, non-tax-qualified policies might allow benefits to begin if someone is incapable of performing just one activity of daily living. Non-tax-qualified policies might also allow the insured to receive benefits upon not being able to cook, balance a checkbook, make phone calls or perform other activities not mentioned here.
- Tax-qualified policies can't provide any long-term care benefits unless a licensed physician has certified that the insured is likely to need care for at least 90 days. Once this initial certification has been obtained, a licensed physician must repeat this certification process at least once each year. Non-tax qualified policies might not require this certification or might at least require it on a less frequent basis.

The tax status of a long-term care insurance policy (tax-qualified or non-tax-qualified) should be disclosed to an applicant before coverage is purchased. In fact, many states require that this disclosure be made via a special form for all long-term care insurance sales.

Conclusion

Despite the many positives of long-term care insurance, the product hasn't been nearly as popular as many people initially expected. The retirement of the large Baby Boomer generation suggested that the market for long-term care insurance would be very competitive, but several factors have combined to have a negative impact on sales.

When talk about long-term care insurance started heating up in the 1990s, the carriers that chose to sell the product had to make assumptions about "lapse rates." Lapse rates are statistics that represent the number of people who purchase insurance but end up cancelling their coverage before receiving any benefits. By properly calculating its lapse rates, insurance companies can estimate the amount of money they will be able to actually keep and the amount that will ultimately be needed to pay benefits to their policyholders.

Since early long-term care insurers didn't have much historical data to guide their initial estimates, they had to make some less-than-educated guesses. Those guesses turned out to be incorrect, with lapse rates for long-term care insurance being significantly lower than expected. In general, people who had purchased early forms of long-term care insurance tended to keep their coverage in place for a long time and ended up filing more claims for benefits than insurers had anticipated.

The misjudged lapse rates meant insurers had to be a bit more careful when investing consumers' premiums. If more money was likely to be needed to honor policyholders' claims, premiums couldn't be put into higher-risk, higher-reward financial vehicles and still satisfy the solvency rules set by state insurance departments.

Meanwhile, the United States began experiencing major economic problems. Those broader economic troubles led to even lower investment returns for individuals and businesses (including insurers) that needed to keep their money in low-risk portfolios.

These various factors caused the market for long-term care insurance to shrink dramatically. Many companies that had been selling the product in the 1990s had exited the market by the late 2000s. Those companies that remained in the market often had to impose major rate increases that didn't please existing policyholders or attract new buyers. Unfortunately, consumers who are interested in long-term care insurance are still being impacted by this instability and are often rightly concerned about present and future costs.

The good news for insurance professionals is that the problems with lapse rates, investment returns and rate increases haven't changed the public's need for long-term care planning. People will continue to grow older and will continue to worry about how they or their loved ones will be able to access nursing and other long-term care services. With more time and more help from the many smart people in the industry, insurers should be able to adjust their business models in order to meet this important need.

CHAPTER 3: INTRODUCING ANNUITIES

An annuity is a long-term contractual arrangement in which someone gives money to an insurance company and is expected to get it back in either a lump sum (plus interest) or a series of regularly scheduled payments. Traditionally, the purpose of an annuity has been to provide a permanent, regular stream of income that cannot be outlived. For example, a senior citizen might purchase an annuity with a lump sum of $100,000 in exchange for the insurer's promise to pay the person $1,000 a month for the rest of his or her life. For people who have already made maximum contributions to a retirement plan, an annuity can also be used to park large sums of money and earn tax-deferred interest.

In either case, as life insurance products, annuities also contain some kind of death benefit that can be paid to an owner's chosen beneficiaries. The circumstances under which the death benefit is payable will depend on the contractual language.

Although annuities don't remove all the uncertainty and personal responsibility from retirement planning, they can ensure that seniors receive at least some dependable income that can be layered on top of Social Security benefits. This may explain why many people consider an annuity to be the reverse of a life insurance policy. Whereas life insurance financially supports beneficiaries if someone dies too soon, an annuity can financially support someone if he or she lives too long and runs out of savings.

There are annuities to attract conservative investors and annuities for people who are willing to take more risks. Products called "fixed annuities" guarantee a return of the money investors

put into them and will often promise higher interest rates than certificates of deposit (CDs). Products called "variable annuities" are less likely to guarantee a full return of a person's initial investment, but they have the power to produce higher returns.

Long-term investors and long-term savers are also sometimes won over by an annuity's tax features. Most annuities go through an "accumulation period," during which the value of an annuity can grow on a tax-deferred basis and earn a compounded amount of interest. So, in simplistic terms, no one pays taxes on the money until it comes out of the account, and interest can be credited to both the amount invested (known as the "principal") and any previously earned interest. Consumers receive these positive benefits in exchange for less liquidity than they might find in CDs or mutual funds.

Fixed and Variable Annuities

People who care more about saving money than engaging in high-risk, high-return ventures tend to prefer fixed annuities over variable annuities because fixed annuities contain more guarantees. The traditional fixed annuity guarantees a return of all money given to the insurance company plus a guaranteed amount of compounded interest. Regardless of the minimum interest-rate guarantee for a fixed annuity, the amount of guaranteed interest might be higher during the first few years of a contract's term.

The risk to the fixed annuity purchaser is minimal because the insurance company invests the owner's premiums in conservative bonds and government securities. The consumer is responsible for picking the right contract and insurer, while the insurer is responsible for investing the principal in a manner that will satisfy the contract's guarantees. As long as the insurance company does not become insolvent, the annuity owner's money will be safe. However, the owner must accept the possibility that the guaranteed interest from a fixed annuity will not keep up with inflation.

Variable annuities appeal to investors who are willing to put some of their money at risk in exchange for potentially higher returns. The owner typically shoulders the responsibility of investing his or her money in one or several "subaccounts" (which are similar to mutual funds), and the annuity's account balance will go up or down depending on how those subaccounts perform.

In addition to absorbing market risks, owners of variable annuities will usually be charged account management fees on an annual basis. Most variable annuities contain some basic guarantees, such as a guarantee that the owner's annuity will never be worth less than the original principal amount, but most of these guarantees are only available if buyers are willing to pay extra fees that reduce their potential return.

Deferred and Immediate Annuities

Fixed and variable annuities can be either immediate or deferred. The annuity shopper's choice between an immediate annuity and a deferred annuity will depend on when the person wants to start receiving payments from the insurance company. Let's go over the options.

Deferred Annuities

A "deferred annuity" is often favored by individuals who don't need consistent, additional income at the time of purchase but envision needing it in the future. When people buy a deferred annuity, their goal at that moment is to watch their principal expand for several years. Presumably at a much later date, they'll cash in their deferred annuity for a lump-sum payout or for divided payouts that will be disbursed throughout their remaining lifetime. Often upon the conclusion of a deferred annuity's contract term, the money in an existing deferred annuity is transferred to a new deferred annuity.

Between the time it's purchased and the time payments begin, a deferred annuity goes through an accumulation period. During the accumulation period, the owner's account is expected to grow without negatively affecting the person's tax situation.

Immediate Annuities

An "immediate annuity" creates an income stream for the owner soon after the sale date. In general, the owner starts receiving payouts within one year of entering into the contract.

People who buy immediate annuities might care less about growing their principal and more about maintaining their current income level for as long as possible. An immediate annuity can help them achieve their goals by giving them payouts on a monthly, annual or other set schedule rather than in a lump sum.

Immediate annuities don't go through a traditional accumulation period because money is being taken out of them at the same time that the account would otherwise be growing in value. Also, opportunities for tax deferral with an immediate annuity are relatively minimal because taxation on an annuity begins when money is taken out of the owner's account. Since they are generally meant to serve as a source of immediate cash payments and not as a long-term savings vehicle, immediate annuities are also known as "income annuities."

The amount of money a person receives regularly from an immediate annuity will be determined by the principal, the person's life expectancy and the fixed or variable status of the annuity. With all other factors being equal, a larger principal will translate to bigger immediate payouts because the insurance company will have more money to give out in the first place. But because annuities are designed as supplementary sources of income that last a lifetime, immediate payouts offered to a younger person can be lower than those offered to an older person. This can be true even if the younger individual pays more principal to the insurance company.

Most immediate annuities are fixed and give budget-conscious owners the security of knowing that their scheduled payouts will not dip below a guaranteed minimum dollar amount. However, some people worry that these products will not keep up with inflation. In efforts to confront this concern, insurance companies have designed some riders (add-on features in insurance contracts) that can either automatically increase annuity payouts every year or at least ensure that payouts will temporarily keep pace with consumer price indexes.

Parties in an Annuity Contract

No matter who sells the product or how the seller has organized it, an annuity is a legal agreement that bestows rewards and responsibilities upon multiple parties. These parties include the insurance company, the annuity owner, the annuitant and the beneficiary.

The Insurance Company

The insurance company behind the annuity has a contractual obligation to eventually pay money to a person or other entity. In return, the insurer collects fees from investors or is allowed to invest owners' money and keep a portion of any positive yields.

The Annuity Owner

The "annuity owner" is the person who puts money into the annuity. He or she chooses how much to invest and, in the case of variable annuities, how the invested amount should be allocated among various subaccounts. The owner is usually (but not always) the party who will be held responsible for paying taxes on the annuity.

The annuity owner has many of the same rights as the owner of a life insurance policy. The owner can surrender the contract, choose a beneficiary and, in some cases, borrow money from the annuity's cash value. The owner hangs onto these rights until the contract expires or is terminated. An annuity may be owned by one person, several people, a trust or a corporation.

The Annuitant

An annuity owner also gets to designate an "annuitant." The annuitant is the person whose life expectancy influences the size of payouts from the insurance company. In most (but not all) cases, the annuitant is also the person who receives the income created through the annuity. Because annuity payouts are determined, in part, by life expectancy, an annuitant must be an actual person rather than a trust or corporation.

In most cases, the annuity owner and the annuitant will be the same person. In other words, people will invest their own money with a goal of creating an income stream for themselves. But it's also possible to have one person as the owner and another person as the annuitant. For example, one spouse might own an annuity that pays income to the other spouse, or a company might own an annuity that pays income to a former employee. However, designating different people as the owner and annuitant can create unexpected tax problems and may even cause death benefits to go to beneficiaries at an inappropriate time. (Beneficiary and tax issues will be explained in more detail later in this chapter.)

Unless he or she is also the owner, the annuitant lacks the right to borrow money from the annuity, alter investments within the annuity, or partake in any of the previously mentioned privileges that are granted to the annuity owner. In fact, some contracts let the owner eliminate an annuitant from the original contract and choose a new one.

The Beneficiary

The "beneficiary" is a person, corporation or trust that receives death benefits if someone passes away before income payouts have begun. Depending on the annuity, a beneficiary might also be entitled to benefits even if the insurance company has already started making payments from the owner's account.

The annuity owner chooses the beneficiary and can alter his or her choice after the annuity has been issued. As is the case with a life insurance policy, owners can designate multiple beneficiaries, divide death benefits equally or unequally among those multiple beneficiaries, list contingent beneficiaries or pick themselves as beneficiaries. If the owner and the beneficiary are different people, the beneficiary cannot borrow from the annuity, alter investments within the annuity, or partake in any of the other previously mentioned privileges that are granted to the annuity owner.

The role of the beneficiary may seem simple, but it can be complicated if the annuitant and the owner aren't the same person. Some annuities require that any applicable death benefits be paid to beneficiaries when the annuitant dies. Others will only pay death benefits when the owner dies. Annuities that will pay death benefits only when the owner dies are considered "owner-driven." Annuities that will pay any applicable death benefits if the annuitant dies before the owner are considered "annuitant-driven." (For tax reasons, an annuitant-driven annuity might also need to provide death benefits to a beneficiary if the owner dies before the annuitant.)

Because of the different rules for owner-driven and annuitant-driven contracts, the owner's choice of a beneficiary should be made with great care. Imagine, for example, a husband and wife who are involved in an annuity transaction. The couple's intention is for the surviving spouse to eventually be able to benefit from the annuity and for their children to receive death benefits when both spouses die.

Now assume the couple decided to purchase an annuitant-driven annuity with the husband as the owner, the wife as the annuitant and their children as beneficiaries. If the wife dies before the husband, the money from the annuity might flow immediately to the children rather than to the husband. To avoid this problem, the husband could have listed himself as the main beneficiary and listed his children as contingent beneficiaries.

Now imagine the same couple is involved but that the husband dies first. Again, any death benefits from the annuity might go to the children as beneficiaries instead of to the surviving spouse. If the husband had intended for his wife to benefit from the annuity after his death, he could have listed her as the main beneficiary and listed his children as contingent beneficiaries.

There are even scenarios in which a co-owner automatically forfeits a financial interest in an annuity upon the other owner's death. To ensure that the intended beneficiaries only receive death benefits at the intended time, annuity contracts should be examined thoroughly by all parties and drafted with care.

Annuitization

If an annuity owner is ready for the insurance company to start paying an income stream, the "annuitization" process will begin. With an immediate annuity, this process tends to begin no later than six months to a year of the owner's last (and often only) premium payment. With a deferred annuity, the process generally begins several years after the purchase, during which the annuity has had a chance to accumulate some tax-deferred interest.

During traditional annuitization, the insurance company usually pays out the same amount in installments on a set schedule to an annuitant. Some variable annuities allow the owner to choose between receiving level payouts upon annuitization or payouts that will go up or down depending on market performance.

In most annuitization situations, payouts are fixed at an equal amount and are scheduled to continue at least throughout the annuitant's lifetime. When the owner chooses this option, the amount of each individual payout owed to the annuitant will depend on the account balance and a figure called the "benefit rate." The benefit rate is the dollar amount the insurer will pay in each installment (usually on a monthly basis) for every $1,000 in the owner's account.

The benefit rates offered by different insurance companies will vary, but all benefit rates will be based, to a large extent, on the annuitant's life expectancy. Payouts from most immediate annuities will reflect the benefit rate that was offered by the insurer when the annuity contract was signed. Payouts for most deferred annuities will be based on either the benefit rate offered

by the insurer at the time of annuitization or the guaranteed minimum benefit rate that was offered by the insurer when the contract was signed.

With life expectancy serving as such an important factor in the calculation of benefit rates, it ought to come as no surprise to the reader that older people receive higher benefit rates than younger people and that men receive higher benefit rates than women of the same age. Some insurers will also increase their benefit rates for annuitants with serious health problems.

Once annuitization has begun, the insurer generally may not reduce the benefit rate or the size of the scheduled payments. Suppose, for example, that a consumer bought an annuity and annuitized the account for life when it was worth $100,000 at a benefit rate of $10 per thousand. The person would then be entitled to $1,000 each month for life. This would be the case even if the annuitant ends up living longer than the insurance company originally expected. In this regard, the risk to companies selling annuities differs from the risk to companies that only sell life insurance. For the life insurer, the risk is that the person will die too soon to make the company profitable. For the company issuing an annuity, the risk is that a person will die too late.

Very often, people use the term “annuitization” as if it were synonymous solely with lifetime, monthly income. In fact, modern annuitization involves several other options for the owner. Instead of occurring monthly, lifetime payouts can go to the annuitant every year, every season, twice each year or on a different schedule. The owner might also choose to have payments made beyond the annuitant’s lifetime or for a shorter amount of time.

Income Tax Concerns

Tax breaks represent one of the most significant reasons why annuity sales have been so fruitful over the past few decades. At this point, we will look at the relationship between the federal tax code and annuities and cover some of the tax consequences that prospective buyers should know about.

The material presented here is intended only to summarize an annuity’s potential tax features. Specific questions about how the Internal Revenue Service might interpret an individual’s tax situation should always be referred to a professional with substantial knowledge of tax law.

Tax Deferral

Like an IRA, an annuity is one of the few financial options available today that allow investors to accumulate money and temporarily avoid paying taxes on investment gains. This opportunity for tax deferral doesn’t make an annuity tax-free or tax-deductible. The owner merely has the choice to wait awhile before paying certain taxes to the government.

