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For Illinois Insurance Professionals

PROMOTING INSURANCE PROTECTION

Printed in the United States of America.
▪P1▪

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CHAPTER 1: REVIEWING TERM LIFE INSURANCE

Introduction

Buying life insurance can often be an emotionally and intellectually strenuous task. Once prospects have bravely confronted the inevitability of their death and have made the responsible choice to consider its impact on their finances, they need to tackle a wide range of potentially intimidating questions in order to pick the insurance product that best suits their unique needs, such as:

- How much life insurance should I buy?
- Who should I choose as the beneficiary?
- Should death benefits be payable in a lump sum or in periodic installments?
- What will this purchase mean for the rest of my portfolio, including any retirement or estate planning concerns?
- How can I be sure I'm buying from the right person or the right company?

With a careful blend of patience and expertise, life insurance professionals can guide consumers toward the right answers to those questions. But once those basics have been addressed, respectful attention must be paid to the choice between term life insurance and permanent life insurance. Passionate arguments have been made for and against each of these two general types of coverage, and agents may have developed a bias toward one or the other based on the carriers they represent or the types of clients they hope to attract. Such bias, even if it's a purely subconscious one, can create unexpected negative outcomes for the public in the form of unmanageably higher insurance bills, inadequate coverage amounts or even a full lack of coverage when insurance would otherwise be at its most beneficial.

Although the choice of term life over permanent life or vice versa might seem obvious to the trained insurance salesperson, statistics suggest a need for greater education among the buying public concerning these fundamental options. According to a 2013 survey sponsored, in part, by the Guardian Life Insurance Company of America, approximately 60 percent of people in their 20s and 30s don't know the difference between term life insurance and permanent life insurance.

While this chapter will focus largely on the positives and negatives of term life insurance, we strongly encourage you to also review the details of permanent life insurance (whether that's whole life, universal life, variable life or some other permanent product) as part of your professional development. Providing a detailed and balanced comparison of the two options can promote trust with current and future policyholders and show that any recommendations you make regarding term vs. permanent have been formed with care.

Term Life Insurance vs. Permanent Life Insurance

Term life insurance provides a death benefit to a beneficiary if the person covered by the insurance dies within a pre-determined period of time. That pre-determined period of time is the policy's "term," which can be bought to last for one, five, 10, 20 or some other set number of years. If the person covered by a term life insurance policy survives the term, no death benefit is paid, and the insurance company keeps whatever premiums were paid by the policy's owner. This form of insurance is often bought by young and middle-aged adults who need life insurance until they've raised a family or paid off a mortgage loan.

Term life insurance is the opposite of permanent life insurance, which generally doesn't expire unless the policyholder opts to stop paying for it. Whereas most term life insurance policies end up insuring many people who don't die until after their coverage has expired, permanent coverage can remain in effect regardless of the insured person's age and can pay a death benefit to a beneficiary even if death doesn't occur until the insured is elderly.

Permanent life insurance is also more complicated than term life insurance because it can be used for purposes other than providing a death benefit. For example, unlike a term life insurance policy, permanent life insurance allows owners to accumulate a type of tax-deferred savings through what's known as the policy's "cash value." Permanent life is also a common component of an estate planning strategy designed to minimize various inheritance taxes.

The differences between term life insurance and permanent life insurance are occasionally compared to the differences between leasing an apartment and owning a home. Buying term life insurance is comparable to leasing an apartment in the following ways:

- It's usually a fairly simple transaction that might only require a limited amount of expert assistance from a licensed professional.
- It involves a contract that will ultimately expire (with the potential option of renewal at the end of the contract's term).
- It's usually cost-effective in the short term but less favorable financially over the span of several years.
- It tends to be suitable for people whose financial needs and plans—particularly in regard to family—are likely to change.
- Although the buyer is paying money to the insurer on a regular basis, the buyer is not building any equity (or, in this case, cash value) that can ultimately be used to pay for other important expenses.

Buying permanent life insurance, on the other hand, is similar to buying a home in the following ways:

- It requires a more careful shopping process (usually with more detailed assistance and advice from a licensed professional).
- It involves a contract that cannot be canceled by the insurer, other than in rare cases, such as instances of fraud.
- It's comparatively more expensive in the short term but can become cost-effective in later years, particularly when the insured enters senior citizenship.
- It tends to be suitable for people whose financial needs and plans—particularly in regard to family—are not likely to change much.
- It allows the owner to slowly but surely build equity in the product in the form of cash value, which can ultimately be used to pay for other important expenses.

Who Needs Term Life Insurance?

Assuming you have determined that someone is a good candidate for some type of life insurance, here are several circumstances in which term insurance (rather than permanent insurance) might be the best choice:

- The person wants to provide for his or her children but expects them to be financially independent in adulthood.
- The person's main concern involves not burdening a spouse with sizable mortgage debt.

- The person plans on paying for a child's college education but wants to safeguard against a situation in which the person dies before the child's education is complete.
- The person is otherwise ideally suited for permanent life insurance but cannot afford the typically higher premiums.
- The person is chiefly concerned about providing a death benefit for a beneficiary and is not particularly interested in using life insurance as a savings tool or as something to borrow against.
- The person is required to have life insurance for a limited time as part of a divorce settlement or child support agreement.
- The person either does not have children who will be attending college or expects to fund college expenses via some other means besides life insurance.
- The person is in a relatively low tax bracket and wouldn't necessarily benefit from any tax-deferred increases in a permanent life insurance policy's cash value.
- The person is likely to die with a fairly modest and uncomplicated estate.
- The person can currently afford permanent life insurance but will be experiencing a long-term decrease in income sometime within 10 years of buying a policy.
- The person foresees wanting permanent coverage at a much later date but is worried about becoming sick and ultimately being ineligible for it.
- The person is part of a business ownership team and needs insurance on other owners and/or key employees but does not have enough cashflow to justify permanent life insurance.
- The person is part of a business ownership team and needs insurance on an owner or key employee who is likely to leave the company in the next few years.
- The person claims to be interested in permanent insurance but is not confident that he or she will keep the coverage for more than a few years.
- The person already has permanent life insurance but would like to supplement it in order to afford an even bigger death benefit.

Conversely, here are some circumstances in which permanent life insurance—not term life insurance—might be the better option:

- The person has a spouse who will need financial assistance regardless of when the insured person dies.
- The person has a special-needs child who is likely to require financial support throughout his or her lifetime.
- The person is not disciplined enough to save money on his or her own.
- The person is interested in building a policy's cash value in order to pay for an eventual major expense, such as a child's college education.
- The person has a permanent need for life insurance and is likely to be able to afford it over an extended period of time.
- The person is in a high tax bracket or is likely to die with a sizable and complicated estate.
- The person doesn't like the idea of buying term life insurance, surviving the term and never getting any financial benefit from a policy.
- Regardless of the reason, the person foresees wanting life insurance during his or her senior years.

Of course, these sets of criteria aren't absolute. To accurately determine whether term or permanent coverage is best for someone, a life insurance professional must ask clear questions, provide honest answers and, above all else, listen carefully to what a potential purchaser says.

Level Term Insurance

The phrase "level term" is used to describe a term life insurance policy in which the death benefit (sometimes called the "face amount") does not change during the policy period. For example, a $100,000 level term policy would pay $100,000 to a beneficiary as long as the insured person dies while the policy is in force. This is true no matter if death occurs soon after the policy's issue date or just prior to the policy's expiration. The vast majority of term life insurance sold in the United States is level term insurance.

In some instances, the phrase "level term" is used to mean a term life insurance policy with premiums that don't change during the policy period, but this second definition isn't accurate in all cases. You'll read more about premiums for term life insurance in a later section of this chapter.

Decreasing Term Insurance

Decreasing term insurance is life insurance with a death benefit (sometimes referred to as a "face amount") that goes down over the course of the policy period. It is most often purchased to help retire a specific debt, such as a mortgage loan. The decrease in the death benefit might occur at the same rate every year or might be linked directly to the insured's remaining debt. Even as the face amount drops, premiums for decreasing term insurance usually remain the same throughout the policy period.

Decreasing term insurance might be offered for durations that are very similar to the length of most mortgage loans, such as 15 years or 30 years. And although some types of decreasing term coverage can be bought so that the policy's owner chooses the beneficiary, most decreasing term products will name a lender or creditor as the intended recipient of any eventual death benefits.

Despite its ability to help repay the balance of a loan after someone's death, decreasing term insurance is usually viewed as an inadequate tool for families whose income-replacement needs would extend to things besides paying for housing. However, because the face amounts for decreasing term insurance tend to be relatively modest, insurers can relax their underwriting guidelines and offer this insurance to people who would otherwise be ineligible for other types of coverage. Experts generally agree that, despite its imperfections, decreasing term life insurance is often better than no life insurance at all.

Where to Buy Term Insurance

Term life insurance is generally considered one of the simplest types of insurance coverage available. Still, a skilled insurance agent might be needed to calculate the most appropriate death benefit to purchase and can advise consumers regarding which life insurance companies are financially stable and responsive to customer concerns.

In addition to being sold by insurance agents who specialize in life insurance, term life products are also commonly available from banks, professional associations and financial planners. As will be further noted in the next section, it's also a popular group benefit at many workplaces. Permanent life insurance is less likely to be sold through these additional channels because the

products are more complex and require a lot more comparing and contrasting in order to pick or recommend the right type.

Whole life, universal life and variable life are only three of the many forms of permanent life insurance that might require careful study and consideration.

Group Term Life Insurance

For many people in early to mid-adulthood, the workplace is a primary source for life insurance.

Employer-sponsored life insurance is almost always term life insurance that is renewable by the employer on an annual basis. Participating employees might have a small amount of coverage paid for them as an employee benefit and then might have the option to raise the death benefit by making premium contributions from their paychecks.

Although there's hardly anything wrong with accepting group life insurance if it is paid for entirely by an employer, workers should keep the following facts in mind if they are considering buying additional coverage via their group plan or if they believe their employer-paid group insurance is enough to satisfy their life insurance needs:

- Death benefits from group life insurance are often capped at a certain amount. This amount might be a flat amount per employee or might be a multiple of a given employee's annual salary. A competent needs analysis conducted by an experienced insurance agent is likely to show that these caps are likely to leave an employee underinsured.
- Group life insurance is renewable at the option of the employer. Depending on the plan, an employee might not have the ability to convert to an individual life insurance policy if the group plan is ever discontinued or if the employee ever leaves the group.
- Group life insurance tends to involve little or no medical underwriting. Although this can benefit workers who are in poor health and would otherwise struggle to obtain affordable coverage, younger and healthier employees who are thinking about buying into a group plan might actually be able to pay less by buying an individual policy instead.

Term Lengths

For a beneficiary to collect death benefits from term life insurance, the insured individual must die during the policy's term. Depending on the policy being sold, the term might last for one year, five years, 10 years, 20 years or some other set period. Usually, but not always, the cost of the insurance will remain the same throughout the chosen term.

One-year term insurance, known as "annual renewable term," was fairly common several decades ago and suited consumers whose need for life insurance was very temporary, but the cost of issuing policies that lasted for such a short time wasn't always favorable for insurance companies. In today's market, longer terms, such as 5, 10 or 20 years, are far more likely.

In many but not all cases, the owner of a term life insurance policy can renew the insurance for another term when the initial term has ended. When consumers exercise this option, the cost of insurance will almost always go up in order to reflect their age and their increased mortality risk. However, policyholders usually do not need to pass a new medical exam as part of the renewal process.

A life insurance company's willingness to offer a lengthy term and/or a renewal option will largely depend on the insured's age. Although it might be technically possible to buy term life insurance as a senior citizen, the term of that policy is unlikely to be especially long or the death benefit particularly large. Similarly, the ability to renew a term life insurance policy might be limited to people who have not yet reached a certain age, such as 60, 65, 70 or 80. In general, buyers who believe they will want life insurance at those relatively late ages will usually find that permanent life insurance (bought as a young adult or during middle-age) is more cost effective than term coverage.

Pricing and Premiums

Compared to permanent life insurance, term life insurance usually allows buyers to purchase the largest death benefit for the least amount of money. This difference in price is generally caused by the following factors:

- Most people who buy term life insurance do not die during their policy's term, making the product comparatively less risky for insurers than permanent life insurance.
- Term life insurance provides basic coverage without any cash value or any other potentially attractive (but usually more expensive) features found in permanent life insurance.
- Due to its simplicity, its lower risk to insurers and other influences, term life insurance is often the subject of price wars among carriers that are all offering essentially the same product.

Premiums for term life insurance are usually level throughout the policy's term. Then, if the insurer and the insured mutually agree to renew the insurance for another term, the premium will rise based on the person's age. At that point, the insured will usually pay a new level premium that will be charged every year during the new term. Although the premiums from one term to the next will increase to reflect the insured's rising mortality risk, the person will not be subjected to price increases on the basis of his or her personal health.

The relatively low cost for term life insurance makes the product fairly attractive to young adults whose need for life insurance is temporary or whose disposable income is either minimal or nonexistent. But due to the increase in cost at the start of each renewed term, premiums can become prohibitively expensive if term life insurance is kept into a person's senior years. For this reason and others, prospects who express an interest in having life insurance into later life are often encouraged to pursue permanent life insurance, which will be comparatively more expensive in early years but often cheaper beyond middle age.

Even if a senior citizen expresses interest in renewing term life insurance, the carrier that issued the policy might deem the renewal too risky and not allow it. To avoid any unpleasant surprises regarding the ability to renew term life insurance, prospects and their advisers should carefully review a policy's renewability clauses.

Renewability

Policyholders who wish to keep their term life insurance beyond the initial term usually can extend their coverage for at least one more term at a higher price. Renewal options will become scarcer or nonexistent as the insured person approaches or reaches senior citizenship. If renewal is allowed at all beyond ages near 65 or 70, the cost could be prohibitive. The limits on renewability

and the increase in cost for each new term reflect the increased risk of death at older ages.

Usually, the right to renew term life insurance will not be contingent on a reevaluation of an insured's health. For the minority of term life insurance products that require additional medical underwriting prior to renewal, the initial cost might be lower than for guaranteed renewable products.

Even if a term life insurance policyholder lacks the chance to renew for another term, the person might be able to exercise conversion rights, which let the person exchange the term insurance for permanent coverage. You'll learn more about conversion rights later in this course.

Reentry Term

Buyers who choose reentry term insurance have the ability to pay comparatively low premiums upon renewal if they satisfy certain health-related requirements. If the insured's health has declined to the point where those requirements are no longer satisfied, the person will pay renewal premiums based on the deterioration in health status and could face significantly increased costs. However, reentry term provisions will include a guaranteed maximum premium, which can cap the amount of the increase.

Conversion Options

Conversion options let term life insurance policyholders exchange their term coverage for permanent coverage from the same insurance company. Conversion options might be included free of charge within a carrier's standard term life insurance products or might only be offered as an add-on or "rider" for an additional charge.

Conversion options can be helpful for the following types of consumers:

- People who really want permanent life insurance but can't yet afford it.
- People who are unsure as to whether life insurance will be needed on a permanent basis.
- People who aren't necessarily interested in permanent coverage now but want to guard against needing it later and being too sick to qualify for it.
- People who might be interested in selling their policy to an investor as part of a "life settlement" or "viatical settlement." (Life settlements and viatical settlements provide a lump sum to the insured in exchange for policy ownership rights, including the ability to be named as the policy's beneficiary. Whereas viatical settlements involve policies sold by terminally ill policyholders, life settlements involve policies sold by policyholders who are in poor health but are not considered terminally ill. Investors will typically only purchase term life insurance policies that can be converted to permanent coverage.)

Of course, because permanent life insurance lasts longer and provides more features than term life insurance, conversion will require payments of higher premiums. Premiums after the conversion might be based on either the age at which the insured person originally bought term life insurance, known as the person's "issue age." Alternatively, the post-conversion cost might be calculated on the basis of the person's "attained age" at the point of the conversion.

When the cost of the converted coverage is based on the person's issue age, the policyholder will be charged as if he or she had opted for permanent coverage from the very start of the insurance transaction (or the most recent policy term) and as if the term coverage had never been purchased. In this case, the policy's owner might need to pay an additional lump sum equal to roughly the difference between the person's previous term life insurance premium payments and what the person would've paid for permanent coverage. The issue age method of pricing the conversion might benefit (and only be available) for people who opt to convert during the early years of their policy's term.

When the cost of converted coverage is based on the person's attained age, the policyholder will essentially be charged as if he or she were a brand-new customer. This method of pricing might be more expensive than a conversion done on the basis of issue age, but it can still be beneficial for individuals who have experienced a decline in their health and might otherwise be ineligible for permanent coverage.

As helpful as conversion options might be, note that they might only be possible for a limited time or at certain intervals. For example, the option to convert might only occur every five years or end at a certain age, such as 65 or 70. Also, if a term life insurance customer wants permanent coverage and is still in excellent health, it might be wise for the person to shop around and obtain permanent life insurance pricing options from other companies before opting for a conversion. Even if the person's current insurer will allow a conversion, cheaper options for permanent life insurance might be available form a different carrier.