On a federal level, an annuity generates no tax bills until the owner or the annuitant receives a payout from the insurer. If a deferred annuity goes untouched, the owner will encounter no tax penalties during the accumulation period. If the owner makes a partial withdrawal from a deferred annuity but doesn’t annuitize the funds, he or she will only pay taxes on the withdrawal, and the money left over will continue to grow on a tax-deferred basis. Fixed immediate annuities are poor vehicles for tax deferral because payouts begin right away and some of the money is automatically treated as taxable income.

Qualified vs. Non-Qualified Annuities

The federal tax treatment of an annuity payout will depend on how the owner paid for the contract. “Qualified annuities” are paid for with pre-tax dollars, which means the principal in these accounts was not previously counted as part of the owner’s taxable income. Since the principal was never taxed, taxes must be paid on the entirety of any money received from the insurance company.

Qualified annuities are often purchased within employer-sponsored 401(k) plans and IRAs. Like those common retirement vehicles, qualified annuity contracts limit the initial amount of money investors can contribute to their accounts. They also require that payouts begin by a specific date, usually by the time the accountholder is 70 ½.

“Non-qualified annuities” are funded with after-tax dollars, which means the principal was already counted in one form or another as part of the owner’s taxable income. Since the principal was already taxed, only a portion of a person’s annuity income will be taxable.

Unlike qualified annuities and many kinds of employer-sponsored retirement plans, non-qualified annuity contracts usually do not limit the amount of money investors may put into their accounts, and they don’t need to be annuitized by the time the accountholder reaches age 70 ½. The tax-related information in this chapter (unless stated otherwise) applies solely to non-qualified annuities.

Taxation of Annuity Death Benefits

When beneficiaries receive money from the insurance company, they will usually need to pay taxes on the difference between the account’s value and the owner’s principal investment. Although death benefits from a deferred annuity will generally need to be paid out when the owner dies, the annuity can continue to grow on a tax-deferred basis if the beneficiary is the owner’s spouse.

Depending on the annuity, money left in a deceased owner’s account may be subject to estate taxes. In general, the entire value of the annuity can be considered part of the owner’s estate for tax purposes if the person’s death occurs before annuitization. If death occurs after annuitization, the value of payments that will continue after the person’s death can be considered part of the estate. If no one will receive payments or death benefits after the owner’s death, the annuity will have no remaining value and won’t be part of the estate. Most estates, though, are exempt from federal estate taxes. In 2017, only estates valued at more than $5.49 million after a person’s death were taxed.

Surrender Charges

“Surrender charges” are often the biggest drawback to annuities and help show why the products do not suit every consumer’s financial situation. These charges result in a percentage-based deduction from the owner’s account if the owner withdraws money or opts out of the contract before a specific date.

The owner’s inability to access money from an annuity can create problems big and small. A relatively small problem concerns the interest rates applied to fixed annuities. Imagine, for example, that a person buys a fixed deferred annuity that will credit 5 percent interest to the person’s account annually for seven years and also features a surrender charge that will remain in force for seven years. Three years pass, and an improved economy creates a financial climate in which many insurers now offer fixed deferred annuities with short-term interest guarantees of 7

percent. The person in our example knows about these better deals but would not be able to get out of the existing contract for another four years without having to pay a significant surrender charge.

Now, suppose the circumstances are more serious and that the owner needs money to handle a financial emergency. Even in these urgent cases, the account balance could still suffer a big blow thanks to surrender charges.

Federal Surrender Charges

IRS-mandated surrender charges suggest that the federal government approves of annuities when they are used for retirement purposes but frowns upon them when they are bought and sold with other motives in mind. Owners who make early withdrawals will need to pay regular income taxes on the money they receive and will also surrender an additional 10 percent to taxes if a withdrawal occurs before they turn 59 ½. The regular income taxes and the additional 10 percent penalty will be applied to any portion of a withdrawal that is not considered a return of the owner's principal. (Regardless of the principal amount, a portion of practically any withdrawal or payout will be treated as taxable income.)

There are some exceptions that can nullify the 10 percent tax penalty (but not the requirement to pay regular income taxes). The 10 percent penalty generally does not apply if any of the following statements are true:

- The owner is at least 59 ½.
- The owner has a permanent, total disability.
- The owner has died, and payments are going to a beneficiary.
- The annuity involved is immediate, and payouts are being received on a regular basis in substantially equal amounts rather than in a lump sum.
- The owner has decided to annuitize a deferred annuity and will be receiving substantially equal payments based on his or her life expectancy for at least five years or at least until the owner turns 59 ½ (whichever is scheduled to happen later).

Even if an owner is willing to accept the 10 percent penalty, an early withdrawal can create a bigger tax bill than expected. Under a concept known as "last in, first out," an early withdrawal will first be treated as a gain and then as a partial return of principal. In other words, if an owner purchases an annuity for $10,000 and makes a $5,000 withdrawal after the account has grown to $15,000, the entire withdrawal will be fully taxable. Similarly, if the owner were to make a $6,000 early withdrawal from that account, $5,000 of it would be fully taxable, and only the remaining $1,000 (the amount in excess of the account's gains) would be treated as a non-taxable return of principal.

There may be additional exceptions (or exceptions to the exceptions) that can impact taxpayers. In addition, like issues related to beneficiaries, the rules regarding early withdrawals and taxation can be very complicated if the annuitant and the owner are not the same person. For more specifics regarding federal withdrawal penalties, contact the IRS or speak to a tax professional.

Company-Mandated Surrender Charges

Even if an owner has passed age 59 ½ and can avoid federal surrender charges, the owner might still need to pay a company-mandated surrender charge when money comes out of an annuity prematurely. Insurance companies tend to lose money on an annuity during its early years. Surrender charges help make up for losses if the owner cancels the contract before the insurance company can make a profit on it.

Surrender charges can differ greatly depending on the type of annuity and market conditions. In some cases, the surrender charge will come out of the annuity's total cash value. At other times, an insurer might only take surrender fees out of the principal and leave accumulated interest alone. On occasion, principal will remain intact, and the insurer will deduct the interest earned over a set period of time from the owner's account.

If consumers research annuities via the mainstream media, they will probably come to the conclusion that there is a standard surrender charge for annuities that starts at 7 percent or so and lasts roughly seven years, with each passing year resulting in a 1 percent reduction in the fee. In reality, the size and duration of a surrender charge can be better or worse. In terms of length, research conducted during the development of this course uncovered annuities with surrender fees that were as brief as three months and as long as the annuitant's lifetime. In terms of size, one annuity came with a surrender charge that began at a rate of 25 percent. Another product combined long duration with large size by reportedly featuring a surrender charge that started at nearly 18 percent and lasted 17 years. (Be aware that many states have rules regarding the duration and/or size of surrender charges. Some of the mentioned examples from this paragraph came to our attention because they resulted in disciplinary action.)

Free Withdrawals

Insurers soften their sometimes rough surrender penalties by usually giving owners a chance to withdraw small amounts of money from their annuities without losing any additional principal or interest. Most contracts allow annual withdrawals that may not exceed 10 percent of principal at one time.

Before they prepare to withdraw from an annuity, owners should understand there might be a waiting period (perhaps one year) before the penalty-free withdrawals can begin. Owners should also know that these withdrawals might not be permitted forever. The insurer can limit withdrawals by disallowing them after a pre-determined number of years or by putting an end to them once cumulative withdrawals reach a set percentage of the principal.

The free 10 percent withdrawals keep surrender charges at bay for people who need a little extra cash now and then. They do not, however, exempt the owner from tax laws. People must still pay income taxes on these partial withdrawals, and the government can still knock payouts down by 10 percent if they occur before the owner turns 59 ½.

Death Benefits

The typical annuity offers a death benefit equal to at least the principal investment, minus any withdrawals of principal that were made by the owner. If an annuity experiences positive investment gains and is worth more than the principal sum when someone dies, beneficiaries can collect this larger amount instead and will be required to pay income taxes on the extra money.

Death benefits from annuities can be handed over to the beneficiary in a number of ways, often at his or her choosing. For example, the entire death benefit might be provided in a lump sum, or it might be converted into an income stream that makes regular payments to the beneficiary for several years. For a limited time, the beneficiary of a deferred annuity might be able

to keep the annuity untouched and allow it to earn tax-deferred interest. Even greater flexibility might exist if the beneficiary is the owner's spouse.

At first, all of this information about death benefits might sound fair or even favorable to beneficiaries, but there's a big catch. The standard death benefit sometimes only applies if someone dies while the annuity is in the accumulation period. If an owner has an immediate annuity or has annuitized a deferred annuity, the insurer might pocket the remaining balance in the account and use the money to make payouts to its other customers. If the owner wants to start receiving payments from an annuity but also wants them to continue after someone dies, the owner should carefully review his or her annuitization options.

Conclusion

Even people with a background in insurance or finance might wonder what a certain annuity contract provision really means. It is important that you not only explain annuities well but also listen carefully to people's concerns and goals. By taking both of those responsibilities seriously, you give yourself a good chance of being a professional success and a leader in your field.

CHAPTER 4: EVALUATING CYBER RISKS

Introduction

Modern technology has blessed us with many conveniences and efficiencies. Among other things, we can access a wealth of information from our phones or other small devices, purchase a wide range of products and services over the internet, and store large amounts of electronic data on "clouds" from practically any computer at any time.

Unfortunately, those advances have redefined the nature of various risks for businesses and individuals. The handy gadgets that contain all sorts of private information about ourselves or our customers can be lost or stolen. The payment information we submit to an online business might be intercepted by an untrustworthy person and used to steal our identity. And no matter how much a vendor might advertise its services as "safe," all the information we upload to a cloud provider has the potential of being viewed by pesky and anonymous hackers.

For today's modern businesses, the risks associated with technology can become very real very quickly. Practically every day, we hear stories about a retailer that has had its customers' credit-card information stolen or a health care provider that has experienced a security breach and jeopardized the privacy of its patients. These occurrences can ruin a company's reputation and can cost a business untold amounts of money in the form of lawsuits, regulatory fines and crisis management.

Recognition of these sorts of "cyber" risks has inevitably led to changes in the insurance industry. Carriers specializing in commercial lines have attempted to protect themselves by adding and clarifying cyber-related exclusions in their basic property and casualty products. Yet they've also acknowledged the demand for an insurance-related solution to cyber risks and have introduced new options for security-conscious organizations. These options are part of an emerging market for what is sometimes known as "cyber insurance."

While the market for cyber insurance is growing, experts still aren't even in complete agreement about whether to call this type of coverage "cyber insurance," "cyber-risk insurance" or something else. (For the sake of consistency, we will use the term "cyber insurance" from this point forward.)

The next several pages will guide you through the evolution of cyber insurance. You'll learn about the ways in which insurers addressed cyber risks in the past and how you can help prospects and policyholders in the present. We'll even look a bit ahead and raise some key questions that are likely to be integral to cyber insurance's future.

All the while, we'll emphasize the overall importance of risk management in regard to cyber threats. This message ought to apply not only to those producers who plan to sell cyber insurance but also to those who collect any type of client information and want to keep it secure. As former FBI director Robert Muller once warned, "I am convinced that there are only two types of companies: those that have been hacked and those that will be."

The Birth of Cyber Insurance

According to a report from the U.S. Department of Homeland Security, the first insurance product designed specifically to address cyber-related risks debuted in the 1970s. Most businesses, though, either didn't concern themselves much with these types of risks or assumed they had adequate coverage against technology-related threats via the standard forms of commercial property and casualty insurance. Over the next 30 years, stand-alone cyber insurance was purchased occasionally by banks but hardly ever by anyone else.

The first major movements toward a cyber insurance market were made by insurance carriers near the start of the 21st century. In response to widespread fears surrounding Y2k and what might happen to all sorts of computer systems in the year 2000, insurers began taking a hard look at their own cyber-related liability and began adding strict exclusions to their policy language. Commercial property forms began limiting coverage to "tangible property" and made it seemingly impossible for a business to be compensated for the loss of valuable data. Then, slowly but surely, policies for business interruption and general liability began using benefit triggers such as "direct physical damage to property," thereby making it harder for businesses to utilize their insurance following a technology-related shutdown or the accidental disclosure of customers' private information. Increased vigilance regarding terrorist threats and the possibility of widespread cyberattacks added to insurers' concerns and became an extra incentive for carriers to enforce the new and narrower language.

Businesses can still insure themselves against certain types of cyber risks, but they should expect to pay extra for it by either purchasing a stand-alone cyber insurance product or having a cyber-specific endorsement added to a pre-existing insurance policy. Either option has the potential to help manage cyber risks, but companies that care less about the size of premiums and more about obtaining broad coverage with high dollar limits tend to choose a stand-alone product. This is particularly true when a business is equally concerned about first-party losses (such as those related to an unexpected shutdown) and third-party losses (such as those related to liability for a data breach).

Note, however, that generalizations about cyber insurance are difficult to make, and attention to each carrier's product offerings is important. This course material was written at a point when the market for this type of coverage was still hadn't produced much uniformity compared to other insurance solutions.

Unlike many of the major types of property and casualty insurance being sold, cyber insurance still has no "standard form" with common provisions and exclusions that are worded similarly

from carrier to carrier. A major component of one carrier's cyber insurance product might not be available from a competing carrier. Similarly, the process for evaluating applicants for cyber insurance might be fairly complex at one insurance company and relatively simple at another. Significant differences in coverage, pricing, and underwriting are likely to continue until the insurance industry has had adequate time to measure the severity of cyber risks and learn more about customers' needs. (Note, however, that some insurers are pushing for a unified standard form and have made the case that standard coverage would make the industry more capable of managing its exposure to various cyber risks.)

The differences and inevitable changes in the cyber insurance market increase the importance of dedicated, knowledgeable insurance professionals to concerned businesses. When a business expresses an interest in cyber coverage, the business's insurance broker should evaluate all of the available options and carefully confirm that the product being purchased will, in fact, address the business's goals. Once coverage has been issued, the broker should pay close attention to changes in the market and not assume that the business's existing cyber insurance will always be the most comprehensive or affordable option. Although businesses certainly have a responsibility to implement reasonable security measures in order to reduce cyber risks, they should not be expected to navigate this new sector of the insurance market on their own.

Common Cyber Insurance Customers

In general, a business's willingness to purchase cyber insurance will depend on answers to the following questions:

- How big is the business?
- How much personal or financial information does the business store about its customers or clients?
- Is the business highly regulated and required by law to keep personal or financial information secure?

A large business that collects a significant amount of data about its customers and is subject to federal privacy laws is generally more likely to purchase cyber insurance than a small business that maintains relatively little data and has no extraordinary obligation to keep that data private.

So far, some of the most common purchasers of cyber insurance have been as follows:

- Cities and municipalities.
- Health care providers.
- Financial institutions.
- Insurance companies.
- Law firms.
- Major retailers.
- Technology firms.

Though on the rise, stand-alone cyber insurance is not purchased by a majority of businesses. Some businesses continue to believe that their basic property and casualty insurance packages will adequately protect them against cyber-related losses. Many others have taken the important step of discussing cyber insurance with insurance experts but have ultimately determined that the cost of coverage is too big for their budget.

Individual producers can help widen the cyber insurance market by educating business owners and risk managers about the potential gaps in commercial property and commercial general liability policies. Meanwhile, carriers may be able to stabilize pricing of cyber insurance by advocating for more sharing of information about cyber threats and any related losses. Both of these approaches to expanding cyber insurance's popularity are explained in later sections of this course.

The Role of Loss-Related Data

Insurers have long believed in the "law of large numbers," which essentially says that larger amounts of data are more reliable than smaller amounts of data. If an insurer lacks enough data about a particular type of risk, it cannot price related coverage accurately and will usually either refuse to cover the risk or only agree to cover it in exchange for high premiums. Conversely, if the insurance community believes it has significant amounts of data about a risk, it is easier for carriers to arrive at a fair price for a related insurance product and less risky to enter the market.

Access to and analysis of more data is critical to the future of the cyber insurance market. This is one major reason why the insurance community has expressed support for greater sharing of cyber-related information and greater uniformity in regard to reporting cyber breaches. While insurers and other interested parties have learned a great deal about security lapses at major health carriers and the theft of credit-card information from major retailers, less is known about the frequency and cost of similar incidents at smaller businesses or in other sectors of the economy. Such incidents tend to receive fairly little publicity or might not even become public at all. The gap in information puts insurers at a disadvantage and ultimately hinders competition in the insurance marketplace.

With more data at their disposal, insurance companies should be able to form a firmer understanding of cyber risks and adjust their pricing accordingly. More information can create clearer distinctions between high-risk and low-risk applicants and might make carriers more inclined to dangle cost-related incentives to those businesses that are willing to demonstrate a firmer commitment to privacy and security. In an ideal scenario, those incentives will ultimately benefit society at large because businesses that want to lower their cyber insurance costs will be more inclined to implement strict security plans in the first place.

The Role of Government

Since 2012, the U.S. Department of Homeland Security has sponsored a series of workshops and roundtables that emphasize the important link between insurance and data security. These events—which have included significant participation from insurance carriers, risk managers, government officials and experts in information technology—have suggested that there is broad agreement regarding the need for greater sharing of information and the manner in which a healthy insurance market can lead to a better-protected public.

As cyber risks have become more apparent, parts of the federal government (such as the Federal Trade Commission and the Department of Commerce) have drafted security recommendations for businesses. Insurance companies have been viewed as valued consultants in the drafting of these standards due to the amount of sensitive information they typically collect and their own experiences with risk management. Though these recommendations aren't intended to be used specifically by insurance companies, it is certainly possible that some carriers will consider them when evaluating an applicant for cyber insurance.

So far, the federal government has generally supported the idea of a bigger and more stable market for cyber insurance. The government has assumed that insurers can play an important

role in educating businesses about cyber risks and in using the threat of high insurance premiums to improve businesses' behaviors.

In addition to requests to facilitate more sharing of information about cyber threats and actual breaches, the government has been asked by insurers to help stabilize the market by creating a federal backstop for cyber insurance risks. Presumably, this type of backstop would work in a manner similar to the federal terrorism-risk insurance program, with insurers agreeing to offer cyber insurance on a wider basis in exchange for the government agreeing to cover catastrophic losses above a certain dollar amount. However, this type of government-backed cyber insurance program would likely require legislative action and has not yet gained significant support in Congress.

More information about the relationship between cyber risks and the federal government can be found later in this course.

Contemplating First-Party and Third-Party Losses

A business that is concerned about cyber risks should consider its susceptibility to "first-party losses" and "third-party losses."

First-party losses are the financial losses or costs that a business might encounter after a cyberattack or data breach regardless of whether any of its customers, clients or other third parties might have been harmed. Examples of first-party losses include the following:

- The business's temporary loss of income resulting from the unexpected shutdown of its computer systems.
- The business's temporary or permanent loss of valuable proprietary information, such as trade secrets, resulting from cyber theft.
- The cost to replace stolen or misplaced computer hardware.
- The cost to repair and re-secure the business's breached computer systems.
- The amount demanded by a hacker in exchange for either "unfreezing" a business's computer systems or agreeing to not disclose sensitive data.

Third-party losses are the financial losses or costs that a business might encounter if it is held liable for a potentially harmful cyberattack or data breach. Examples of third-party losses include the following:

- Amounts paid to customers, clients or other third parties in lawsuits stemming from a cyberattack or data breach.
- Amounts paid by the business to defend itself in lawsuits stemming from a cyberattack or data breach.
- Amounts paid as part of "crisis management" in order to minimize potential lawsuits stemming from a cyberattack or data breach (such as the cost of notifying impacted customers and providing credit-monitoring services to them).
- Amounts paid to the government in the form of regulatory fines.

Be aware that even an excellent cyber insurance product is unlikely to address all of these potential losses. Some losses (such as the first-party loss of data) are difficult to translate into dollar amounts and are therefore harder than other risks to insure. Others (such as amounts paid to criminals and amounts paid in the form of regulatory fines) are potentially incompatible with insurance because compensation for them could be perceived as an indirect endorsement of illegal activity. Therefore, those risks will either be uninsurable or have large deductibles and high premiums.

Regardless of the specific loss being contemplated, producers who advise businesses about cyber insurance should carefully review all policy language before recommending a particular product.

Coverage Under Other Insurance Policies

In addition to their common concerns about cost, businesses often choose not to purchase cyber insurance because they believe they already have adequate protection under their existing commercial insurance package. Whether these businesses are correct about the scope of their commercial property and casualty insurance is currently a matter of heated debate among lawyers, courts and carriers. Arguments for and against coverage of cyber-related losses tend to depend on the type of policy being discussed. But in general, rather than relying on traditional types of policies, separate cyber insurance products are likely the best solution for insuring against cyber risks.

Cyber Coverage and Commercial Property Insurance

Successful claims of cyber-related property damage are relatively rare due to language found in standard policy forms from a private company called the Insurance Services Office (ISO). Though insurance companies aren't required to use ISO language, many carriers choose to do so.

Since roughly the start of the 21st century, most ISO commercial property policy forms have made distinctions between damage to "tangible property" and damage to "intangible property." Standard policy language includes coverage for damage to tangible property but excludes damage to intangible property. For clarity, today's ISO forms will typically state that data is intangible and is, therefore, usually not insured against property damage, other than in small amounts.

Cyber Coverage and Commercial General Liability Insurance

Commercial general liability insurance is purchased by businesses that want to protect themselves from the following risks:

- Bodily injury to another person (such as a client, a customer or a visitor to the business's premises).
- Damage to another person's property (such as the property of a customer or client).
- Personal or advertising injury (including, but not limited to, the violation of someone's privacy rights).

Bodily Injury or Property Damage and CGL Insurance

Though relatively rare, claims of bodily injury after a data breach or cyberattack tend to focus on the alleged stress and other mental health issues that are sometimes experienced by victims, such as customers whose privacy has been breached. Most commercial liability insurers use policy language based on wording from the ISO, which typically defines "bodily injury" to mean "bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time." In general, claimants who have asserted that this definition includes temporary bouts of stress (such as the kind that might be felt by a customer after learning about a data breach) have received little support from carriers and the courts. Similarly, businesses that expect their commercial general liability insurance to cover them for cyber risks on the basis of property damage will typically

run into the same issue of tangible vs. intangible property mentioned earlier.

Personal and Advertising Injury and CGL Insurance

Businesses have had greater—albeit still mixed—success when claiming that their commercial general liability insurance policy's coverage of "personal and advertising injury" would include cases in which their customers' private information is breached or improperly exposed. Common ISO language defines "personal and advertising injury" to mean, in part, "oral or written publication, in any manner, of material that violates a person's right of privacy." Until recently, unlike the aforementioned definition of "bodily injury," the definition of "personal and advertising injury" did not include a specific exclusion related to electronic data.

Despite some earlier court decisions that upheld coverage for businesses after data breaches, recent developments seem likely to make cyber-related coverage under the "personal and advertising injury" definition far less common. Two relatively recent court cases, for example, have focused on the word "publication" and have ultimately resulted in policyholders having to pay significant amounts out of pocket in order to manage customer backlash. In one case, computer tapes containing the personal information of thousands of customers and employees fell out of a vehicle. Although the business spent money to notify those individuals and get ahead of a potential crisis, the Connecticut Supreme Court ruled there was no "publication" of the information (and therefore no coverage for personal and advertising injury) because the tapes were ultimately returned without being accessed. In a separate case out of New York, information about a business's customers was, indeed, published by computer hackers, but the court ruled that insurance for personal and advertising injury would have only applied if the insured business—not the hackers—had done the publishing.

In order to clarify the limits of coverage even further, the ISO released several endorsements that are to be used in conjunction with its standard commercial general liability policy form. These endorsements, while many in number, are all designed to clarify that cyber-related risks (including those related to personal and advertising injury) are not supposed to be covered by commercial general liability insurance.

Not all carriers use ISO language as the basis for their policies, and those that do are sometimes slow to implement the organization's revisions to its coverage forms. However, the ISO's actions and insurers' willingness to take their customers to court send the same signal: Even if their customers don't like it, carriers are not inclined to cover cyber losses under traditional types of commercial insurance.

Getting Approved for Cyber Insurance

The level of scrutiny given to an applicant for cyber insurance will depend on the chosen carrier and, to a certain extent, the recent history of cyber threats and how an applicant is equipped to deal with them.

Carriers seem to have already arrived at the collective conclusion that many instances of cyber breaches or attacks can be traced back to human error. This understanding is likely to be reflected in the kinds of questions that applicants are asked and the weight that will be given to a business's answers. Carriers will evaluate applicants on the basis of advanced technological audits, sometimes at applicants' own expense. The underwriting process will also take into account the applicant's character and overall commitment to risk reduction. A reasonably fair assumption is that the business's systems will ultimately evolve along with technology but that an applicant's obvious commitment to security is unlikely to change.

Here are some questions that might be important to a carrier when it is evaluating an applicant for cyber insurance:

- Does the applicant have any written internal policies related to data security?
- Has the applicant demonstrated a commitment to enforcing its written security policies?
- Does the applicant train and periodically retrain its employees regarding data security policies?
- Does the applicant already have a plan that will be followed in the event of a security breach?
- Does the applicant have a clearly defined managerial structure with clear lines of accountability?
- What type of data does the applicant collect and store?
- How much data does the applicant collect and store?
- How many people have access to the applicant's data?
- What is the applicant's cyber-related loss history?
- What is the loss history of businesses that are similar to the applicant?
- Do any vendors share, store or receive data on the applicant's behalf? If so, what procedures or protections are in place to manage the applicant's liability for data breaches and cyberattacks?
- How much insurance is the applicant requesting?

Policy Features and Exclusions

The next several sections will summarize the provisions and exclusions that might be contained in a cyber insurance policy. But as was mentioned earlier in these materials, there is no "standard form" for cyber insurance. When advising businesses about how to manage cyber risks, producers should make no assumptions regarding what a particular product will cover or exclude.

Notice to Potential Victims

If a security incident has made it possible for someone's personal information to be accessed inappropriately, the impacted business should take steps to notify everyone whose information may have been compromised. In some cases, this might be a legal requirement. In others, it is simply a smart form of crisis management that keeps clients and customers informed of the situation. As much as customers don't like having to cope with breaches of their data, their opinion of a business is likely to deteriorate even more if they believe the business is trying to hide a very serious problem.

The costs of notifying potential victims of a cyber breach can be expensive, particularly if there are thousands of people to contact. In many cases, those costs will be covered by cyber insurance.

Identity Theft Protection

In order to reduce the amount and impact of class-action suits after a data breach, cyber insurers will often provide a limited form of identity-theft protection to a business's customers who might have been affected by a cyber-security incident. This protection is typically in the form of credit-monitoring services, which are meant to catch instances in which exposed data is used to take out loans or create other forms of debt in a victim's name. Depending on the policy, the carrier might get to choose the vendor who will provide the credit-monitoring services.

Acts of War and Terrorism

Since 2001, the federal government and the insurance community have wrestled over how to insure businesses against terrorism-related risks. A federal reinsurance program was eventually established so that commercial policyholders could have access to some terrorism-risk coverage (albeit at a cost) and so insurers wouldn't be responsible for all losses that might arise from a catastrophic event. However, the general requirement to offer terrorism-risk insurance to commercial insurance applicants and commercial policyholders is limited to certain types of insurance products and does not extend to cyber insurance policies.

A stand-alone cyber insurance policy is unlikely to respond in cases where cyberattacks are clearly an act of war or terrorism. Yet it is important for producers and their clients to clearly understand how those war and terrorism exclusions are defined.

For example, consider a cyberattack that is widely rumored to be connected to a particular foreign government. Would those facts alone be enough to either deny a cyber insurance claim or provide benefits under a cyber insurance policy? Or would other factors contribute to a carrier's decision, such as the specific country rumored to be involved, whether the attack leads to retaliation by the United States, or whether the federal government officially classifies the attack as an act of terrorism?

As was mentioned earlier in these materials, many insurance professionals have suggested that the federal government's existing program for terrorism risk be expanded or used as a template in order to stabilize the cyber insurance market and eliminate some of the coverage-related confusion. After all, they argue, the federal government is responsible for keeping the country safe from foreign attacks, often makes policy decisions that increase the threat of attacks, and likely has more information about potential attacks than anyone at an insurance company.

So far, the federal government has expressed interest in strengthening the cyber insurance market but has not endorsed a national insurance program meant to manage cyber risks.

Acts by Employees

Whether a concern relates to accidental loss of a laptop, the inadvertent infection of company data or outright theft of a company's information, it is important to understand how claims involving employees will be handled. Depending on the policy, there might be an outright exclusion for breaches and attacks caused by a business's own workers. Alternatively, a carrier might make a distinction between breaches and attacks caused by unintentional employee error and those that were caused with clear intent to harm the organization. When this distinction is made, acts that are clearly crimes by employees are less likely to be covered by cyber insurance.

Regulatory Fines

Since insurers don't want to encourage illegal activity, they are often hesitant to sell products that allow their customers to be reimbursed for regulatory fines. In the event that a cyber insurance policy includes coverage for regulatory fines, the policy will usually have a sublimit associated with those fines. The sublimit attempts to find a middle ground on this issue by providing some help to policyholders but also making it likely that a business will still suffer some out-of-pocket losses in the event of a major regulatory violation.

Note, however, that certain laws and rules don't allow violators to use insurance in order to cover regulatory fines. Businesses that are concerned about whether insurance can be used to pay fines associated with a particular state or federal law should consider consulting an attorney.

Forensic Investigations

A forensic investigation can help a business and the insurance company determine how a breach or cyberattack actually occurred. One obvious benefit of an investigation is that it can identify potential solutions to the business's cybersecurity problems and make it less likely that a similar scenario will arise again. In some cases, an insurance company might agree to pay for a forensic investigation and will even choose the vendor to conduct it.

Business Interruptions

Some cyber insurance products will cover the kinds of first-party losses that might occur if a cyberattack forces a business to temporarily close its doors. Though this might seem like valuable protection for businesses engaged in e-commerce, careful consideration should be given to any waiting or "elimination" period contained in the policy's language. As part of this evaluation, the business should also consider the likely length of a cyber-related shutdown.

Consider, for example, a company that is reasonably confident that a cyberattack won't force a shutdown that lasts more than three days. If the business interruption component of a cyber insurance policy calls for a seven-day elimination period before benefits can begin, the coverage is unlikely to ever be usable. However, if the same business has an elimination period of three or four days or less, the coverage has a greater chance of being helpful.

IT Errors and Omissions

Errors and omissions coverage can be an important part of an insurance portfolio for business that create their own software and share it with their customers. If the business's software transmits a virus to customers' computers, the business might be liable for the damage. Though cyber insurance might be part of the solution to this problem, companies that make and share their own software might want to also examine the contents of their existing product liability or errors and omissions policies first.

Computer Hardware

Certain types of damage to a business's hardware, including its computers, might actually be covered by traditional forms of commercial property insurance. Unlike data, a desktop or laptop computer can be touched and is therefore considered a type of "tangible" property. You'll recall, however, that the data stored on a computer is "intangible" property and is usually exempt from coverage under common commercial property and casualty policy forms. So even if an insurer agrees to replace a computer, it won't necessarily agree to replace everything stored on it.