Term/Permanent Life Insurance Combinations

Occasionally, insurers will combine term life insurance and permanent life insurance into a single policy. For example, the following combined (or "blended") policies were created for parents with significant differences in their two incomes:

- Family income policies.
- Family maintenance policies.
- Family protection policies.

A family income policy includes both permanent and decreasing term life insurance on the life of a family's main income earner. If this person dies while the decreasing term portion is in force, the surviving parent will receive a monthly death benefit until the end of the term (presumably to help with child-related expenses) and will also receive the face amount of the permanent life insurance component. The duration of the monthly death benefit will depend on how much time is left during the term at the time of the insured's death. If the insured parent dies after the term, the surviving parent will only receive the face amount of the permanent life insurance component.

Consider this basic example:

- A family purchases a family income policy with a 20-year term built into it. If the insured parent dies in year 19 of the term, the surviving parent will receive monthly payments for the remaining year of the term plus the face amount of the policy's permanent life insurance component. If the insured parent dies after the 20-year term, the surviving parent will receive the face amount of the policy's permanent life insurance component but won't receive a monthly income.

A family maintenance policy also combines term insurance and permanent insurance but does not tie the duration of the surviving parent's monthly death benefit to the timing of the other parent's death. Instead, the duration of the monthly death benefit is chosen in advance (such as for 20 years) and will be paid as long as the insured dies while the term portion of the policy is in force.

Consider this basic example:

- A family purchases a family maintenance policy with a 20-year term and a 20-year benefit period. As long as the insured parent dies before the end of the 20-year term, the surviving parent will receive monthly payments for 20 years plus the face amount of the permanent life insurance component. If the insured parent dies after the 20-year term, the surviving parent will receive the face amount of the permanent life insurance component but won't receive a monthly income.

A family protection policy is unlike the two products mentioned in our two previous examples because it is meant to insure an entire household rather than just a family's top earner. In general, this involves a combination of permanent life insurance on the family's top earner, a relatively high amount of convertible term life insurance on the other parent and a lesser amount of convertible term life insurance on any children. In the case of any children, the insurer typically engages in no medical underwriting and will agree to insure any future child as long as the new son or daughter lives past a few weeks of birth (often 15 days).

Optional Riders

Additions to a carrier's standard life insurance policy are known as "riders" and often involve additional benefits in exchange for an additional premium.

An example of a term life insurance rider is an "increasing term rider", which makes the policy's face amount go up during at least part of the term. This rider might appeal to prospects who have concerns about inflation or who believe their beneficiaries might need additional financial assistance during the end of a term (such as a scenario in which a surviving child might need more money to pay for college tuition).

Optional riders for term life insurance tend to be fewer than for permanent life insurance. However, here are a few policy features that might be offered at an additional cost:

- A "double indemnity rider," which doubles the death benefit if the insured dies during an accident rather than from illness or natural causes. (The rider might be paired with "dismemberment coverage," which provides money to the insured if the person survives an accident but loses a limb or eye.)
- A "return of premium rider," which pays back a portion of premiums to the policyholder if the insured does not die during the policy's term.
- An "accelerated death benefit rider," which allows a terminally ill person to use part of the policy's death benefit to fund medical care and other expenses.
- A "long-term care rider," which allows the insured to use part of the policy's death benefit to fund long-term care services (such as private nursing care).

Conclusion

By now, you should have a firm understanding of term life insurance and its benefits and shortcomings. The debate about term life vs. permanent life insurance will likely continue for as long as the two products exist. Yet there should be no mistaking term life's importance to people whose insurance needs might fluctuate or whose disposable income is small.

CHAPTER 2: INSURING AGAINST NATURAL DISASTERS

Introduction

Scientists and insurers often agree that it's only a matter of time before people from across the nation experience a natural disaster in their area. The Federal Emergency Management Agency (FEMA) has estimated that three-fourths of the United States is susceptible to flooding, hailstorms, hurricanes and earthquakes, and that figure doesn't even account for the wildfires, tornadoes, landslides and droughts that can also strike a community.

At its worst, nature plays no favorites when deciding where to unleash its wrath. In recent memory, merciless hurricane seasons have wrecked communities in New Jersey, Louisiana and Mississippi, and nearly untamable blazes transformed luxurious homes in California into ugly ash. Some homeowners who tried to safeguard properties from fire by building with bricks or stone have realized that their favored materials don't stand up to earthquakes. Meanwhile, people who once sang the praises of wood-framed dwellings have discovered that their sturdy foundations still don't stand much of a chance against raging flames.

For the insurance industry, the business solution to the natural catastrophe problem is not as simple as merely selling various policies in presumably safe communities and ignoring the rest of the public. If an area isn't prone to earthquakes, it may still be prone to tornadoes. If an area isn't prone to tornadoes, it may still be prone to hurricanes. So although a fearful insurer might be too scared of risk to offer coverage in a particular part of the country, a carrier that refuses to take on any kind of disaster risk will end up with a very limited base of customers. From Washington state to Maine and from California to Florida, insurers must accept the possibility of a looming "catastrophe," which the Insurance Services Office (ISO) has defined as any event resulting in $25 million or more in insured losses. Those insured losses can involve not only structural damage but also business interruption claims, auto claims and theft claims.

Yet compared to some developing countries, the United States is still relatively lucky in regard to natural disasters, in the sense that the catastrophes that hit its soil tend to cause widespread economic hardships rather than extremely long lists of casualties. U.S. catastrophe victims may lose precious belongings or even experience temporary homelessness, but they are at least likely to survive the ordeal. Although this generalization should not be interpreted by readers as a naïve statement that disrespects the memory of men and women who have died from the effects of a natural disaster, it does explain why, from this point forward, we will ignore the life and health consequences of catastrophes and emphasize those insurance products that cover dwellings, businesses and personal property.

There was a time when a solid homeowners insurance policy seemed like all the average person needed in order to protect personal assets against disasters. Decades ago, domestic insurers did excellent business in the homeowners market, aided in no small way by low-key weather conditions. Insurers shared some of the wealth with their customers by beefing up their policies to cover more perils and making them increasingly affordable. But as that era came to a close, and as catastrophes such as quakes, windstorms and large fires arrived with greater frequency, many carriers determined that their homeowners policies were covering more risks than they could manage.

Slowly but surely, the industry closed loopholes in policy language that had made homeowners insurance such a comprehensive product. While coverage narrowed, new and old policyholders failed to notice how these changes affected their vulnerability to major financial loss, and many of them realized all too late that they were not adequately covered for severe damage to their home. Even people who had exhibited enough foresight to purchase a large policy sometimes admitted at a later date that it took a disaster to make them realize how little they actually knew about insurance. Much to their surprise, they sometimes learned after the fact that their homeowners insurance did not cover flood or earthquake damage or that the insurance company would not pick up the entire bill for the reconstruction of their pride-packed dreamhouse.

A handful of disaster victims have sour stories to tell about their experiences with their insurance companies, either because they didn't properly educate themselves when purchasing and evaluating coverage or because their trusted insurance adviser didn't clearly go over policy limitations and exclusions with them. Many of these people can now be found in town halls and other community centers near disaster areas, counseling victims on how to put their lives back together and how to get the insurance benefits they deserve.

The following course material empowers insurance producers by giving them information to help reduce customer dissatisfaction. In addition to mentioning the typical policies that help buyers manage the financial consequences of natural disasters, the text explains why and where these disasters occur and, perhaps most importantly, describes what insurance consumers can do to keep their property safe and their premiums manageable.

Wildfires

The risk of suffering wildfire damage is small compared to the risks presented by earthquakes and hurricanes, and many insurers are more fearful of major hailstorms than of flames burning out of control. According to FEMA, homeowners have 25 percent chance of experiencing a flood over the course of a 30-year mortgage and only a 9 percent chance of having to cope with a fire.

But if you try spouting those facts at the people who owned the more than 11,000 or so homes that have been lost to wildfires since the early 1980s, you're bound to get an impassioned, disagreeable reaction. Despite the passage of a few decades, residents in the Oakland area are still likely to have clear memories of the East Bay fires of 1991 that scorched their hilly community. The fires, which forever changed the way insurers viewed replacement-cost homeowners policies, were responsible for $1.7 billion in insured damages. Longtime homeowners in Los Alamos, New Mexico, almost certainly can recall the chaos in 2000 when a botched burning by the federal government damaged 1,000 automobiles and forced 18,000 people from their homes. With enough power to turn entire states into disaster areas, it's clear that the risks associated with wildfires deserve a homeowner's respectful attention.

Why and Where Wildfires Occur

Though it's true that major fires have sometimes been set by arsonists, most wildfires don't require any ill will on the part of a human. Instead, they're often linked to innocent campfires that get out of hand and can also be caused by bolts of dry lightning.

In the United States, climate conditions create an annual fire season that begins in summer and stretches through the end of fall. Within this seasonal timeframe, wildfires are at their most destructive when long-term forecasts call for hot, dry and windy weather. Lack of humidity not only helps an unattended fire spread more easily but also makes it harder for firefighters to extinguish a blaze. When fueled by a strong wind, a raging fire can move uphill, endangering people in mountain and valley communities.

As anyone who watches television news knows all too well, no one can accurately predict the next day's weather 100 percent of the time. However, insurance professionals who worry about wildfire risks can keep an eye on the moisture content of a chosen area thanks to scientific measuring systems. Two popular measuring sticks are the Keetch-Bryam Drought Index and the Palmer Drought Severity Index. The Keetch-Bryam Drought Index reflects the amount of moisture in soil on a scale of 0 to 800. The index drops after rainfall and rises after a dry day. The Palmer Drought Severity Index is used to evaluate long-term climate conditions, as opposed to daily changes in moisture content, and has a base of zero. Negative numbers indicate a drought, and positive numbers indicate moisture.

Considering the standard climatic recipe for wildfires, it's no wonder that California residents suffer more frequent and intense wildfires than citizens in any other state. The area is prone to hot and arid summers, and by the autumn months, desert winds often blow strongly toward the Pacific Ocean, helping fires overcome some of the state's hillier topography.

The state's sometimes sky-high home values add to insurers' wildfire worries. Even flames covering a very small radius in California can amount to millions of dollars in insured losses if they make contact with some of the prized canyon properties belonging to the rich and famous.

But no matter how much attention the state receives in regard to this peril, California clearly has no monopoly on wildfires in America. Florida, another coastal location with valuable real estate, has had its own problems with these disasters. Meanwhile, Montana, Oregon, Washington, Arkansas and even Wisconsin, which surrendered 3,800 acres to wildfires in a single incident in 2005, have also sustained significant damage.

Controlled Burns

Despite public service announcements that encourage Americans to prevent forest fires, experts say the occasional fire, when kept under careful watch, can have a positive impact on the environment and can actually prevent costly and unruly wildfires in the long run. Fires set intentionally for these beneficial purposes are known as "controlled burns." A controlled burn acts as a housecleaning of the ecosystem. From a risk prevention standpoint, the idea is to burn away all the old, dead vegetation that might fuel a fire and replace it with a barrier of spotless land or fresh, less-flammable plant life. Of course, performing a controlled burn in an area every 15 to 30 years does not make insurance companies entirely immune to wildfire losses, but it might mean the difference between an inconvenient number of property insurance claims and an indisputably catastrophic level of loss.

According to the San Francisco Chronicle, the state of California was engaged in controlled burns until the 1960s, when nervousness among the public and insurance companies helped put a temporary end to the practice, which resurfaced a few decades later. The misgivings surrounding controlled burns are still expressed by some of today's homeowners and insurers and relate mainly to the possibility that federal and state forest officials will not be able to keep these intentional fires within safe

boundaries. Though many controlled burns are executed on government land, there is always at least the small chance a fire will find its way onto private grounds, leaving insurers exposed to property losses and liability claims. In 2000, a controlled burn in Los Alamos, New Mexico, damaged 48,000 acres in four counties, destroyed approximately 200 homes and prompted the forced evacuation of 18,000 residents. Conversely, a string of wildfires in San Diego County in 2003 made local observers wonder why authorities had not been lighting controlled burns in the area prior to those fires.

As an alternative to the sometimes risky controlled burns, a few communities have unleashed their livestock in fire-prone areas and waited patiently for goats and other animals to graze their way through all of the flammable, old plants. This approach has its upsides, not the least of which is its non-reliance on man-made flames that could damage property and harm wildlife. The technique is also less reliant upon favorable weather conditions since, unlike in a controlled burn situation, it can be done safely and effectively in hot, dry or wet conditions. One obvious drawback, though, is that grazing is a much slower procedure than a controlled burn, even with a sizeable amount of hungry animals on hand.

The Urban Wildland Interface

Challenges in modern wildfire prevention have been compounded by homeowners' increased movement into the "urban wildland interface," a term used to describe the buffer zone between developed land and relatively untouched forestry. Whereas wildfires from previous generations often had nothing in their paths to damage other than timber and maybe the occasional warehouse, today's fires can burn through an increasing number of high-priced residential properties and foster more insured losses than previously imagined. Researchers at Colorado State University claimed the population of the urban wildland interface grew by 52 percent between 1970 and 2000. In 2007, the New York Times cited a report from the University of Wisconsin that said more than 8.6 million new homes had been built in the West within 30 miles of natural forestry since 1982.

Unfortunately, people's desire to live away from crowded cities and closer to nature hasn't always coincided with an enhanced understanding of wildfire risks. After spending most of their lifetimes in densely populated cities and suburbs where fire hydrants stood on every corner and where sidewalks and streets covered far more ground than vegetation, many new residents of the urban wildland interface enter into the community without having been schooled in fire prevention techniques. In love with the change of scenery sitting outside their window, they often keep or even augment the brush and forestry on their property for decorative purposes rather than realizing that such plants are extremely likely to add fuel to a fire. In some cases, wildfire risk mitigation has only arrived in the wildland urban interface at the insistence of property insurance companies.

Wildfires Fueled by Climate Change

Another challenge to fire prevention could materialize if scientists' predictions about climate change are accurate. As the planet grows hotter, evaporation occurs at an increasingly rapid rate, which increases the likelihood and severity of droughts in fire-prone areas. Global warming also influences the level of carbon-dioxide in the earth's atmosphere and, therefore, could negatively impact the amount of brush and other plants that help small fires grow into uncontrollable disasters. Time will tell if the complex science behind global warning has a significant impact on the way property insurance is underwritten, although many carriers already view the issue as a serious concern.

Hurricanes and Tornadoes

It's not surprising that many insurance consumers are misinformed about their carrier's approach to wind damage. Based on policy language and tradition, coverage of this peril is broad in some respects and very limited in others. The typical homeowners insurance policy's references to wind are general enough for coverage to apply after many types of catastrophes, including major hurricanes, tropical storms and tornadoes. Yet various exclusions in insurance contracts allow companies to deny portions of catastrophic claims when destructive winds are paired with flooding.

Until the 1950s, wind-related disasters weren't overly problematic for insurance companies. A smaller U.S. population in those days meant there weren't as many densely inhabited areas filled with valuable real estate, and a lack of residential air conditioning kept many people from settling in hot and high-risk coastal states such as Texas and Florida.

In more recent years, however, shifts in population density and climate conditions have combined to make wind catastrophes a relatively common subject on the evening news. Today, roughly 50 percent of Americans live within 50 miles of a coast, and according to an assortment of trade groups quoted in National Underwriter, the property owned in coastal areas from Maine to Texas is worth more than $7 trillion. Meanwhile, higher sea-level temperatures may explain why the windstorms of today are frequently among the most intense weather events in our nation's history.

Hurricanes have been particularly damaging for homeowners and insurers in coastal areas. In 1992, Hurricane Andrew swept through Florida, left 11 insurers in a state of insolvency and became, up to that point, the costliest U.S. catastrophe in history. Insurers introduced predictive catastrophe models and windstorm deductibles in response to the storm, but those measures have clearly not spared carriers from hurricane losses in subsequent years. Of the 10 costliest hurricanes in American history (not counting final figures for Hurricane Ike in 2008), the vast majority have occurred in the 21st century. Chief among them was Hurricane Katrina, which cost insurers $41 billion and necessitated more than $100 billion in government aid to residents of New Orleans and other affected places.

As for residents of inland states, statistics show they shouldn't feel entirely protected from wind. Midwesterners, for example, still have to cope with the fact that the United States is more prone to tornadoes than any other country, with more than 1,000 incidents typically reported each year. When viewed all at once, these various statistics suggest wind-related risk mitigation ought to be important to producers and policyholders in any region.

Why and Where Hurricanes and Tornadoes Occur

Hurricanes form at certain oceanic depths when sea temperatures are at least 80 degrees. As they move along the waterways, storm clouds absorb warm air from the lower portion of the atmosphere and release cooler air into the upper portion of the atmosphere. These storms continue to grow in strength until they hit land or are impacted by different weather conditions.

Hurricanes are created in the same general manner as other tropical storms, but they involve stronger winds and tend to push taller amounts of water onto the surface. At minimum, a hurricane

is carried by a wind traveling at 74 mph and is accompanied by waves that are initially four feet high.

Many of the hurricanes impacting the United States come from the Atlantic Ocean and the Gulf of Mexico in a season running from June through November. Communities below or barely above sea level are particularly vulnerable to major storm damage.