Even though a computer can be considered tangible property and be covered by traditional types of insurance, a claim for a damaged computer might be denied if the damage relates to a cyberattack rather than to a fire, a natural disaster or a burglary. In order to insure hardware that becomes unusable because of a cyberattack, special cyber insurance might be necessary, or a business might need to self-insure for this type of risk out of its own pocket.

Breaches Experienced by Vendors

Many businesses use vendors in ways that require the sharing or collection of customers' data. Though sometimes unavoidable, the sharing of data between a business and its vendors can create challenges related to effective risk management. Vendors might not take cyber security as seriously as their clients or might at least be exposed to different types of risk due to their line of work and the large amounts of data they hold. There might also be uncertainty regarding who is ultimately liable—the vendor or the vendor's client—if a vendor experiences a breach or cyberattack.

In order to provide some liability protection for themselves, businesses should consider cyber risks before cementing a relationship with a new vendor. Depending on the circumstances, this might mean adding a contractual requirement that forces the vendor to purchase cyber insurance. It might also include making it contractually clear that the business enlisting the services of the vendor will not be liable for any data breaches or cyberattacks that occur while data is in the vendor's possession. As an extra safeguard, and as a way of dealing with cases in which those two options aren't practical, a business might consider making sure that its own cyber insurance policy includes coverage for breaches and attacks involving the business's vendors.

Defense Costs

A cyber insurance policy should include coverage of defense costs in case the policyholder is sued for wrongdoing. Ideally, coverage of defense costs should not reduce the policy's overall dollar limit and should be based on a "duty to defend" rather than a "right to defend." A duty to defend is broader than a right to defend and allows the insured to receive paid legal counsel even if the carrier later determines that a claim for damages should not be covered by the policy. A mere right to defend might force the insured to pay out of pocket for legal assistance in cases where liability is relatively ambiguous.

Dollar Limits

Since class-action suits involving data breaches typically involve millions of dollars, it might be unwise to purchase cyber insurance that caps benefits at a fairly low dollar amount. However, many carriers are worried about being too exposed in the cyber market and tend to put a cap on the amount they will sell to any single business.

Many businesses have responded to insurer-imposed caps by purchasing separate cyber insurance products from several different carriers. Essentially, this creates a potential scenario in which one carrier would be the primary insurer after a cyber-related loss and the other carriers would cover losses above certain amounts if the primary coverage is ever exhausted.

Regardless of whether a business purchases one or several cyber insurance products, dollar limits should be examined carefully so they match the business's specific needs. For example, if a business is primarily interested in covering itself for cyber-related business interruptions and is less interested in cyber liability coverage, it should examine how the policy's overall dollar limit addresses those specific business interruption concerns. In this case, a policy that has a $1 million dollar overall limit but puts a $1,000 limit on business interruption losses (with the rest meant to cover cyber liability) would be a misleading and potentially harmful choice.

Claims-Made vs. Occurrence Policies

The vast majority of cyber insurance policies are "claims-made" policies and are not "occurrence policies." A claims-made policy only pays claims that arise during the policy period. An occurrence policy pays claims regardless of when they are made, as long as the event that triggered the claim occurred during the policy period.

To understand the difference between claims-made and occurrence policies, consider a scenario in which a breach occurs near the end of a policy's expiration date. With a claims-made policy, the business would not necessarily be covered if impacted customers decided to sue the business after the policy's expiration date. With an occurrence policy, the business would potentially have coverage for this type of lawsuit.

When purchasing coverage for the first time, some businesses will want a long "retroactive date," which would allow them to be covered for breaches or cyberattacks that actually occurred prior to the policy's issue date but still haven't been detected. Most insurers, though, will reject this request and will make the policy's retroactive date identical to its issue date. In other words, for coverage to be possible, both the claim and the incident leading up to the claim must occur during the policy period.

Dealing With Claims

Businesses that are aware of a situation that might result in a claim against their cyber insurance policy should contact the insurer as soon as possible. Adequate notice allows the insurer to plan for losses and to potentially minimize those losses through various forms of crisis management.

Even if a business is completely unaware of a situation that might result in a claim, the business should periodically review its security plans to ensure they are up to date and in line with the organization's current business practices. Once an applicant has been approved for coverage, security plans should not remain stagnant. In fact, failure to maintain certain security measures could jeopardize coverage of future losses.

Conclusion

By now, you should have a firmer understanding of the growing market for cyber insurance. But despite the benefits of cyber insurance products, keep in mind that even a fairly comprehensive insurance plan can't protect an organization's reputation after a breach or cyberattack. If a business is truly concerned about cyber risks, it should consider a multi-faceted strategy that not only includes insurance but also stresses the importance of training, vigilance and accountability.

CHAPTER 5: FIGHTING INSURANCE FRAUD

Introduction

When advocacy groups such as the Coalition Against Insurance Fraud (CAIF) claim that instances of insurance fraud add up to roughly $80 billion each year, you might reply instinctively with the same dismissive line a comedian once used in response to a government report that said a certain percentage of Americans do not fill out their census forms: "How do they know that?"

Fraud, after all, differs from crimes like theft, battery and assault, in that those crimes are usually noticed by a victim. If someone breaks into your home, you will likely find damage to a door or a window, along with the empty spaces where your prized possessions once stood. You will probably file a police report, and an officer will give you the old "We'll let you know if we hear

anything" speech. Law enforcement officials might never even come close to snatching your burglar, but they will at least document the fact that a crime has been committed.

With fraud, there are no broken locks, shattered windows or empty spaces to make the misdeed obvious. Instead, at its core, there is a psychological trespass, an attempt by one person to take advantage of another's trust. Sometimes our instincts and our detective skills allow us to uncover a lie. But our judgment is bound to fail us occasionally, and other people's lies will be able to hide themselves within our trusting nature.

Whether by failing to cover their tracks or by leaking their plans to the wrong individual, every single person who has ever been exposed as part of a fraud was a sloppy liar. And because we can only base fraud statistics on the people who have been caught, those statistics can never accurately account for the good liars who go undetected as they bilk insurers out of big bucks.

That said, the inevitable softness of the $80 billion estimate should in no way give our society an excuse to brush off the need to lobby for increased fraud awareness. For those readers who are inclined to ignore the prevalence of insurance schemes, let's assume for a moment that the $80 billion figure from the CAIF is a great exaggeration. For argument's sake, let's chop the estimate down by more than one-half to roughly $30 billion, a more conservative number that many other insurance experts have cited. To put that number in perspective, losses from Hurricane Andrew totaled somewhere between $15 billion and $26 billion, and insured losses from the September 11 terrorists attacks came to roughly $38 billion. As all insurance professionals who lived through those events know, the catastrophic level of destruction greatly affected the availability of affordable coverage in the damaged areas for several years.

If anything good can be said about fraud, it is only that it is less physically dangerous than a hurricane or a terrorist attack. But even if we decide that the $30 billion price tag for fraud is the more accurate estimate, we are still acknowledging that, from a financial perspective, the insurance industry is suffering financial losses on par with an Andrew-like hurricane or a terrorist attack every year, all because of lies. And, of course, the asterisk that must follow the $80 billion could just as easily mean fraud costs insurers even more than the CAIF suggests.

Consumer Views on Fraud

For emotional reasons, we might avoid thinking about the prevalence of fraud. If we allow ourselves to believe that our fellow human beings, the people we put our trust in every day, are capable of stealing $80 billion or more, we may risk having to deal with sad, cynical thoughts that conflict with our desire to feel safe and happy. We may become upset when, for example, we are forced to think about an innocent motorist who died when a driver from behind intentionally crashed into her so he could pocket some cash through his no-fault auto policy.

But professional insurance producers should not relegate their sadness solely to those sorts of situations. Instead, they should realize the enormity of a societal problem and feel upset because most Americans admit to tolerating insurance fraud and because this tolerance is often directly linked to a poor opinion of the insurance industry.

The aforementioned CAIF conducted a phone survey, quizzing 602 respondents about their attitudes toward insurance and fraud. The results of this study seem to prove that people can have divisive attitudes about ethics even when a given issue has undeniably negative connotations attached to it.

Insurance companies, which have an obvious incentive to take strict stances against fraud, would probably like all of their customers to be what the study called "moralists." These people believe there is absolutely no excuse for committing fraud and that anyone who engages in it deserves punishment.

Moralists made up the largest group in the survey, but this should not necessarily reassure insurers and make them think the average person sees eye-to-eye with the industry. In fact, the moralists were merely the victors of a tight four-group race, accounting for roughly 31 percent of respondents.

Twenty-two percent of people fit into a category called "realists." These respondents generally agree with moralists that committing insurance fraud is wrong, but they do not believe in prosecuting fraud with an iron fist. They even recognize some situations in which fraud is acceptable.

About a quarter of the participants had a more passive take on insurance fraud. These people, termed "conformists," believe insurance fraud is so common that it is an acceptable crime, if not an encouraged one.

If insurers can view moralists as their allies in a war against fraudsters, people who the study called "critics" might be viewed as their enemies. Critics do not just tolerate fraud. They often justify it by accusing insurers of mistreating consumers and having excessively greedy agendas. Critics belonged to the smallest group in the CAIF study but still accounted for a significant 21 percent of respondents.

The big picture developed by this study is clear: Insurance fraud occurs on such a frequent basis because only one-third of our society absolutely refuses to tolerate it. If the industry wants to live to see a day when only amoral creatures engage in fraud, its prevention strategy must be aggressive and aim to change a lot of people's minds.

Defining Fraud

Before you can convince someone to think differently about anything, you need to step away from your own situation, block out as many personal biases as possible and try to understand the other person's opinion, as well as the reasoning that nurtures the opinion. You want to know not only what the person thinks but also why the person thinks that way.

If insurance professionals step far enough out of their work environments, they might learn, much to their surprise, that what is obviously fraud to them is something else to the average consumer. Many people who work for insurance companies have a broad definition of fraud that encompasses any embellishment or lie affecting a person's insurance coverage. Many consumers, though, use a less inclusive definition. They agree with insurers that outright lying constitutes fraud, but they also believe embellishing facts on an application or claim form is worthy of a lesser charge.

To illustrate the different definitions, let's use a medical example. Pretend you are given blood tests by your doctor that cost about $100 combined and are not covered by your health insurance. After your appointment, your physician prepares a bill for your insurance company and lists different tests. These tests are very similar to the ones he actually performed, but they cost $150 and are covered in full by your insurer.

If we use the first definition (the one more common among insurers), your doctor has committed insurance fraud by exaggerating his performed services to the insurance company and affecting your coverage. People who use the second

definition might view the situation differently. You went to the doctor for blood tests, and he provided them to you. Though his billing of similar tests involved some deception, it was not as if he claimed to have performed a clearly unrelated procedure such as some form of cosmetic surgery. He knowingly stretched the truth. But did he really commit fraud?

In order to avoid overblown semantic arguments, we will use the first, broad definition from this point forward whenever referring to insurance fraud. Now that we have addressed the fact that many people put conditions on what can be considered fraud, we can move forward and examine why consumers allow themselves to set those conditions in the first place.

To insurance professionals whose self-concepts are grounded in their work, someone who commits insurance fraud is merely a thief who has no ethical principles. Sometimes the details of an exposed scam sadly support such a harsh judgment of fraudsters. At other times, however, people deceive and steal from insurers for what they believe to be matters of principle rather than greed.

In these cases, insurance professionals certainly need not excuse fraud, but they should note the criminal's motives. If enough principled people justify insurance fraud in a given circumstance, it might be a sign that the public has a major problem with the industry and that one way to prevent fraud might be to provide better service at a more economical price.

Insurers' Reluctance to Fight Fraud

Even among their peers, insurance producers have noted somewhat soft approaches to fighting fraud. Unhappy with the prevalence of fraud but resigned to its existence, some insurance professionals believe their individual actions cannot single-handedly stop the offenders who cheat insurers out of money. They often reason that paying questionable claims or agreeing to quick settlements in claim disputes is cheaper than fighting it out with a policyholder in a courtroom.

On a case by case basis, such reasoning often makes sense. But when insurers agree to pay a potentially fraudulent claim or settle with a policyholder without much of a fight, they are not merely making a single financial compromise that settles an individual claim. Instead, with each compromise, they add to a pile of money that slowly but surely grows and becomes a significant portion of the $80 billion or so that insurers say they lose each year to fraud.

Learning About Fraud and Becoming Proactive

If they wish, insurance professionals who care about fraud can focus on improving the industry's image or changing society's views on white-collar crime. But we know that changes in public opinion tend to occur gradually. Waiting for such changes, assuming they will occur at all, is unlikely to reduce the serious insurance fraud problem today or tomorrow.

With this in mind, the most immediate progress in the fight against fraud can only be made by people in the insurance business. Until consumers, law enforcement officials and lawmakers offer greater anti-fraud support to the industry, insurance professionals must join together to help themselves.

If the insurance community is to ever truly unite to combat fraud, it must do away with the notion that fraud is something to detect only after a policyholder files a claim. Besides unnecessarily burdening claims departments with nearly all of the physical tasks related to fraud detection, this notion ignores the ethical responsibilities all agents and brokers have to insurance companies.

Whether they are employed by an insurer or hired by a policyholder, ethical insurance professionals must bring consumers and insurers together only in good faith and should not transfer high risks to an insurer without informing the carrier of the risks. This obligation applies to health insurance brokers who work with chronically ill customers, auto insurance agents who work with inexperienced drivers and, yes, all insurance producers who work with any consumer who seems likely to have fraud-related motives.

In the rest of this chapter, agents and brokers will learn about fraud in various lines of insurance and how to spot it. Insurance producers will also be alerted to situations in which people within their industry have hurt the anti-fraud cause through their own fraudulent activity.

Stopping Fraud Before It Starts

While the individual agent or broker is not expected to take on the role of a police inspector, he or she is expected to keep an eye out for red flags of fraud, document any of those flags as they pertain to a particular consumer and share the documented concerns with those in his or her organization. Although some insurance companies hire professional investigators to observe, interview and analyze prospective and current policyholders who seem intent on committing fraud, any informed agent or broker with analytical thinking skills can contribute greatly to fraud prevention.

Early Red Flags

Fraud schemes differ from one line of insurance to the next, but some general red flags seem to apply to all types of insurance at the application stage. Some possible signs of fraud are concretely visible on an application, while others become noticeable only once insurance producers look more closely and observe how an applicant acts and how the pieces of information provided by the applicant fit together to form a bigger picture of the person's credibility.

Still, in keeping with this "bigger picture" idea, it is important to note that the existence of a single red flag or even several red flags does not necessarily prove a consumer has committed insurance fraud or is even considering it. Insurance professionals must analyze each customer's circumstances within a reasonable framework and not put every consumer in a needlessly defensive position. Ideally, by sharing suspicions of fraud with other professionals and analyzing these situations together, insurance producers can increase their chances of exposing fraud and minimize the number of false accusations that penalize innocent people.

As you read the following hypothetical example, you will probably realize that some of the presented red flags could be explained innocently on their own terms and would not necessarily justify a fraud investigation. But just as you would in a real-life situation, you will notice how accumulating facts and analyzing those facts can help you form a clearer picture of a prospective insured at the application stage.

Consider This Example

Louise works as an insurance agent and has been in the business for a long time. Most of her new customers come to her through referrals, either by co-workers who are planning their

retirement or by her own longtime customers who know she will treat their friends and family members honestly and fairly.

James became one of Louise's potential customers merely by chance. He had cold-called Louise's company in search of a policy, and she just happened to be the agent who picked up the phone. When James visited Louise's office to apply for a policy, Louise noticed almost immediately how restless he seemed, leaning forward on the edge of his chair. She also noted some odd entries on James' application. Apparently James had lived in three different cities in the previous two years and now had his mail sent to a P.O. Box in a small town. Louise had taken the long drive down to the same town once or twice to visit a relative and thought to herself that this guy had come a long way just to apply for insurance.