According to FEMA, tornadoes are basically spinning thunderstorm clouds that make contact with the ground. These clouds usually touch down at the tail end of a storm and are categorized by meteorologists based on factors such as wind speed. Mild tornadoes earn a zero on the commonly used Enhanced Fujita Scale and have winds that are slower than 86 mph. The most intense tornadoes earn a 5 on the scale and blow at speeds above 200 mph.

Although a tornado can blow across a strip of land at any time of year, twister season generally runs from late winter until the middle of summer. The season begins a little earlier in southern states than in northern states.

Not surprisingly, the region that is most at risk during tornado season is the one known as "Tornado Alley." The geographical boundaries of Tornado Alley vary depending on who you ask, but it's safe to say that this area generally includes much of the South, the Midwest and the Great Plains. While Iowa, Alabama, Kansas and other states have all experienced the most intense kinds of tornadoes on multiple occasions, tornadoes are more likely to occur in Texas than in any other state.

Covering Collapse

Because hurricanes and tornadoes are sometimes strong enough to make even a sturdy house structurally unsound, we'll review how the typical homeowners insurance policy treats instances of collapse. In most cases, policy language defines "collapse" to mean an instance in which all or part of a building falls down or caves in and becomes uninhabitable. The term generally does not apply when visible bulging, shrinking or cracking has merely made collapse a possibility. It also is not used to mean a situation in which a building has been broken into separate pieces but is still standing.

Homeowners insurance covers losses caused by collapse if the collapse is due to a peril listed in the personal property section of the policy. Such losses are also covered when they are brought on by hidden decay, hidden damage caused by insects or vermin, the weight of animals, people or property or the weight of rain on a roof. Collapse caused by improper construction may be covered if the collapse occurs during the construction stage.

For the victim of a hurricane or tornado, these various provisions and exclusions mean a dwelling's collapse will be covered if it is caused by the force of wind or by the weight of debris that has been blown onto the building by a storm. However, it is important to note that collapse after a hurricane is not covered when it has been aided by the force of flood waters. To insure against this kind of loss, a homeowner would need to purchase adequate flood insurance.

Removal of Debris and Trees

Even if a hurricane or tornado doesn't make direct contact with a dwelling, the home can still be damaged by debris and trees that get flung about by super-strong winds. The cost of removing debris and fallen trees from the residence premises can sometimes amount to thousands of dollars. Luckily for the homeowner, this expense may be covered by insurance.

The most common type of homeowners insurance policy covers removal of debris after a windstorm. In general, this coverage does not increase the insurer's limit of liability. However, when the cost of removing the debris and repairing or replacing damaged property is greater than the insurer's limit of liability, the homeowner may receive an additional 5 percent of coverage that can be applied specifically to debris removal.

When a tree falls on the residence premises due to wind, a homeowner may be reimbursed for its removal. In the typical policy, this free additional insurance has a cumulative limit of $1,000 per occurrence, and no more than $500 may be applied to the removal of a single tree. For removal to be covered, the tree needs to have either done damage to the homeowner's property or blocked access to a driveway or a ramp for disabled persons.

Following a windstorm, policyholders often wonder who is responsible for removing a neighbor's tree from their property. Regardless of where a fallen tree once stood, the party who suffers the property damage should file a claim with his or her own insurance company. The neighbor might be liable for the loss only if the tree was obviously dying or was not being maintained properly by its owner.

Windstorm Deductibles

In order to reduce their exposure to risk after Hurricane Andrew, many insurers in coastal states added windstorm deductibles to their homeowners insurance policies. According to the Insurance Information Institute (III), these deductibles were used in 18 states and the District of Columbia in 2018.

The amounts and triggers of these deductibles may vary significantly from one policy to the next. Whereas one insurer's wind deductible might apply to any kind of windstorm, another carrier might only enforce the deductible after a hurricane. A report on the subject by National Underwriter showed some deductibles were triggered when winds reached a specific speed, when a windstorm lasted for a particular length of time, or when winds of a particular speed were detected within a specific distance from an insured's property.

Windstorm deductibles are typically listed as a set percentage of a dwelling's insured value. If a homeowner has insured a home for $100,000 and has a windstorm deductible of 5 percent, he or she will end up paying out of pocket for any portion of wind-related losses below $5,000. Insurance consumers may be eligible for flat, dollar-based wind deductibles if they pay an additional premium. Some companies might even agree to drop the windstorm deductible altogether if an insured retrofits a home in a manner that satisfies various structural requirements.

Windstorm Coverage From the States

With windstorm disasters being so costly over the past 25 years, it's no wonder many private carriers have been hesitant to cover homes in high-risk areas. At one time or another, homeowners in many states have found that insurance companies will either refuse to sell property insurance to them or only provide policies that do not list wind as a covered peril. For residents of these communities, the insurance shortages have created some obvious problems. Affected property owners aren't just unprotected against significant losses; they also may be in violation of their mortgage lending agreement since lenders often require borrowers to maintain all-risk insurance on their homes.

In response to such predicaments, many states have established insurers of last resort for high-risk homeowners. These state-

initiated entities may provide comprehensive homeowners insurance coverage to area residents, or they might simply cover the windstorm risks that have been refused by private insurance carriers. Regardless of what specific perils they cover, these insurers of last resort usually charge consumers higher premiums than private insurers. The higher premiums reflect not only the insured property's high risk potential but also these entities' general desire to avoid competing with private carriers. Wind-prone states with a government-initiated insurer of last resort include Florida, Texas and Mississippi.

Disaster Coverage for Homeowners

Homeowners generally have some insurance protection against fire losses and wind losses. This is because various wildfire and wind damages are covered under a homeowners insurance policy, which borrowers must purchase in accordance with mortgage lending agreements. Of course, mortgage lenders do not enforce this requirement out of concern for the homeowner. Rather, they require homeowners insurance as a way to protect their own investment. The home essentially serves as the collateral in an agreement between the lender and the borrower. If the borrower defaults on the mortgage loan, the lender can get its money back by having the property sold to satisfy the debt. However, if the property is ever damaged beyond repair by fire or some other peril without any insurance money to compensate for the loss, the lender would not necessarily be able to secure a full return of the borrowed funds.

Since the minimal homeowners coverage required in lending agreements is meant to protect the lender and not the borrower, the basic insurance policy might provide insufficient benefits to disaster victims in times of crisis. For instance, the policy might cover the entirety of the lender's investment but only a small fraction of the homeowner's personal belongings. Displaced victims may also sadly discover that their basic policy doesn't adequately pay for "additional living expenses," such as the cost of staying temporarily in a hotel. The good news for cautious homeowners is that they're free to go above and beyond the terms of their lending agreement and purchase additional insurance as a way of filling in those possible gaps.

Be Aware of Moratoriums

Some strange things tend to happen in the insurance market following a catastrophe. After resisting solicitations for enhanced coverage for years on end, it's only after a disaster that many people actually make the effort to review their policies and seek out more protection for their property. And yet, after pushing so hard for the public to purchase more insurance, carriers have a history of making decent coverage difficult to obtain in the days, weeks, months or even years after a disaster.

Subsequent to a widespread loss, at least a few insurance companies might institute a moratorium on sales of various products, including life, auto and homeowners insurance. Previously issued policies remain in force during these moratoriums, but new customers aren't accepted, and veteran customers may be incapable of making changes to their coverage.

Moratoriums are sometimes a necessary form of risk management for insurance companies and will probably cause nothing more than annoyance and inconveniences for customers as long as the freezes on sales are fair and temporary. Matters become more disruptive, however, when moratoriums continue for long stretches. Consumer groups and others point out that long-term moratoriums on homeowners insurance could harm the real estate market, with banks and mortgage companies unwilling to exempt borrowers from the insurance requirements in lending agreements. In the summer of 2002, for instance, fire-related moratoriums by several property insurers in Colorado were allegedly not only halting real estate sales but also being continued for unnecessary reasons. According to at least one local politician at the time, insurers were being detrimentally cautious by refusing to do business in communities that were at least four miles away from all previous wildfires. Similarly spirited accusations and battles have been common in other states after disasters, particularly in coastal regions, and have led to the creation of several state-sponsored insurance entities that can cover high-risk properties.

What Is Homeowners Insurance?

With no moratorium in place, consumers can protect themselves financially from disasters by purchasing a homeowners insurance policy. This kind of insurance provides benefits to the policyholder when damage is done to an insured dwelling, a detached structure or personal property. It also compensates people for loss of use of a dwelling and provides some liability insurance for the homeowner.

For generations, insurers have sold multiple kinds of homeowners policies, including such basic products as HO-1 policies and such deluxe products as HO-3 policies. Even the plainest policies in today's market are likely to cover damage to insured property in the event of fire, severe wind, hail, theft, explosion or riots.