Louise became more uncomfortable when she got to the spot on the application for a home phone number, and she asked James why he had left this portion blank. James said he did not have a permanent phone at the moment but could be reached at his mother's number for the time being.

Louise next asked for a photo I.D. and noticed James had crossed the line that separates restlessness from genuine annoyance. He sighed in frustration and said he had left his wallet in his car, which was parked several blocks away, and asked Louise if she really needed an I.D. in order to process his application. Louise held firm, and James left the office, returning a minute later with a driver's license that had been issued just five days earlier.

Louise then steered the conversation toward policy specifics. To her, James seemed to want an unusually large amount of coverage. He said over and over again that he wanted to err on the side of caution and claimed to not care how much he had to pay in monthly premiums for comprehensive insurance.

Near the end of their appointment, Louise explained how the company would go about processing James' application and how, if approved, he could pay premiums via checks payable to the insurance company. James said he would prefer to pay in cash and was prepared to make a payment or two on the spot if doing so would mean quicker approval. Louise declined his offer and promised to contact him at his mother's house once his application had been fully processed.

After James left, Louise documented her many suspicions, mentioning that, in her opinion, this applicant appeared likely to commit insurance fraud. An underwriter at her company read her report, performed a background check on James and discovered that he owed thousands of dollars to various lenders and thousands more to his ex-wife for child support. A few days later, Louise sent a letter to James' P.O. Box and used the phone number James had given her to leave a message on an anonymous answering machine. The insurance company had denied his application.

Granted, our example is absurd because James did absolutely nothing to make himself seem like an honest person. You, the reader, probably stopped giving him the benefit of the doubt long before you reached the part about Louise's company denying the application. But that, of course, is the point. A reasonably intelligent insurance producer who gathers facts and analyzes them can indeed aid insurers by spotting red flags of potential fraud and certainly has the ability to detect possible fraud in situations that are not nearly as blatant and intentionally ridiculous as this example.

With this in mind, let's explore common fraud-related scenarios in specific lines of insurance. If you notice situations that seem very similar to the ones mentioned here, you may need to consider voicing your concerns.

Auto Insurance Fraud

For a long time, insurance fraud was thought of as something an individual committed alone or with a few close confidants. But today, it almost seems as though those were the innocent good old days, back when individuals committed fraud but thought it best not to get too many strangers directly involved in their scams. Modern auto insurance fraud is often an example of organized crime and involves many participants.

Auto insurance fraud rings tend to be most common in states with no-fault auto insurance laws. The rings can be extremely complex. In some instances, these operations have included drivers, passengers, witnesses, doctors, lawyers and police officers in their schemes. Each of these participants takes a cut of the billions of dollars that insurers allegedly lose each year because of phony claims.

Organized auto insurance fraud is more than just a serious problem for insurance companies who want to keep their money out of crooks' hands. Perhaps more than any other kind of insurance fraud committed on the consumer's end, auto insurance fraud deserves the attention of all people; those with insurance and those without, those who drive and those who ride in the passenger's seat. Rather than a seemingly victimless crime, this range of deceptions often hurts the innocents among us. To better understand why, let's look at an example of how an auto insurance fraud ring tends to function.

Organized Crime and Staged Accidents

Rob is part of an auto insurance fraud ring and is one of two passengers, plus a driver, in an inexpensive car. As they ride down some of the quieter roads in an area where reasonably high speed limits are permitted, Rob and the other passenger are watching for certain kinds of drivers. The less witnesses, the better, so they ideally want to find someone who is traveling alone.

A nice car would be preferable, too, the kind of model that people could probably only afford if they had decent jobs and the kind that the owner might insure heavily to compensate for even a single scratch on the beautiful machine. They look at license plates as well, hoping to spot a tourist who would not want to waste time and money to challenge an insurance matter in a faraway state court. After what seems like an hour, they finally settle on a car they can all agree on, a car driven by a man who has no idea he is about to become a victim of fraud.

Rob's driver follows the man and is eventually able to move in front of the other vehicle. Keeping an eye on the distance between the two cars and adjusting his speed for a preferable amount of impact, Rob's driver slams on the breaks, and Rob holds his breath for a split second to brace himself for the forceful push that occurs when the two cars meet.

Rob's fellow passenger is all set with his fake vomit, ready to moan, groan and rub his stomach at the very second when the innocent driver approaches. Meanwhile, Rob tries to focus on what to say about his back, not wanting to overdo it. (That might call for x-rays and other unbiased medical tests that could expose the fraud.) But Rob wants the innocent driver to believe he is dealing with enough soreness and pain to warrant a few grimaces and mumbles, especially when turning his neck a certain way.

The innocent driver would normally be cursing at Rob and his friends, but his heart softens as Rob says he feels a little dizzy. Rob and the other members of the ring apologize to the innocent driver all at the same time, competing with one another so much that all he can really make out is something about an animal jumping in front of the car and the word "sorry" again and again.

After swapping driver information, one of the co-conspirators tells the victim they have been on the phone with the police to report the accident. Sometimes when doing these jobs, that is indeed what is happening. But on other occasions, the companion is actually phoning an off-duty police officer who is in on the scheme.

After the accident is squared away, Rob and his gang visit a personal injury attorney who will fight for assorted reimbursements from any applicable insurance companies and who gets all of them an appointment with the same doctor. The doctor's office is as basic as they come, with no modern equipment in sight or any other visibly sick patients waiting for their own appointments. The doctor's practice, Rob knows, is only a front for these insurance scams and, come to think of it, so is the body shop that estimated the allegedly major damage on Rob's already beat-up jalopy.

If those mechanics knew how little they were making from these scams compared to the big cuts that the lawyer and doctor take home each time, they would probably threaten to expose the whole operation. But there is no need to hold a grudge against the doctor. After all, she's the one who testifies to insurance companies and courts about Rob's phony back problems, headaches and other nagging soft-tissue ailments that are difficult to disprove. She and the lawyer are the ones with enough power and prestige to get the insurance companies to pay the claims.

The innocent driver will get his car fixed, and he will walk away without a scratch on his body. In this regard, this accident is different from the one in which a scam artist hit and killed a 71-year-old grandmother and the one in which a driver who was supposed to hit another vehicle accidentally hit a telephone pole and killed a 64-year-old woman, who was supposed to witness the staged crash.

Rob might think about these two cases of organized auto insurance fraud gone wrong and feel sad for a moment or two, but this feeling quickly goes away when he is reminded of the insurance checks that will soon be coming to him. From Rob's point of view, there's no need to feel guilty, no need to be sad. Nobody died from what took place … not today anyway.

Organized Crime and Real Accidents

Sometimes, an accident is not staged in any way, but doctors, lawyers and their associates work with victims to build a fraudulent case after the fact. Many small, local newspapers summarize accident reports in each issue, and any persistent reporter can usually obtain a copy of a police report or at least get a glance at one for note-taking purposes. For a fee, people called "ringers" or "steerers" might impersonate someone from the press or take advantage of a source at a police station or an insurance company and gather the names of people involved in recent car accidents.

This person might then contact accident victims and, if they have not yet contacted their insurance company, the ringer will suggest they hold off until a particular doctor examines them. If the ringer has reason to believe an insurer already knows about the accident, he or she might tell victims that their insurer insists they see a specific doctor.

At that point, the ringer moves out of the picture, having not committed any claims fraud, and allows the lawyers and doctors to handle the rest of the situation. Maybe these scams work because the doctor and lawyer actually convince the patient that he or she suffers from certain after-effects from the accident. Maybe there are legal, physical or financial threats involved. Or maybe the accident victims recognize an insurance scam when they see one and are perfectly willing to become players in the master plan if doing so might net them a few bucks.

Organized Fraud's Effect on Premiums

Organized auto insurance fraud has attracted so many people and gone undetected for so long that, in many states, particularly those with no-fault auto insurance laws, responsible drivers have struggled to obtain affordable, high-quality coverage. Fraud prevention allegedly helped drop auto rates in the no-fault state of New York in 2005, but in the not too distant past, an increased number of drivers had no choice but to accept the comparatively expensive coverage offered by the government, as traditional insurers became weary and more selective when selling policies to new customers. Perhaps deciding that enough was enough, Allstate Insurance Co. filed a $107 million lawsuit in 1998 against 45 individuals, including lawyers and doctors, who allegedly participated in auto insurance fraud rings.

Unorganized Auto Insurance Fraud

As much as this chapter emphasizes organized auto insurance fraud, it is not meant to imply that less organized, less complex auto fraud committed by a single person or a select few no longer deserves any attention. Insurance professionals must still fight against some policyholders who engage in more traditional schemes, such as reporting a car as stolen when the owner can no longer make payments on the vehicle. Insurers who base auto rates on geography, a somewhat unpopular practice among many urban consumers, need to look out for people who use fake addresses to lower their premiums. More recently, according to National Underwriter, the rise in e-commerce has allowed some fraudsters to insure their beat-up old cars online and then claim the car was damaged in an accident.

Some insurers have also been seriously bothered by teenage daredevils with passions for drag racing. In contrast to the classic game of chicken, in which the winner's rewards consist of bragging rights and the continued use of all four limbs, today's victorious street racers often take home a customized part of losers' cars as their trophies. For the hotshot driver who treats each one of his car's bells and whistles as if they were his children, the loss of a race and, therefore, a prized accessory can seem unbearable. In order to compensate for these losses, some racers tell police officers and insurance companies that their vehicles and accessories were stolen, vandalized or damaged in a legitimate accident rather than gambled away or wrecked in a contest.

Red Flags and Auto Insurance Fraud

Of course, if an insurance producer only had to memorize a few red flags in order to put a stop to fraudulent claims, insurance fraud would not be much of an important subject for continuing education. In terms of auto fraud, as well as fraud in connection with other coverage, the developers of this course do not naively believe that the general tips found in this chapter can end fraud. Yet for nearly every section of the industry, there are a handful of

common-sense red flags that can at least help professionals minimize such crime.

Before you even begin scrutinizing a particular claim for hints of fraud, you should realize that many successful perpetrators do not just become involved with a single scam. Many of them have committed fraud before.

For this reason, you might find it helpful to view information about a potential fraud as if it were only one piece of a puzzle. Something might appear innocent within the context of a single claim but might not when viewed with the other claims the person has filed. One claim might lead you to investigate another, which might then make you want to review the person's application. Little discrepancies might convince you that digging for more facts to unearth the truth is worth the effort.

To guard against fraud rings, insurance professionals should take note of doctors and lawyers who seem to be involved in an unusually large number of accident cases. Does one doctor typically diagnose patients only with those soft-tissue ailments mentioned earlier, such as back pain and headaches that are difficult to disprove? Do many of the doctor's referrals come to him or her via a lawyer?

Similar advice applies to the people directly involved in auto accidents. Members of a fraud ring often switch roles from one accident to the next. A driver in one crash could be a passenger in another crash. If someone has been listed as a driver or passenger in several accidents, insurance professionals might want to examine the circumstances of each event in order to discover any suspicious similarities. Looking into claims involving people with similar names is also helpful and, as we will discuss later, simpler than ever before thanks to search engine technology and shared claims information among insurance companies.

Sometimes criminals are easier to spot from the start, and the investigator needs to do less digging to find the truth. Alarm bells should automatically go off when a person claims to have lost control of a car in the rain when there have been no recent reports of rain in the area. Again, odd circumstances do not prove fraud. Maybe it did rain in the driver's neighborhood but not near yours. But such odd circumstances should absolutely force all employees who are working on questionable claims to use their heads and be alert to the possibility of fraud.

Medical Insurance Fraud

The majority of this chapter focuses on insurance fraud committed by policyholders. Agents and brokers who provide health coverage could certainly create a decent-sized list of this kind of activity. That list might include instances of patients abusing prescription drug plans by forging doctors' signatures and placing orders for medicines at multiple pharmacies. Perhaps that list would also include policyholders who mark former spouses on their health plans as dependents, a deception insurers can remedy relatively easily by checking public records.

But according to a study reported by the Journal of the American Society of CLU & ChFC (a financial industries trade publication), health care providers are more likely to commit insurance fraud than patients. On one hand, this makes sense, given the managed care systems in the United States, where many policyholders pay a small fee when visiting a physician and let the provider deal with the necessary claim forms. Because the contact between physician and insurer drastically exceeds the contact between patient and insurer, there is a larger window open for the physician to commit fraud as opposed to the patient.

Even if patients receive regular statements from their insurance company about approved benefits and rendered services, they are unlikely to examine their records for billing errors made by a physician unless they have a problem with how much they, themselves, must pay to the provider.

Still, the many documented cases of fraud committed by health care providers may be difficult for insurers to stomach considering the mutually beneficial relationship that ought to exist between the insurance and medical professions. If people did not put a premium on health care for themselves and their loved ones, consumers would have little reason to buy health insurance, and if insurance companies did not exist, physicians would struggle to secure payment for their services and would almost certainly need to more actively market themselves in order to attract a desired number of patients.

Deep down, health care providers and insurers probably understand that they need each other to survive. However, the relationship between the two professional groups has always been a seemingly begrudging one at best. From some doctors' perspectives, insurance companies have been stubbornly tight with money and intrusive when it comes to treatment issues. Good doctors want to be compensated fairly for their services and wish they had the freedom to serve patients without an insurer telling them a patient does not need a particular medicine or surgical procedure. Meanwhile, a good insurer wants to be certain that physicians are not violating the trust the company has given them by demanding payment for services not rendered.

More so than any other topic discussed in this chapter, medical insurance fraud refuses to allow us to stereotype perpetrators as unethical under all circumstances. Sometimes this kind of fraud seems to operate in a stubborn cycle. In order to provide patients with the best care possible and to ensure that they receive payment for providing this care, physicians might deem it necessary to make an adjustment to a claim. At the same time, insurers realize physicians are distorting claims, thereby cheating the system, and the insurance companies react by getting tougher on health care providers and patients and being even more strict about what their policies will and will not cover.

With each side adjusting to the other's new positions, questions must be addressed by compassionate and fair insurers, as well as compassionate and fair doctors. Professional insurers must ask themselves if they have reached a point where their anti-fraud efforts, which take power away from physicians and reduce the number of affordable treatment options for patients, are actually encouraging health care providers to commit more fraud. Do some insurers enforce such strict rules when managing health care that sometimes the only option for a doctor with a sick patient is to break those rules?

Meanwhile, medical professionals must ask themselves how they can justify fraud for the good of a patient today if their actions will almost certainly force insurance companies to become even more involved in treatment issues tomorrow. They must understand that insurers have justifiable reasons to protect themselves from fraud and that even though there are many good and fair doctors in the system, there are also some bad and selfish practitioners whose frauds have nothing to do with what is best for patients. If insurance companies do not stand up to these unethical doctors by tightening their overall hold on health management, all insureds might suffer the consequences.

Examples of Medical Insurance Fraud

Perhaps the most indefensible forms of medical insurance fraud are those that cheat patients along with insurers. Suppose Mary injures her back and goes to a clinic that she assumes employs specialists who can treat her condition. This is a very busy clinic, but with one look inside, Mary senses something is different about it. As she observes others and goes through her own appointment, she thinks, "This is the fast-food, assembly-line version of health care." The employees engage no one in conversation and have an unstated yet still obvious agenda that involves getting patients in and out the door as quickly as possible.

A woman who looks like a nurse runs through some standard procedures, taking Mary's temperature and checking her weight. Mary tries to go into detail about exactly where and when her back hurts, but the nurse seems focused on something else, looking at the clipboard filled with Mary's insurance information and not looking up or taking notes. The nurse rushes Mary into a back room filled with bubbling hot tubs like those Mary has seen in spa brochures. She tells Mary to get in, leaves her there for 15 minutes and returns to get her out of the tub and to schedule a follow-up appointment.