HO-1 and HO-2 policies, rarely sold these days, are known as "named-peril" policies because they only provide financial protection against those dangers that are specifically mentioned in the insurance contract.

The HO-3 policy is the standard product for modern homeowners and is known as an "all-risk" policy because it provides financial protection against every danger that might affect a dwelling other than those that are specifically listed as exclusions within the insurance contract. Some of the excluded perils within HO-3 contracts are listed next:

- Flood.
- Earth movement, including earthquakes and volcanic eruptions.
- Wear and tear.
- Mold.
- Rust.
- Rot.
- Acts of war.
- Nuclear reactions.

How Much Will Coverage Cost?

The cost of homeowners insurance is dependent upon many factors. Highly valued properties cost more to insure than low-valued properties, though premiums may differ in various states. Citizens of disaster-prone states, such as California, Louisiana, Mississippi and Florida, generally pay higher homeowners premiums than people living in places like Illinois and North Dakota, where catastrophes are not as common.

Cost will also be determined by the homeowner's choice to either accept basic coverage or insure the dwelling and other property for a greater amount than a lender requires. At the very least, a mortgage lender is likely to require that a borrower insure a home up to the entire amount of the mortgage loan or up to the replacement cost of the dwelling in its current condition. But as

the borrower pays down the mortgage loan and as the structure and contents of the dwelling depreciate with wear and tear, the homeowner might opt for a policy that can replace both the damaged dwelling and its contents as if they were as good as new.

Timing and competition can impact insurance costs. A calm, catastrophe-free period tends to bring homeowners insurance rates down. Conversely, people who purchase or renew homeowners insurance in the few years after a catastrophe are likely to face higher premiums. In good and bad markets, though, each insurance company might offer cost-cutting opportunities to favored customers. For example, it's common for homeowners to receive a discount on their homeowners insurance if they buy their auto insurance from the same carrier.

What About the Deductible?

Both before and after they purchase a homeowners policy, insurance consumers can influence the size of their premiums through their choice of a "deductible."

From the standpoint of homeowners insurance, the policy's deductible is the amount of otherwise insurable losses, expressed in dollars, that will not be covered under the insurance contract. Ideally, insurance deductibles benefit policyholders by keeping premiums down. At the same time, they benefit insurance companies by making carriers less responsible for small claims.

Higher deductibles correspond with lower premiums, while lower deductibles correspond with higher premiums. Deductibles for most homeowners policies start as low as $250 and are commonly increased by policyholders to $500, $1,000 or more. In areas that are prone to specific kinds of disasters, the insurance company might insist on a separate deductible for those specific perils. Though not commonly applicable to fire coverage, separate deductibles may exist for hail or wind damage. Unlike a policy's main deductible, the separate deductible is usually expressed as a percentage of the policy's value, often in the range of 3 percent to 5 percent.

Levels of Replacement Coverage

Homeowners have at least four levels of coverage to choose from when deciding how to insure their dwelling and personal property. The cheapest and lowest brand of coverage, known as "actual cash value coverage," is an extremely rare breed, at least within the context of insuring a dwelling. It covers the value of a home up to the policy limit but subtracts for depreciation. Perhaps the most common level of coverage is "replacement coverage," which, as its name suggests, covers the cost of replacing the home in a similar form with similar building materials, up to the policy's dollar limit. It does not subtract for depreciation.

Most insurers will not pay an entire claim for partial damage to a home unless the policyholder has insured the property for at least 80 percent of its replacement cost.

Two additional levels of coverage go beyond the requirements of most mortgage agreements and were created in an effort to shield homeowners from major out-of-pocket expenses after a disaster. "Guaranteed replacement coverage" is generally the most expensive variety of homeowners insurance but gives the policyholder more potential benefits than all the other levels of insurance that are available in the market.

Like regular replacement cost coverage, guaranteed replacement coverage covers the cost of rebuilding a home in a similar form with similar materials. But unlike regular replacement coverage, guaranteed replacement coverage has no dollar limit for replacement of the dwelling. In other words, if a person's house burns down, a guaranteed replacement policy forces the insurance company to pay for a brand-new, similarly configured home regardless of cost. This coverage ensures that a policy will fund the construction of a new home even if the property had been improperly appraised when the insurance was purchased and even if the cost of construction and building materials soars during the course of home ownership.

Despite the comparatively high premiums that homeowners pay for guaranteed replacement coverage, many industry professionals believe that current prices might not be enough to compensate insurers in the event of a catastrophe. The East Bay fires near Oakland in 1991 taught property insurers a lesson and convinced many of them to stop selling limitless guaranteed replacement policies and to switch to a newer, stricter product known as an "extended replacement cost policy." This kind of insurance entails more benefits than a regular replacement policy. Like a guaranteed replacement policy, it protects the policyholder if the cost of rebuilding a dwelling exceeds the policy's benefit limit. However, the excess coverage is capped, usually at no more than an additional 20 percent of the policy value.

As an example, let's pretend a consumer insured his home for $250,000 through an extended replacement cost policy 10 years ago. Due to a catastrophe, the house is destroyed, and contractors estimate that it will now cost $320,000 to rebuild the property. Thanks to the extended replacement cost policy, the owner should receive roughly $300,000 from his insurance company ($250,000 plus 20 percent) minus any applicable deductibles. Yet because of a 20 percent cap on excess coverage, the owner will be responsible for paying the remaining $20,000.

The limits of extended replacement cost coverage, as well as those of actual cash value and regular replacement policies, ought to give homeowners an incentive to review their policies on a regular basis and update their coverage limits as needed.

Covering People's Stuff

Sometimes homeowners are fortunate enough to still have a roof over their heads after a force of nature but are rocked emotionally and financially by the damage done to their dwelling's contents. "Contents coverage" can solve part of that problem because it reimburses policyholders for the loss of various belongings.

The typical homeowners policy includes contents coverage equal to a certain percentage of the dwelling's insured value, often within the range of 50 percent to 75 percent. So, if a homeowner insures a dwelling for $100,000 with contents coverage that is equal to 75 percent of the dwelling's insured value, the homeowner may receive up to $75,000 from the insurance company as compensation for damaged or lost belongings.

Although basing the limits of contents coverage on a dwelling's insured value helps to keep coverage understandable for homeowners, such a simple formula is not guaranteed to favor the insurance customer at claim time. Suppose, for example, a policyholder owns an old, poorly maintained house but has a soft spot for cutting-edge gadgets and other expensive items. In that case, the default amount of contents coverage, based on the home's insured value, might prove insufficient.

Regardless of a dwelling's insured value, standard contents coverage limits the amount of money homeowners may receive for the loss of special collections and extravagant items.

Valuables such as stamps, works of art, coins and boats aren't excluded entirely in homeowners insurance policies, but coverage of these items tends to be minimal in both size and circumstance. Full coverage for these belongings is almost always only available at an additional cost through an add-on product called a "personal property floater."

Suppose, though, that a policyholder is a typical homeowner with standard contents coverage and no special collections to speak of. A fire breaks out in the owner's home, sparing the structure from serious damage but destroying a lot of electronic equipment, including a home theater system that the person bought for $5,000 several years ago. Leaving deductibles and policy limits out of the equation, will the policyholder receive $5,000 from the insurance company? We have no way of answering accurately unless we know whether the person has actual cash value coverage or replacement cost coverage for the lost equipment.

As mentioned earlier in our examination of dwelling coverage, actual cash value coverage reimburses the homeowner for replacement of property minus depreciation. Replacement cost coverage, on the other hand, pays for brand-new property, paying no attention to depreciation. Despite rarely being used to insure a dwelling, actual cash value coverage is standard for the contents portion of a homeowners policy. Disaster victims can still use the proceeds from cash value insurance to purchase brand-new items, but they are responsible for the difference in cost between a new item and an old one.

Replacement cost coverage is available to consumers if they are willing to pay a bit more for the insurance. When armed with replacement coverage, fire victims usually receive a monetary advance from their insurance company that is equal to the actual cash value of damaged property. They then use their own money and the advance to purchase new items and can send receipts to their insurer for reimbursement beyond the advance.

Dealing With Additional Living Expenses

For homeowners whose dwellings are destroyed by a fire or windstorm, the cost of the disaster amounts to much more than just the cost of replacing the home's structure and its contents. Unless they can depend on the kindness and long-term hospitality of friends and family members, the people who are made homeless by a disaster have to bank on spending a lot of time sleeping in hotel rooms or rented apartments and eating a lot of meals in restaurants. For a family that has nowhere else to go and has to wait indefinitely for their home to be rebuilt, the bills for these unavoidable expenses can be enormous. Luckily, a lot of these sudden costs are covered by a homeowners insurance policy.