Two weeks later, Mary receives a statement from her insurance company regarding her trip to the clinic. She expects trouble, believing there is no way on earth her insurer is going to cover a quarter-hour soak in a whirlpool. But to her surprise, she owes nothing. However, the insurer has paid for some tests Mary does not remember having done and is also paying the clinic a few hundred dollars for some muscle therapy she has never heard of. Mary tosses the statement in a drawer, winces again as she rubs her back and decides to contact a certified medical doctor who might be better equipped to help her manage her pain.

The details in that example were contrived for simplicity and clarity's sake, but the story's general outline is based on numerous examples of seedy medical operations that have successfully bilked millions of dollars out of insurance companies by charging them for bogus procedures at phony clinics. As reported by the Wall Street Journal and other news outlets, the state of Florida recognized the serious problems caused by these insurance schemes and took it upon itself to expose the people behind them. Inspectors discovered rudimentary setups, some under the supervision of a licensed physician and others operating under stolen doctor's billing number. In many cases, the lax attention these clinics received from regulators, as well as the pressure on insurers to pay claims quickly, allowed crooks to reap large profits. By the time investigators received a tip about a suspicious clinic, there was already a good chance the operation had packed up and reopened elsewhere, and the money for the phony treatments had already been doled out by the insurance companies.

Other medical insurance scams involve purely selfish motives of patients as well as physicians. In a scheme known as "Rent-a-Patient," doctors appeal to policyholders' desperation or greed by rewarding them for undergoing pointless medical procedures. A patient might receive the nose job he or she always wanted with the understanding that the surgeon will bill the insurer for necessary surgery as opposed to a cosmetic operation. Sometimes patients are paid in cash for acting as guinea pigs. In an absurd travel promotion, as reported by Knight Ridder Tribune Business News, some 1,800 Utah residents were involved in a scam in which policyholders received an all-expenses-paid trip to California in return for undergoing colonoscopies. Insurers in Utah said total claims from the venture amounted to $27 million.

Among more legitimate health care providers, some hospitals have been accused of billing Medicare for procedures performed by resident employees as opposed to the faculty physicians listed on claim forms. Individual physicians have been accused of "upcoding," billing insurers for more expensive procedures that are only somewhat related to those actually performed on a patient. Other physicians "unbundle" their services by charging insurers for each individual service provided to a patient when those services should be grouped together and billed at a lesser rate. Some doctors get caught billing an insurance company twice for one procedure. In an example that seems to incorporate unbundling and double-billing, investigators at Pennsylvania Blue Shield recalled a health care provider who administered chemotherapy in split doses so he could double his profits.

Detecting Medical Insurance Fraud

Claims departments and investigative teams can sometimes spot medical insurance fraud merely by looking at a situation and applying some common sense to it. One doctor obviously could have benefited from a crash course in mathematics and personal stamina when he claimed to treat 200 patients a day.

To catch potential fraud that is not so obvious, many medical insurance companies have utilized software that scrutinizes doctors' billing practices and alters questionable bills automatically.

Workers Compensation and Disability Insurance Fraud

Workers compensation fraud, which National Underwriter once estimated at costing insurers $5 billion each year, is yet another complex crime that insurers ought to examine from various angles.

Stereotypically, this type of fraud brings lazy employees to mind who either stage accidents or fake injuries in order to avoid going to work. But stopping there and only noting that aspect of the issue would be detrimental to the insurance community and unfair to the many hardworking people who deserve financial assistance when their jobs take dangerous turns.

From an insurance perspective, workers compensation fraud is as much an employer problem as it is an employee problem, with many companies actively deceiving insurers to obtain coverage and discouraging injured laborers from claiming the benefits rightfully owed to them.

Before we examine some of the more complex sides of these crimes, let's start comfortably by exploring the stereotypical employee fraud that most people associate with workers compensation and highlight some red flags that might help employers and insurance professionals detect it.

If a workers compensation claim doesn't seem to make sense, some kind of investigative team might be called in to handle the situation. Sometimes insurance companies employ their own teams, and sometimes employers or insurance companies outsource the work to private investigators.

All witnesses to an accident should be interviewed as soon as possible so that their recollections can either confirm or contradict the injured person's story. If an employer can only provide vague reports of an incident, the investigator's job becomes tougher, and an accusation of fraud could unfortunately boil down to nothing more than one person's word against another's.

An employee's status with a company can hint at the truth surrounding an accident. If an organization has announced

layoffs, a person who believes he or she will soon be one of those laid off might panic and turn to workers compensation fraud.

Coworkers are important sources of information in these situations because they might have been the audience for an injured person's thoughts. Or, in a more optimistic outcome, they might be able to assure doubters that the person was a dedicated employee who would probably not engage in serious deceit. Temporary employees and new hires who make workers compensation claims often arouse some suspicion because their coworkers have not known them long enough to vouch for their character.

Accidents involving no witnesses are obvious causes for concern. This is especially the case when they occur on Monday mornings, since some workers might try to make their employer responsible for injuries actually suffered on weekends. These employees will seem even less credible if they have reputations around the office as athletes, physical risk-takers or avid outdoorsmen.

Once the worker is out of the office, investigative teams sometimes observe the person from afar. If the employee has a second job, a team might visit the second workplace to see if the injured person shows up for duty. Sometimes teams catch an allegedly disabled person moving heavy furniture, playing an aggressive game of softball or taking part in other strenuous activities that seem to contradict an injury claim.

When these significant discoveries are made, they may lead to a claim being denied, thereby saving the insurer and employer money. In some cases, however, these seemingly defenseless exhibitions of physical strength are not clean-cut examples of people getting caught in a lie. Some injured parties have successfully argued that an investigator merely observed them on one of their better days or did not take note of the many hours they spent recovering from the heavy lifting or the softball game. As weak as those lines of defense may seem, most professional fraud investigators attempt to strengthen their cases against supposed insurance cheaters by documenting an extensive pattern of suspicious activity before challenging a claim.

Red flags also fly when people injure themselves at work despite having a reasonably safe job. Though freak accidents do occur, an employer or an insurer might wonder, for example, why a receptionist or clerical employee has filed for workers compensation benefits twice in the past five years.

In more perilous lines of work, however, fraud detection can seem insurmountably difficult. Consider, if you will, the construction industry. Here is a field packed with physical risks and destined to produce a relatively high amount of legitimate disability claims. Construction workers undoubtedly realize this, and some of the dishonest ones might try to commit fraud.

Like medical insurers, those professionals who offer workers compensation policies to high-risk businesses can sometimes feel ethically torn. They are smart enough to know that some people are engaging in fraud, yet greater scrutiny of claims could inadvertently clog the flow of benefits to deserving recipients and make insurers seem guilty of unethical conduct.

Logic suggests that because people who own construction companies will likely pay a large premium for workers compensation coverage, these employers should be just as serious about fraud prevention as insurers. Undoubtedly, many business owners subscribe to this ethical attitude. But too many others focus on the price of workers compensation coverage and believe cheating insurers and employees out of money and benefits is the best way to keep premiums down.

Though individual insurers may differ in how they underwrite workers compensation, they generally base their decisions about these policies on the number, salaries and job duties of the employees who will be covered by a policy. High-risk business owners have been known to misrepresent all of those factors when applying for coverage. Rather than listing their entire workforce on a payroll, a construction company might pay some laborers either partially or entirely under the table. Instead of listing employees properly as roofers, a company might put them in a comparatively safer category, such as general carpentry. These examples nearly mirror a real development, covered by the San Diego Business Journal, in which six construction companies were charged with defrauding several area insurers out of $5.5 million.

Life Insurance Fraud

Life insurance fraud has probably been around as long as insurance itself. History tells us, for example, that two women were hanged in 1884 by authorities in Liverpool, England, for allegedly poisoning men in order to collect death benefits. Yet despite its extensive history, this brand of fraud is still an understandably delicate issue. Imagine that your spouse or someone else close to you has just died and someone from an insurance company insinuates that you may be guilty of faking the death or even murdering your loved companion for an insurance check. Most insurers don't want to be seen as heartless and are willing to accept a minimal amount of fraud to avoid this kind of perception from the public.

This type of fraud intrigues us, maybe because many of the related scams seem like storylines from crime novels. Still, these frauds can also make us furious for reasons that have nothing to do with stealing from insurance companies and everything to do with using other people as pawns in selfish games of life and death.

Before discussing specific examples, we will first examine life insurance fraud at its lightest level; light only in the sense that even though money might be stolen from an insurance company, the perpetrator's selfishness does not extend to the physical endangerment of innocent people.

The more intricate life insurance fraud schemes in the United States tend to involve relatively small policies from several companies. Utilizing small policies for these deceptions serves two purposes. First, it allows the criminals to maximize coverage without seeming suspicious to any particular insurer. Secondly, because smaller policies are less likely to require physical examinations from policyholders, it gives perpetrators the occasional option of taking out policies on unsuspecting individuals.

Once the policy has been in effect for a reasonable amount of time, the thief tries to secure a falsified death certificate in the insured's name. In one of the more elaborate frauds to attract media attention, this step in the scheme process was completed by a ring-leading funeral director who shared in the insurance payouts. In another case, a woman merely photocopied her deceased first husband's certificate and doctored it so that her living husband was listed.

Arguably the most darkly amusing examples of attempted life insurance fraud are those in which one spouse runs a scam while the other spouse remains completely oblivious to it. The clueless husbands and wives get up every morning, kiss their partners

goodbye, go to work and come back home to their companions, all the while not realizing that, at least as far as an insurance company is concerned, they are supposed to be dead. Investigators arriving at homes of alleged widows to discuss beneficiary issues have been greeted at the door by some understandably confused yet very much alive husbands. One woman, profiled in Forbes magazine, could not understand why her allegedly deceased husband got so upset at her for faking his death without even telling him first.

"He's such a jerk," she said in prison. "If it weren't for him, I wouldn't be in here."

Life Insurance Fraud Overseas

People intent on faking someone's death in order to collect life insurance benefits have had greater success when they have used foreign settings in their stories. A husband might claim, for example, that his wife traveled to Central America and died there.

Cultural and political factors are keys to making these scams work. In some parts of Mexico, for instance, autopsies are not as common as they are in the United States. This would prevent insurers from routinely verifying deaths by matching a body's fingerprints to those of the policyholder. Deaths are even tougher to prove when they occur in Third World countries where recordkeeping systems are basic at best and, therefore, more easily corruptible. Political strife also hinders fraud prevention, particularly when civil wars claim so many casualties that authorities cannot accurately document all deaths.

It is also worth noting that foreign countries have their own problems with insurance fraud. In parts of Africa, where the AIDS virus has spread at alarming rates over the years, it appears as though it is an open secret that some doctors knowingly provide infected patients with clean bills of health so the sick can obtain life insurance.

Murder and Fraud

Some insurance producers encounter situations that seem to point toward murder. Suppose a woman claims her husband died in a fall while rock climbing, yet word gets out that the man suffered from a nearly incapacitating fear of heights. Or maybe the insurer is investigating an accidental drowning of a man's wife, and the producer finds out that the woman could not swim and did not bring a change of clothes along with her for what the husband claims was a week-long boat trip. Perhaps a policyholder has lost his wife and children in a fire and the producer discovers that his first wife died in similar circumstances and that the man was once investigated for mail fraud. Is it the ethical responsibility of the producer to make the insurer aware of these concerns?

As human beings, we would probably like to come to the comforting conclusion that these situations add up to nothing but coincidences and that the people who we shake hands with and do business with would never do the terrible things that these various clues suggest. Yet our faith is shaken whenever we read or hear news reports about people who committed fraud through means that would not factor into even our worst nightmares. Consider these three examples compiled from court documents and news reports:

- In 1990, a former insurance agent bought life insurance for his wife, worth $700,000. The day after coverage went into effect, in February 1991, the agent complained to his wife about her snoring and convinced her to take a dose of the 12-hour decongestant Sudafed.

  The wife went into a coma, and her husband called 911 in hysterics. The operator wondered if the agent's display of panic was an act, and so did medical professionals who tried to treat his wife but could not figure out what had caused her symptoms. When offered permission to see his spouse at the hospital, the agent declined but did suggest to the doctors that she might have been suffering from cyanide poisoning.

  Sure enough, the Sudafed tablet that the wife had taken that night was laced with poison, and the medical team was able to save her life. Later, in front of family and police, the agent said he knew he would probably be suspected of the poisoning, especially since he was due to collect so much money through his wife's life insurance. But he assured everyone that her coverage exempted poisoning.

  Two other area residents were not as lucky as the agent's wife. Kathleen Danicker and Stan McWhorter, both in their 40s, died from ingesting cyanide-laced Sudafed later that month. The deaths forced the drug's manufacturer to order a recall, which determined that someone had tampered with five packages of the medicine.

  According to court records, it turned out that the agent had not only lied about the poison exemption on his wife's policy. He had specifically asked if the insurance covered that peril. Handwriting experts determined he had signed for a pound of sodium cyanide at a chemical plant prior to the poisoning, and authorities accused him of tampering with multiple packs of Sudafed in order to cause a massive recall and draw attention away from his motive to kill his wife. The agent was found guilty of several charges and sentenced to life in prison. The United States Court of Appeals for the Ninth Circuit affirmed a district court's rulings in 1995.

  "The only detail missing from [the agent's] calculus was the identity of the people he would kill. That he was unaware of the victims' identities does not make his conduct any less culpable," U.S. Circuit Judge Alex Kozinski wrote. "Nor does the victims' anonymity make his crime any less gruesome. If anything, the randomness of the act only renders it more cruel."

- In another case, Paul Valdos and Kenneth McDavid had died six years apart, in 1999 and 2005 respectively, but the differences between them in death pretty much ended there. Both men had been found in Los Angeles alleys with fatal upper-body wounds and tire marks on their bodies, apparent victims in murders that involved no witnesses. Coming forward to identify both bodies were Helen Golay and Olga Rutterschmidt, grandmotherly types who apparently befriended them when the men were homeless and who had subsequently put them up in apartments with paid utilities for about two years before the accidents. Supposedly, the relationships between the men and these seemingly good Samaritans was so strong that Valdos and McDavid listed them as beneficiaries for several small life insurance policies. Even though Valdos had children who survived him, it was Golay and Rutterschmidt who were allowed to claim his body and bury it in an unmarked grave.

  Realizing these connections, authorities probed deeper into both cases. A review of the numerous insurance policies revealed that Golay and Rutterschmidt

assumed various identities in relation to the men. Sometimes they claimed to be their business partners, other times their aunts, cousins or even fiancées. Some insurers suspected fraud when it came time to pay the death benefits, but they said the women knew how to fight the system and that various issues prevented the companies from revoking the policies.

According to the Associated Press, undercover agents began tracking the women and observed a blind man, Josif Gabor, accepting a ride from Rutterschmidt and writing on a series of forms en route to a bank. Sorting through trash that the woman discarded at the branch, officials found ripped envelopes with an insurance company's name on them, as well as bank documents featuring Gabor's name. Investigators also found rubber stamps designed to form several men's signatures among the women's possessions.

In federal fraud charges brought against the women in May 2006, officials alleged Golay and Rutterschmidt had scammed insurance companies out of more than $2 million in claims related to the Valdos and McDavid deaths. The women pleaded not guilty.

Meanwhile, investigators had been building a murder case around a 1999 Mercury Sable station wagon. Records showed that an hour before anyone found McDavid's body, Golay had a car towed a few blocks away from the crime scene. The same kind of vehicle, with damage to its front, was later abandoned near Rutterschmidt's apartment. Though the car was never registered in either woman's name, police discovered a note in Golay's daily planner that listed a matching license plate number. Checking the car for evidence, police found DNA on the underside that they said matched McDavid's. In 2008, Golay and Rutterschmidt were sentenced to life in prison for first-degree murder and conspiracy to commit murder for financial gain.