Homeowners insurance reimburses policyholders for "additional living expenses," which may be defined as costs the homeowner incurs as a direct result of not being able to live in his or her dwelling. Under this definition, reimbursable expenses may include money spent on meals and room and board but would not include any expenses that the homeowner would have incurred regardless of a disaster.

An insurance policy may contain a dollar limit on additional living expenses, a chronological limit or both. Dollar limits are usually no less than 20 percent or so of the damaged dwelling's insured value. Chronological limits are usually no shorter than one year. Most policyholders don't come close to reaching these limits, but delays during the rebuilding process sometimes make more coverage a wise buy.

The probability of maxing out on a policy's additional living expenses is greater when an event, such as a hurricane, has done tremendous damage to a wide stretch of land in a densely populated area. In this scenario, builders are likely to be in high demand and short supply, meaning that a homeowner who hopes to have a dwelling rebuilt in a matter of months may instead have to wait a year or more before being able to move into a freshly constructed dwelling.

Coverage During Evacuations

Catastrophes can sometimes behave like unpredictable monsters, capable of taking one house as a casualty and leaving a neighboring house alone. People whose homes are left relatively unscathed amid a disaster should consider themselves very lucky, but such good fortune doesn't necessarily mean a person's insurance policy will not come into play.

As safety personnel try to gain control of a crisis, local authorities may call on all residents in the area to evacuate. If homeowners are forced to leave their homes but don't suffer any damage to their dwelling or contents, their homeowners insurance will often still cover the cost of hotel rooms, meals and clothing, though a thorough review of some policies may reveal otherwise. If these items are covered, the evacuated policyholder should still expect to be responsible for the policy's deductible.

Limits on Detached Structures and Business Property

In addition to the limits and exclusions mentioned on previous pages, a standard homeowners insurance policy won't necessarily reimburse a disaster victim in full for damage to detached structures. Common detached structures include garages, sheds and barns. Coverage of damage to these structures is generally limited to 10 percent of the dwelling's insured value, though full replacement coverage can be obtained for an additional premium. Keep in mind, however, that an insurance company can deny an entire claim for damage to a detached structure if the homeowner uses any part of the garage, shed or barn to conduct business or to store property (other than vehicles) used by a business. Furthermore, a homeowners policy provides minimal coverage of business property that is damaged or destroyed within a dwelling, and it usually includes no coverage of business data that may be lost in a fire.

Coverage for Renters

When weather damages an apartment building or a rented home, structural damage should be covered by the landlord's insurance policy. But what about damage to tenants' belongings and the additional living expenses a renter would incur? In nearly every case, neither landlords nor their insurers are required to indemnify a tenant for these losses and expenses.

If they want some financial protection, most renters can be approved for "renters insurance," a close relative to homeowners insurance that applies to tenants' personal property. The perils covered by renters insurance aren't as exhaustive as those covered by the typical homeowner's policy. But a basic renters policy still deserves a mention in this text because it insures the policyholder against many weather-related disasters.

Like homeowners insurance, renters insurance can cover a dwelling's contents on either a replacement cost basis or an actual cash value basis, with the latter option usually available at a lower price. If a fire or windstorm makes an apartment or rented home temporarily or permanently unusable, the tenant is covered for additional living expenses until those expenses exceed a certain percentage of the policy's value or until a particular time

frame, such as one year, has passed. For landlords, the temporary loss of rental income after a disaster might be covered under their homeowners policy if they live in one of the building's units.

Fire Safety Tips for High-Risk Homes

People from all economic backgrounds can take safety measures to reduce their exposure to disaster risks. In addition to potentially saving people's lives and giving added protection to property, the following tips, when observed, could have a positive impact on a homeowner's search for affordable insurance coverage. Let's address these suggestions in order, beginning with those that are relatively easy (or cheaper) to accomplish and concluding with those that are probably only practical for people who have the opportunity to build their home from the ground up.

At the very least, a homeowner in a fire-prone area should monitor the exterior of a house and remove any hazardous plant materials within close proximity to the dwelling. Roofs should remain free of leaves and pine needles, and debris should be cleared regularly from gutters.

A homeowner's landscaping plans should include the creation of sufficient "defensible space," which acts as a safe zone, separating a home from the weeds, bushes and trees that could give fuel to a fire. Fire safety experts recommend creating a defensible space of 30 feet to 100 feet, depending on a dwelling's specific location. Because fire has an easy time spreading uphill, homes situated on steep slopes may need more defensible space than other dwellings.

If the idea of creating defensible space doesn't appeal to the homeowner for aesthetic or financial reasons, the person should consider a few bits of information. First, the creation of defensible space doesn't doom the homeowner to a life without lovely exterior greenery. Not every tree near a person's home must come down for safety purposes. In fact, some well-placed trees can aid in the suppression of wildfires by blocking some of the winds that transport flames from one area to the next. Also, in parts of California and other states, someone who is opposed to creating defensible space may not have much choice in the matter. In recent years, property insurers have threatened to cancel customers' coverage if, after fair warning, a homeowner ignores an order to clear brush from the land around a high-risk house. Meanwhile, ordinances in some West Coast counties make defensible space a legal requirement for residents.

Other life-saving and money-saving suggestions call for some major home improvement projects. For the purpose of fire protection, roofs comprised of wood shingles can be replaced with tile or some other noncombustible material. If the homeowner opts for a roof made of metal, a buffer should be placed between the metal and a dwelling's wood frame. Otherwise, the metal might simply act as a conductor during a fire and help the frame burn. Adding a pond to the property is also a potentially smart option, especially when a home is in a secluded area and far away from a natural body of water.

Perhaps the best way for a person to manage wildfire risks is to consider them before purchasing or building a home. People in fire-prone areas would be wise to avoid building or buying a log cabin and should resist any attraction they might have to wooden decks or wood-burning fireplaces.

When considering possible neighborhoods for their next home, people should be concerned if a property's location might complicate matters for professional firefighters. A property's proximity to firehouses and fire hydrants is an important underwriting factor, and few insurers are likely to jump at the chance to insure a property that can't be accessed by fire trucks via clearly marked and easily travelable roads. In fact, members of the Laguna Beach community in California may have helped keep their homeowners premiums under control, following major fires in 1993, by reconstructing roads in a manner that improved access for emergency vehicles.

People with the desire and financial resources to go the extra mile in the name of risk management can promote safety and reduce premiums from the ground up by building a "fortified home." This kind of dwelling is built to withstand the impact of various disasters, including fire, earthquakes and windstorms. Among other characteristics, a fortified home is likely to feature an inflammable roof, reinforced doors, impact-resistant windows and an extra-secure foundation.

Though these homes' appearance and cost may have kept them from capturing the public's attention, their proponents say the homes are getting prettier and cheaper over time. Builders have been experimenting with a brand of asphalt for roofs that mirrors the look of wooden shingles while minimizing fire risks. Meanwhile, the addition of fortified features to a building is said to increase regular building costs by roughly 5 to 10 percent.

Wind Safety Tips for High-Risk Homes

Like most other catastrophic acts of nature, major windstorms may pack a weaker punch than expected if a homeowner has taken special precautions with his or her property. In many cases, taking the precautions may also qualify a homeowner for affordable and high-quality insurance.

When it comes to maintaining a home in a manner that's resistant to major wind damage, special attention should probably be paid to the dwelling's roof. Insurers usually prefer to only cover shingled roofs younger than 25 years old and other roofs younger than 50 years old. Hip roofs, which are slanted on all sides, tend to withstand wind better than flat roofs.

Roofs, though, are hardly the only part of a dwelling that should be reinforced when windstorms are in the forecast. Doors and windows should both be strong enough, by means of shutters or other materials, to withstand the impact of debris at a high speed. This recommendation also applies to the outer door of an attached garage. Very often in a windstorm, personal property stored in a home remains safe from harm until a damaged garage door creates an entry point for the tornado or hurricane. Specifications for doors, windows and other possible entry points might be listed within local building codes.

When thinking about landscaping around a dwelling, remember that windstorm damage is frequently caused or worsened by projectiles from people's yards. To reduce the probability of a flying object damaging a dwelling, homeowners may want to trim their trees on a periodic basis and replace mounds of decorative rocks with a softer sort of material.

A Few Words on Floods

Homeowners insurance covers a policyholder against many potentially disastrous perils. But as anyone who has made a claim for losses after a hurricane knows full well, this insurance doesn't cover flood damage. To guard against the financial consequences of a flood loss, a homeowner is likely to need a flood insurance policy from the National Flood Insurance Program (NFIP).

The premiums, terms and conditions for flood insurance policies are generally determined by FEMA, but the policies themselves

are usually sold and serviced by private insurers. These insurers are known as "Write Your Own" companies.