- In another real-life example, a baby girl died before she reached three weeks of age, an apparent casualty to Sudden Infant Death Syndrome (SIDS), a rare condition that usually only strikes babies who are put to sleep on their bellies and whose mothers have substance abuse problems. Yet the baby's mother had no known drug problems at the time and, family members said, knew how to take proper care of her children. When the baby died, the family said the mother went into a deep depression and got hooked on gambling at casinos, an unshakable habit that put her deep in debt by the time she gave birth to another daughter roughly 15 months later.

  When this second daughter was born, family and friends gave the mother $380 and, according to taped conversations reported in the Chicago Tribune, the mother bought a life insurance policy for the child "to be like a savings plan." She later said an insurance agent pressured her into purchasing a $200,000 policy for the baby girl, though the insurance employee said it was the mother who pursued the policy and that the purchase seemed suspicious because the mother was in debt and did not have life insurance for herself or her other children.

  Ten days after the policy went into effect, the mother phoned her husband and told him their daughter was sick. Despite her husband's orders to take her to the emergency room, the mother decided to wait and see if the child improved. The next day, the mother screamed in front of the baby's crib. The baby, with blood near her nose, was dead at the age of seven weeks.

  Telling people she had lost another child to SIDS, the mother tried to collect on her daughter's insurance policy. Insurance employees suspected fraud and reported the situation to police. Authorities brought fraud charges against the mother in 1998, accusing her of killing her daughter to pocket insurance money.

  Besides building a circumstantial case around the woman's past, which involved gambling problems, bad checks and other frauds, prosecutors said the odds of two daughters dying from SIDS were highly unlikely. Though the condition was once thought to run in families, scientists now say there is conclusive evidence to show it is not a genetic disorder. An expert witness, who had studied thousands of SIDS cases, said he had never encountered a child in his research who died with blood near the nose, and he suggested the bleeding resulted from pressure put on the daughter's blood vessels, possibly during suffocation. A jury convicted the mother in February 1999, and she was sentenced to 21 years in prison.

You might have noticed that of the three examples, the third case most specifically mentions an insurance agent, and, indeed, this case deserves to be viewed as more than just a chilling instance of a consumer trying to defraud an insurance company by any means necessary. The daughter's death in the example should make insurance professionals stop for a moment and realize that their sales practices can play a role in immensely serious outcomes.

Insurance professionals know something is only insurable if it has financial value to the applicant. Adults, for example, buy life insurance policies so their spouses and children are compensated for the income that they will no longer have access to after a death. With this in mind, it is true that a life insurance policy for a child could pay for death-related expenses. But does a child's death typically leave the parents with one less source of income?

Even if we agree that life insurance for children can serve a valid purpose, we may want to seriously consider whether a $200,000 policy is appropriate for a newborn. Yes, it was the insurance company that reported the mother to authorities, and the agent who handled her application apparently did suspect something was wrong. But if this case teaches us anything about ethics, it is that recognizing an ethical issue without addressing it is perhaps even worse than not recognizing it at all. Though no insurance company should be judged based on one agent's action or inactions, the insurer may have reinforced the negative stereotype of the insurance industry by only acting when it came time to pay the death benefits.

Poor public perception acts as a huge barrier to fraud prevention. This situation and others like it force consumers to confront the following question: Do insurance companies really care about preventing fraud for the good of society, or are they willing to tolerate a potential crime as long as someone is paying premiums and has not yet filed a claim?

Property Insurance Fraud

Property insurance fraud often involves expensive items such as jewelry and paintings. Many companies who insure these items can link fraud cases to the appraisal process. An applicant might purchase a phony gemstone, purposely submit fraudulent valuations to the insurer and buy coverage for thousands of

dollars above the item's actual worth. Eventually, the consumer will call the insurance company and report the stone stolen or severely damaged.

Suppose Jane spots a diamond for sale by a jeweler for $5,000. She pays the price gladly, and why not? The jeweler has appraised the stone at an even $6,500, and Jane figures she can eventually make a nice profit from her purchase. The jeweler gives her receipts and other necessary forms documenting the diamond's value, and she is able to insure her find for the full $6,500.

Jane has a friend who knows a thing or two about valuable jewelry, and she cannot resist showing her the diamond, expecting her friend to congratulate her for spotting such a fine specimen. But instead of patting her on the back, the friend tells Jane the diamond is worth a couple hundred dollars at most.

For obvious reasons, this news upsets Jane greatly. She becomes instantly mad at the jeweler for conning her and mad at herself for believing a deal that was too good to be true. Jane could sue the jeweler for blatantly lying to her and giving her false documentation of the jewel's worth, but after thinking it over, she realizes, with all the time and money she would probably spend on a lawyer and a potential court proceeding, she would be lucky if she got half of her money back from the crook. On the other hand, she still has the insurance policy for $6,500. Maybe if she tells a few lies or stages a burglary, she can file a claim and be done with the embarrassing mess.

Even in less extreme situations, buyers and insurers ought to know that some sellers will distort the value of expensive personal property. After all, the seller wants a customer to believe he or she has gotten a great deal and that the item sold is worth much more to the consumer than what he or she has paid for it. For this reason, even when an applicant appears to be requesting coverage in good faith, it is often wise for an insurance company to obtain an appraisal from an unbiased third party. Along with serving the insurer's best interests, this practice can also help the consumer by either confirming an item's value or alerting the buyer to potential fraud.

Property insurance fraud might also involve arson. Fraud in connection with arson seems to be one of the most difficult insurance crimes to prevent, but industry professionals can still rely on some of the general red flags discussed earlier in this text. Does the applicant seem overwhelmed with debt? Does the applicant appear anxious to buy excessive coverage for a building without considering the cost? Does the applicant have any history of fraud?

Dealing With Fraud in Catastrophic Situations

In recent years, insurers have had to deal with more catastrophes than they might have ever imagined. To its credit, the insurance industry paid most claims related to 9/11, even though it could have challenged them based on traditional insurance responses to acts of war. The industry compensated policyholders even more for damage done by Hurricane Katrina, a storm that overtook 9/11 as the most costly catastrophe in our nation's history.

Yet even before the first claims came in from the hurricane, some insurance professionals knew from past experiences that a few policyholders would dare to use widespread tragedy as a springboard for fraudulent schemes. After 9/11, for example, one man claimed his wife went out on a job interview at the World Trade Center and never came home again. Nearly $300,000 into the scam, an insurance worker called a local sheriff's department and talked to someone who had just received an invitation to Thanksgiving dinner from the allegedly dead woman. Such scams are known to us obviously because the people behind them were caught. Insurance companies and law enforcement believe many more cases go undiscovered.

Rather than become discouraged or cynical based on these kinds of cases, insurance professionals can take pride in the many claims they honored following catastrophes and be proud that they helped many people without putting them through extensive scrutiny. These frauds should not necessarily fill the insurance community with shame, as long as an overwhelming majority of processed claims provide financial assistance to people who are beginning the long task of rebuilding their lives.

Fraud Detection Tools

Though insurance producers should not allow themselves to become so swept up by the wonders of anti-fraud technology that they ignore what their experiences and instincts tell them, today's property and casualty insurers have a great friend in the Insurance Services Office, Inc., (ISO) or at least in the fraud database that the company oversees. Before the ISO set up its current service, criminals had a decent chance of committing frauds in multiple lines of insurance without having their frauds linked together by investigators. Despite multiple databases, insurers did not share enough information with one another about their customers for fraud prevention purposes. A questionable claim might have been found in one database but not another.

The ISO's more centralized fraud database has helped investigators connect crimes more easily than they could in the past, but the technology itself has been just as beneficial. Search engine capabilities now allow insurers to perform a wide variety of exploratory investigations of potential fraud. In addition to searching for multiple claims with the same name, address or Social Security number, fraud-conscious professionals can view records featuring different variations on names, addresses and Social Security numbers that the perpetrator might change from one crime to the next.

On the human side, many insurers personally employ or enlist the services of a Special Investigative Unit (SIU). This team, made up of members with insurance, law enforcement and detective skills, delve into all available data about a suspicious claim, interview witnesses to accidents (including the claimant) and may engage in surveillance work.

For some insurers, having a permanent SIU is a luxury they cannot afford. People who have stuck with an SIU for a long period of time, however, typically cite their unit's cost efficiency. SIU proponents have been known to say that for every dollar spent on a unit, an insurer saves $10 thanks to the team's effective anti-fraud work.

If an insurance producer suspects a claimant of fraud, he or she should alert the SIU, assuming the company employs one, and let the specialists do a more thorough investigation. The use of an SIU, however, does not exempt other insurance professionals from any further ethical responsibilities. If you call in an SIU, you ought to understand what the unit will and will not do in order to determine a claim's validity. An insurance company should consider ethical issues, such as personal privacy and deception, and determine if its SIU's tactics are likely to produce results without breaking any laws or any ethical standards.

Insurance companies specializing in certain lines of coverage have sometimes utilized fraud detection tools that cater more to their specific needs. Medical insurers, for example, began using

software programs in the 1990s that automatically reduce reimbursements for health care providers whose claims suggest errors or fraud. These tools can spot irregularities, such as claims filed on behalf of male patients for gynecological treatments and multiple bills for the same service.

Cigna Corp., which has used a program called ClaimCheck, reported that the bill-cutting software saved the company about $60 million during its first four months of use, but doctors have expressed concern with these supposed anti-fraud tools. In their mission to stop fraud, doctors say, these software programs sometimes unilaterally void many legitimate claims. Physicians have reported instances when they have examined a patient during an office visit, performed a biopsy or analyzed a urine test to diagnose the patient and only been reimbursed for the tests. In more extreme cases, doctors say they have performed multiple surgeries on a patient, yet the software only reimbursed them for the first procedure, as if the additional surgery should have been done for free.

The bill-cutting software might catch the occasional thief, but it also presents negative possibilities for patients. Because some insurers have not adequately explained to doctors how their software analyzes claims, physicians have suggested they may have to compensate for the software's sometimes unfavorable determinations by charging patients more for treatment up front. Some have even wondered if a few health care providers will avoid performing various precautionary tests and exploratory procedures if they think an insurer's software will prevent them from being paid for the services.

The prevalence of bill-cutting at major medical insurance companies was responsible, in part, for multiple class-action lawsuits filed on behalf of health care providers near the turn of the century. Demanding payment for services dating as far back as 1996, providers settled with many insurers for hundreds of millions of dollars. In addition to the financial compensation, the insurance companies agreed to improve their communication with physicians and institute a system whereby providers could re-file disputed claims.

Fraud From the Inside

Most of this chapter has focused on fraud committed by people from outside the insurance community. It would be wrong, however, to suggest that this is a completely consumer-driven problem that insurance professionals will never detect among their supervisors, peers or competitors. Some corporate executives, agents and brokers give ethical insurance producers a bad name by committing or becoming involved in fraud. While fraud awareness is necessary when working with consumers, agents and brokers must also address fraud within their own ranks by reporting known misdeeds to authorities and setting high ethical standards for themselves and their coworkers.

Real-life examples of alleged insurance fraud from the inside include the following:

- An insurer was accused of concealing its exposure to asbestos risks in order to attract investors. The asbestos situation allegedly jeopardized the solvency of some Lloyd's of London syndicates, cost people their investments and devastated some investors to the point of suicide.
- A financier allegedly transferred $200 million from five insurers' reserve accounts to a brokerage firm and then used the money for himself.
- Authorities claimed the CEO of an Illinois insurance brokerage used millions of dollars that should have gone to insurers and policyholders to finance his personal projects and company operations.
- A life insurance company went insolvent, allegedly because an executive had transferred money to his other companies, purchased phony reinsurance and spent millions of the organization's dollars on his house.
- One of only two insurers to go bust from September 11, airline insurer Fortress Re allegedly fooled its parent company, a Japanese insurer, by buying cheap reinsurance that acted more like a loan than traditional coverage.
- A life insurer for Cicero, Illinois invested money into failed business ventures instead of paying claims and put the town in debt.
- A Florida auto insurer charged consumers, including the state's insurance commissioner, an estimated $4 million for coverage that policyholders never requested.

Sometimes an entire company is one big fraud. Thousands of policyholders in the United States are actually believed to have been tricked into buying fake coverage from bogus insurers. Many phony insurers prey on the poor, the elderly, the immigrant community and sick people who have been denied coverage elsewhere. These predators offer rates that truly are too good to be true and sometimes use company names that are similar to those of respectable insurers.

Though these companies and the counterfeit coverage they sell have not been licensed or approved by the state, many of the bogus insurers employ licensed agents, hoping the salesperson's credibility will be enough to avoid suspicion. A portion of these agents claim they sell these policies in good faith, only to realize later that they have been fooled just as much as their customers. Certainly, as an insurance producer, you should research the credentials of companies you plan to represent.

At other times, an insurance company and its policies are legitimate but individuals do all the defrauding. In a relaxed and unorganized work environment in which job duties are not specifically defined and errors are nearly untraceable, claims adjusters might manipulate forms so they or an accomplice can receive checks that should go to a health care provider or a policyholder.

In the cases of unethical agents and brokers, frauds are perpetrated because of various types of greed. When this greed is exposed, members of the producer's community tend to express shock and tell reporters things like, "He was such a nice man!" or "I used to sit next to her in church every Sunday."

These statements lend support to an intriguing aspect of the consumer-insurer relationship. As much as the public seems to dislike insurance companies in an abstract sense, people generally have positive feelings about their own agent or broker. The industry as a whole, they might say, is unfair, corrupt and cold-blooded, but agent John Smith and broker Jane Jones are ethical professionals who would not steal a stick of gum even if the grocer left the room.

With these sentiments in mind, agents and brokers have even clearer incentives to learn about fraud and to actively discourage their peers from engaging in it. As difficult as insurance sales is now, imagine how difficult the job would be if a majority of people had negative opinions of their agents or brokers because too many of them acted unethically.

Conclusion

As easy as it is to view fraud prevention as something the claims department should handle, the customer probably does not have a trusting relationship with his or her claims adjuster. Nor is the person likely to have a trusting relationship with the top-level insurance executives or trade groups that have traditionally been the ones to make the case for greater fraud awareness. If the industry wants to reach its customers and convince them that insurance fraud is a problem worth tackling, agents and brokers might be its best messengers.

Below is the Final Examination for this course. Turn to page 117 to enroll and submit your exam(s). You may also enroll and complete this course online:

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FINAL EXAM

1. The _____ is a basic summary of the insurance policy.
   A. coinsurance clause
   B. declarations page
   C. application
   D. proof of loss form

2. A policy's dollar limit is also known as the insurance company's "_____."
   A. limit of liability
   B. surplus
   C. coinsurance requirement
   D. earned premium

3. The time between the policy's issue date and expiration date is known as the "_____."
   A. policy period
   B. elimination period
   C. restoration period
   D. surrender period

4. Property can be insured for either its replacement cost or its _____.
   A. actual production cost
   B. expected cost
   C. actual cash value
   D. net worth

5. Property's _____ is the amount it would take to rebuild or replace the property without taking depreciation into account.
   A. replacement cost
   B. production cost
   C. wholesale cost
   D. actual cash value

6. Commercial property insurance does not cover the loss of _____.
   A. illegal or stolen property
   B. items kept in stock
   C. items valued above their replacement cost
   D. valuables sold from one business to another

7. As soil erodes, _____ can become a concern for many businesses in many states.
   A. hurricanes
   B. sinkhole collapse
   C. nuclear reaction
   D. product liability

8. _____ occurs when a person causes damage on purpose with malicious intent.
   A. Pollution
   B. Vandalism
   C. Morale hazard
   D. Adverse selection

EXAM CONTINUES ON NEXT PAGE

9. Standard kinds of commercial property insurance do not cover _____ losses, other than the cost of cleanup.
   A. fire
   B. windstorm
   C. pollution
   D. tangible

10. Commercial property insurance generally does not cover damage caused by _____.
   A. fire
   B. wind
   C. vandalism
   D. war

11. _____ requires that insurance companies offer terrorism coverage to their commercial policyholders.
   A. The Health Insurance Portability Act
   B. The Deficit Reduction Act of 1997
   C. The Terrorism Risk Insurance Act of 2002
   D. The NAIC Model Licensing Act

12. Assuming the insured's personal safety is not at risk, a business's first priority after a loss should be to _____.
   A. contact an appraiser
   B. document the scope of damages
   C. keep damage under control
   D. notify staff members

13. _____ care is the lowest level of long-term care and does not need to be supervised or performed by a medical professional.
   A. Skilled
   B. Intermediate
   C. Custodial
   D. Hospice

14. Unless long-term care is needed as the result of a sudden illness or serious accident, _____ care is usually the first type of long-term care that someone will receive.
   A. skilled
   B. intermediate
   C. custodial
   D. supervised

15. Adult day care and similar services that give regular caregivers an occasional break from their duties are collectively known as _____.
   A. skilled care
   B. hospice care
   C. respite services
   D. covered services

16. _____ are sometimes thought of as an intermediate step between needing home care and needing care in a nursing home.
   A. Assisted-living facilities
   B. Shared care options
   C. Alternatives plans of care
   D. Elimination periods

EXAM CONTINUES ON NEXT PAGE

17. A “continuing-care community” provides multiple levels of long-term care _____.
    A. at several private medical facilities
    B. all within a relative's home
    C. in the same building or same complex
    D. exclusively in a state-run facility

18. "Hospice care" is intended for patients who are _____.
    A. elderly
    B. recovering from injury
    C. living in poverty
    D. terminally ill

19. The vast majority of long-term care insurance products will go into effect if the insured is unable to perform at least two _____.
    A. non-custodial tasks
    B. activities of daily living
    C. simple equations
    D. memorization exercises

20. A long-term care insurance policy’s _____ is essentially a deductible that is based on a number of days rather than a dollar amount.
    A. elimination period
    B. free-look period
    C. guaranteed-purchase option
    D. attained age

21. In general, a(n) _____ is a health problem that had already materialized by the time the insured completed his or her application for insurance.
    A. pre-existing condition
    B. post-claim underwriting audit
    C. retroactive claim
    D. insurable interest

22. In most states, long-term care insurance must be either “guaranteed renewable” or “_____.”
    A. non-cancellable
    B. claims-made
    C. privately underwritten
    D. Medicaid-approved

23. Many financial professionals advise consumers to purchase _____ for their long-term care insurance.
    A. inflation protection
    B. accelerated death benefits
    C. double-indemnity provisions
    D. Medicaid waivers

24. A “_____” gives policyholders a chance to review their recently purchased long-term care insurance policy and get their money back if they notice something they don’t like.
    A. waiver of premium
    B. free-look period
    C. bed reservation benefit
    D. non-tax-qualified plan

EXAM CONTINUES ON NEXT PAGE

25. Spouses who are interested in obtaining long-term care insurance have the option of purchasing a completely separate policy for each spouse or purchasing a product that allows for "_____."
    A. inflation protection
    B. shared care
    C. return of premium
    D. life LTC riders

26. A producer who wants to sell long-term care insurance must already be licensed to sell _____.
    A. variable products
    B. accident and health insurance
    C. buy-and-sell plans
    D. securities

27. Medicare is the popular federal insurance program that is intended mainly for Americans who are _____.
    A. living in poverty
    B. at least 65 years old
    C. cognitively disabled
    D. supporting children

28. Believe it or not, most long-term care that is provided in the United States is paid for by _____.
    A. private insurance
    B. workers comp programs
    C. charitable organizations
    D. Medicaid

29. In order to police certain types of Medicaid planning, the government requires Medicaid applicants to disclose practically any transfer of assets that were made in the preceding _____ years.
    A. five
    B. seven
    C. 10
    D. 15

30. _____ is a highly controversial issue because it can prevent family members or other survivors of a deceased Medicaid recipient from inheriting the person's money or other property.
    A. Adverse selection
    B. Post-claims underwriting
    C. Estate recovery
    D. Medigap eligibility

31. _____ insurance is designed to replace most of a working person's income if the person is unable to perform his or her job duties because of an illness or injury.
    A. Stop-loss
    B. Catastrophic
    C. Disability
    D. Credit life

32. ____ allow people to give large sums of money to insurance companies in exchange for a long-term stream of income at a later date.
    A. Reinsurance plans
    B. Health savings accounts
    C. Annuities
    D. Mutual funds

33. A _____ allows a homeowner to receive income from a lender in exchange for the equity in his or her home.
    A. medical necessity clause
    B. disability insurance product
    C. reverse mortgage
    D. conventional loan

EXAM CONTINUES ON NEXT PAGE

34. The Long-Term Care Security Act led to the implementation of a long-term care insurance plan for _____.
    A. all senior citizens
    B. federal employees and their spouses
    C. every small business and its employees
    D. individuals with Medicare Part D plans

35. Variable annuities appeal to investors who are willing to put some of their principal at risk in exchange for _____.
    A. longer surrender periods
    B. corporate tax breaks
    C. potentially higher returns
    D. deferral of estate taxes

36. A _____ is often favored by individuals who don't need consistent, additional income at the time of purchase but envision needing it in the future.
    A. deferred annuity
    B. immediate annuity
    C. split annuity
    D. variable annuitization option

37. Between the time it's purchased and the time payments begin, a deferred annuity goes through a(n) _____.
    A. elimination period
    B. accumulation period
    C. payout phase
    D. annuitization phase

38. A(n) _____ creates an income stream for the owner soon after the sale date.
    A. deferred annuity
    B. immediate annuity
    C. structured settlement
    D. Medicaid policy

39. The annuity owner is the person who _____.
    A. receives death benefits
    B. is the measuring life for the annuity
    C. puts money into the annuity
    D. is responsible for the contract's guarantees

40. In most cases, the annuity owner and the annuitant _____.
    A. will be married to each other
    B. won't know each other
    C. will be the same person
    D. won't be specified in the contract

41. Like an IRA, an annuity is one of the few financial options available today that allow investors to accumulate money and temporarily avoid _____.
    A. medical underwriting
    B. age discrimination
    C. paying taxes on investment gains
    D. potential surrender charges

42. _____ are often the biggest drawback to annuities.
    A. Surrender charges
    B. Crisis waivers
    C. High participation rates
    D. Capital gains rates

EXAM CONTINUES ON NEXT PAGE

43. The typical annuity offers a death benefit equal to at least the _____.
    A. value of a selected economic index
    B. combined amount of the owner's pension payments
    C. annuitant's average lifetime income
    D. principal investment, minus any withdrawals of principal that were made by the owner

44. Unlike many of the major types of property and casualty insurance being sold, cyber insurance still has no _____.
    A. standard form
    B. limits of liability
    C. underwriting
    D. exclusions

45. Insurers have long believed in the _____, which essentially says that larger amounts of data are more reliable than smaller amounts of data.
    A. principle of indemnity
    B. rule of insurable interest
    C. law of large numbers
    D. concept of utmost good faith

46. Carriers seem to have already arrived at the collective conclusion that many instances of cyber breaches or attacks can be traced back to _____.
    A. human error
    B. unethical vendors
    C. too much regulation
    D. careful security policies

47. If a security incident has made it possible for someone’s personal information to be accessed inappropriately, the impacted business should take steps to _____.
    A. completely disregard existing security plans
    B. keep the incident as private as possible
    C. file a complaint with a cyber insurance broker
    D. notify everyone whose information may have been compromised

48. Since insurers don’t want to encourage illegal activity, they are often hesitant to sell products that allow their customers to be reimbursed for _____.
    A. defense costs
    B. business interruptions
    C. regulatory fines
    D. emergency risk management precautions

49. Whether they are employed by an insurer or hired by a policyholder, ethical insurance professionals must bring consumers and insurers together _____.
    A. in a manner that maximizes the insurer’s profits
    B. in a manner that results in low costs for the consumer
    C. in a manner that provides the highest sales commission
    D. only in good faith

50. Auto insurance fraud rings tend to be most common in states with _____.
    A. large cities
    B. no-fault auto insurance laws
    C. strict rate regulation
    D. older drivers

END OF EXAM

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ADDRESS _____ **UNIT OR APT. #** _____

CITY _____ **STATE** _____ **ZIP** _____ **COUNTY** _____

TELEPHONE: HOME _____ **WORK** _____

E-MAIL ADDRESS _____

NATIONAL PRODUCER NUMBER (NPN) _____

LICENSE EXPIRATION DATE _____ /_____ /_____

REGISTRATION: (Choose All That Apply)

- ❑ **$69.00 + fee* — 21 credit hours, Discount Package (two self-study courses)**
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Exam questions appear at the end of each course. Use pen or pencil to darken correct choice for each question.

COURSE ONE: Applying Insurance Concepts (10 Credit Hours)

1. ⒶⒷⒸⒹ	8. ⒶⒷⒸⒹ	15. ⒶⒷⒸⒹ	22. ⒶⒷⒸⒹ	29. ⒶⒷⒸⒹ	36. ⒶⒷⒸⒹ	43. ⒶⒷⒸⒹ
2. ⒶⒷⒸⒹ	9. ⒶⒷⒸⒹ	16. ⒶⒷⒸⒹ	23. ⒶⒷⒸⒹ	30. ⒶⒷⒸⒹ	37. ⒶⒷⒸⒹ	44. ⒶⒷⒸⒹ
3. ⒶⒷⒸⒹ	10. ⒶⒷⒸⒹ	17. ⒶⒷⒸⒹ	24. ⒶⒷⒸⒹ	31. ⒶⒷⒸⒹ	38. ⒶⒷⒸⒹ	45. ⒶⒷⒸⒹ
4. ⒶⒷⒸⒹ	11. ⒶⒷⒸⒹ	18. ⒶⒷⒸⒹ	25. ⒶⒷⒸⒹ	32. ⒶⒷⒸⒹ	39. ⒶⒷⒸⒹ	46. ⒶⒷⒸⒹ
5. ⒶⒷⒸⒹ	12. ⒶⒷⒸⒹ	19. ⒶⒷⒸⒹ	26. ⒶⒷⒸⒹ	33. ⒶⒷⒸⒹ	40. ⒶⒷⒸⒹ	47. ⒶⒷⒸⒹ
6. ⒶⒷⒸⒹ	13. ⒶⒷⒸⒹ	20. ⒶⒷⒸⒹ	27. ⒶⒷⒸⒹ	34. ⒶⒷⒸⒹ	41. ⒶⒷⒸⒹ	48. ⒶⒷⒸⒹ
7. ⒶⒷⒸⒹ	14. ⒶⒷⒸⒹ	21. ⒶⒷⒸⒹ	28. ⒶⒷⒸⒹ	35. ⒶⒷⒸⒹ	42. ⒶⒷⒸⒹ	49. ⒶⒷⒸⒹ
						50. ⒶⒷⒸⒹ

COURSE TWO: Providing Insurance Solutions (11 Credit Hours)

1. ⒶⒷⒸⒹ	8. ⒶⒷⒸⒹ	15. ⒶⒷⒸⒹ	22. ⒶⒷⒸⒹ	29. ⒶⒷⒸⒹ	36. ⒶⒷⒸⒹ	43. ⒶⒷⒸⒹ
2. ⒶⒷⒸⒹ	9. ⒶⒷⒸⒹ	16. ⒶⒷⒸⒹ	23. ⒶⒷⒸⒹ	30. ⒶⒷⒸⒹ	37. ⒶⒷⒸⒹ	44. ⒶⒷⒸⒹ
3. ⒶⒷⒸⒹ	10. ⒶⒷⒸⒹ	17. ⒶⒷⒸⒹ	24. ⒶⒷⒸⒹ	31. ⒶⒷⒸⒹ	38. ⒶⒷⒸⒹ	45. ⒶⒷⒸⒹ
4. ⒶⒷⒸⒹ	11. ⒶⒷⒸⒹ	18. ⒶⒷⒸⒹ	25. ⒶⒷⒸⒹ	32. ⒶⒷⒸⒹ	39. ⒶⒷⒸⒹ	46. ⒶⒷⒸⒹ
5. ⒶⒷⒸⒹ	12. ⒶⒷⒸⒹ	19. ⒶⒷⒸⒹ	26. ⒶⒷⒸⒹ	33. ⒶⒷⒸⒹ	40. ⒶⒷⒸⒹ	47. ⒶⒷⒸⒹ
6. ⒶⒷⒸⒹ	13. ⒶⒷⒸⒹ	20. ⒶⒷⒸⒹ	27. ⒶⒷⒸⒹ	34. ⒶⒷⒸⒹ	41. ⒶⒷⒸⒹ	48. ⒶⒷⒸⒹ
7. ⒶⒷⒸⒹ	14. ⒶⒷⒸⒹ	21. ⒶⒷⒸⒹ	28. ⒶⒷⒸⒹ	35. ⒶⒷⒸⒹ	42. ⒶⒷⒸⒹ	49. ⒶⒷⒸⒹ
						50. ⒶⒷⒸⒹ

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Sign Student Name _____ **Date** _____ /_____ /_____

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NAME _____

ADDRESS _____ **UNIT OR APT. #** _____

CITY _____ **STATE** _____ **ZIP** _____ **COUNTY** _____

TELEPHONE: HOME _____ **WORK** _____

E-MAIL ADDRESS _____

NATIONAL PRODUCER NUMBER (NPN) _____

LICENSE EXPIRATION DATE _____/_____/_____

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6. ⒶⒷⒸⒹ	13. ⒶⒷⒸⒹ	20. ⒶⒷⒸⒹ	27. ⒶⒷⒸⒹ	34. ⒶⒷⒸⒹ	41. ⒶⒷⒸⒹ	48. ⒶⒷⒸⒹ
7. ⒶⒷⒸⒹ	14. ⒶⒷⒸⒹ	21. ⒶⒷⒸⒹ	28. ⒶⒷⒸⒹ	35. ⒶⒷⒸⒹ	42. ⒶⒷⒸⒹ	49. ⒶⒷⒸⒹ
						50. ⒶⒷⒸⒹ

COURSE TWO: Providing Insurance Solutions (11 Credit Hours)

1. ⒶⒷⒸⒹ	8. ⒶⒷⒸⒹ	15. ⒶⒷⒸⒹ	22. ⒶⒷⒸⒹ	29. ⒶⒷⒸⒹ	36. ⒶⒷⒸⒹ	43. ⒶⒷⒸⒹ
2. ⒶⒷⒸⒹ	9. ⒶⒷⒸⒹ	16. ⒶⒷⒸⒹ	23. ⒶⒷⒸⒹ	30. ⒶⒷⒸⒹ	37. ⒶⒷⒸⒹ	44. ⒶⒷⒸⒹ
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4. ⒶⒷⒸⒹ	11. ⒶⒷⒸⒹ	18. ⒶⒷⒸⒹ	25. ⒶⒷⒸⒹ	32. ⒶⒷⒸⒹ	39. ⒶⒷⒸⒹ	46. ⒶⒷⒸⒹ
5. ⒶⒷⒸⒹ	12. ⒶⒷⒸⒹ	19. ⒶⒷⒸⒹ	26. ⒶⒷⒸⒹ	33. ⒶⒷⒸⒹ	40. ⒶⒷⒸⒹ	47. ⒶⒷⒸⒹ
6. ⒶⒷⒸⒹ	13. ⒶⒷⒸⒹ	20. ⒶⒷⒸⒹ	27. ⒶⒷⒸⒹ	34. ⒶⒷⒸⒹ	41. ⒶⒷⒸⒹ	48. ⒶⒷⒸⒹ
7. ⒶⒷⒸⒹ	14. ⒶⒷⒸⒹ	21. ⒶⒷⒸⒹ	28. ⒶⒷⒸⒹ	35. ⒶⒷⒸⒹ	42. ⒶⒷⒸⒹ	49. ⒶⒷⒸⒹ
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