By being involved in the flood insurance program, the federal government hopes to achieve at least two goals. The first is to make flood coverage available to homeowners and other individuals who would not be able to obtain it in the traditional market. The second, sometimes overlooked goal is to promote the purchasing of flood insurance so that the federal government will not be overwhelmed with requests for aid after a catastrophe.

In order to make that second goal a reality, any person who purchases a home in a "special flood hazard area" with the help of a federally regulated lender is required to cover the home with flood insurance. A special flood hazard area is a place where there is at least a 1 percent chance of flooding each year.

More than 20,000 U.S. communities participate in the NFIP. Participation in the program isn't mandatory, but a community that chooses not to join makes its residents ineligible for federal flood insurance and might be jeopardizing its right to certain kinds of federal disaster relief. Members of the NFIP must practice flood insurance risk mitigation by enforcing certain building codes. Through its "Community Rating System," the NFIP can give insurance discounts to communities that go above and beyond required risk mitigation by facilitating accurate insurance rating and promoting flood insurance awareness.

Although most buildings that are compliant with modern building codes are eligible for federal flood insurance, a building can't be covered if it's principally below ground level. Coverage is also limited in areas that are part of the "Coast Barrier Resources System." Parts of the United States that are part of this system are listed in the NFIP Flood Insurance Manual, which is accessible online. Buildings in this system are generally not insurable if they were built after the early 1990s.

A flood insurance policy can cover a residential building for as much as $250,000. Contents within a residential building can be covered for as much as $100,000. More coverage is available for non-residential buildings, with structural and contents coverage each maxing out at $500,000. Tenants can cover their contents for as much as $100,000, unless all of their belongings are stored in a basement.

More information about flood insurance is available to professionals through the Federal Emergency Management Agency.

Earthquakes

Fictional, action-packed adventure stories tend to leave people with the impression that every earthquake is a major disaster that visibly splits the ground and rudely shakes people off their feet. But the vast majority of earthquakes do no damage to property and go unnoticed by anyone who isn't obsessed with geology. A case in point is California, where little quakes occur just about every day but where millions of residents go about their daily lives with no noticeable bouts of motion sickness. The fact that the likelihood of a devastating earthquake is small might make homeowners feel somewhat safe, but history also shows that major, deadly quakes have occurred periodically since the dawn of civilization and that guarding against these rare events with the help of insurance may turn out to be a smart move.

Earthquakes Throughout History

References to earthquakes can be found in the literature of ancient Greece, and it's thought that the mythical story of the underwater city known as Atlantis grew out of a real earthquake that wiped out an entire flourishing civilization on the island of Crete in 1400 B.C. A 16th century quake in China's Shaanxi province failed to become the stuff of legend, but, in claiming some 830,000 lives, it did set the record for the deadliest earthquake known to man.

With a few exceptions, the United States has had a much luckier relationship with earth movement than the former populations of Crete and China. But scientists and insurance companies aren't betting on that luck lasting forever. They know full well that the San Andreas fault, a 600-mile fissure running from the Gulf of California and along the coast, behaved like a crazed demon in the early 1900s and have been waiting nervously for history to repeat itself.

San Francisco had suffered a major quake in 1868, but, with few enforceable building codes in place at the time and with city officials clamoring to get the city back on its feet as quickly as possible, the management of earthquake risks was not a major priority in the rebuilding process. As a result, few people and fewer buildings were prepared for the minute-long shake that occurred near five o'clock on the morning of April 18, 1906.

Countless fires reigned over the city once the ground decided to hold still. With water lines out of order, buildings were being blown up in order to create breaks in the land and possibly suppress the flames. Elsewhere, frantic homeowners were enlarging the problem by committing arson against their own homes. Realizing that no insurance company had ever dared to cover earthquake damage, they had grimaced at their suddenly crumbled dwellings and reasoned that their fire policy was their only hope for indemnification.

After the ashes had been swept, it was estimated that half of San Francisco, what was then the seventh largest city in the nation, was homeless. The official death toll was in the hundreds, but historians later uncovered an apparently successful plot by city officials to reduce that number in an effort to aid tourism and population growth. Revelations made public in the 1980s suggested that the actual list of casualties contained 3,000 names.

Maybe the only silver lining to emerge from the 1906 San Francisco quake was the way in which it enhanced the image of insurance companies in the eyes of the American public. According to a report completed by insurance giant Swiss Re, the day's fire policies often specifically excluded coverage for damages when a fire was caused by an earthquake. This exclusion, according to another report by National Underwriter, initially saw insurers employing a chimney test. Essentially, if an insurer couldn't otherwise tell if damage to a dwelling had been caused by an earthquake or a fire, it would check to see if the chimney was still standing. If so, the damage would be ruled a fire loss, and the claim would be covered. If the chimney had been destroyed, the damage would be ruled an earthquake loss, and the claim would be denied. But the magnitude of the San Francisco disaster made the chimney test either impractical or unreasonable for many carriers. Lloyd's of London, for one, eventually decided to pay all San Francisco claims on fire policies regardless of any exclusionary language in its insurance contracts. Coincidentally or not, Lloyd's went on to become the top reinsurance provider for U.S. carriers.

Nearly 100 years after the 1906 quake, scientists, builders, homeowners and insurance companies had still not learned enough about earthquakes or implemented enough risk mitigation measures to avoid additional catastrophic losses on the West Coast. The death toll from a January 17, 1994, quake

in the Northridge section of Los Angeles amounted to a comparatively low 57 people. But a century of population growth in the Golden State had meant that there was a lot more insurable property to be destroyed by a disaster than there had been in the Bay area of 1906. Even when the old San Francisco numbers are adjusted for inflation, the 1994 Northridge quakes still qualify as the costliest example of earth movement in U.S. history, having caused $40 billion in total losses and more than $12 billion in insured losses.

Why and Where Earthquakes Occur

Despite centuries of study, it's only been within the past several decades that scientists have begun to gain a firm understanding of how and why earthquakes occur. In ancient times, people believed a sudden shake of the earth was a way for a god or goddess to demonstrate his or her anger. Later, people picked up on a theory by Aristotle and assumed the shaking was caused by winds trapped in caverns.

Today, most earthquakes are believed to be the byproduct of "plate tectonics," a scientific theory relating to the constant movement of the earth's crust. At a basic level, modern seismologists believe various portions of the crust sometimes get in one another's way as they slide along their paths. This puts tremendous stress on the earth until, finally, the stress passes along a weak, cracked portion of crust, known as a "fault," and is released in the form of seismic waves. The release of these waves is sometimes felt by humans in the form of shaking. The underground source of the shaking is known as the earthquake's "focus," and the place on the surface just above the focus is known as the "epicenter."

Most seismologists believe we lack the tools and knowledge to predict the strength, time and location of an earthquake, though this hasn't kept hopeful prognosticators in the United States, China and other countries from trying. Over the years, some scientifically trained soothsayers have claimed we can determine the likelihood of an earthquake by tracking elevation, water temperature, conductivity and the speed of sound in a given area. At one point, scientists in China even claimed peculiar behavior by animals was an indicator of a coming quake.

Instead of putting their faith in sound waves, critters and other variables to pinpoint the exact time, force and place of earth movement, many seismologists trust the historical record and use old data and maps to make somewhat broad pronouncements about earthquake risks. For example, the scientific world is unlikely to state that a moderately sized earthquake will rattle a particular town in spring 2025, but experts may be willing to state that there is a 75 percent chance of a moderately sized quake rattling that town within the next 20 years. Most of these experts are likely to freely admit that their broad predictions, while based on historical facts, should be interpreted as estimates. They would not be entirely surprised if that moderate quake in that town didn't happen for another 50 years or if two moderate quakes occurred in consecutive years.

Based on what history and science tell them, insurance professionals who underwrite earthquake risks have come to put a tremendous amount of emphasis on a building's proximity to fault lines. Attention to fault line proximity has made earthquake risk management extremely challenging in California, where hundreds of cracks in the earth's crust (many of them visible to the human eye) are spread throughout the state and where, according to the California Earthquake Authority, more than two-thirds of residents live within 30 miles of a fault. In the eyes of some risk managers, places like San Francisco are additionally risky because they were built largely on landfills and because many of their buildings were constructed prior to the implementation of modern building codes.

Indeed, annual earthquake losses in California greatly exceed earthquake losses in other states. However, many Americans who live outside of California believe they are at least slightly at risk for a major earthquake and have purchased the appropriate insurance coverage to better manage that disastrous possibility.

In addition to being a hot topic in California, earthquake insurance is most popular in Washington, Missouri and Oregon. This makes sense because Washington and Oregon are in the West, where a large majority of all U.S. quakes occur, and because Missouri sits in a fault area known as the New Madrid Seismic Zone, along with parts of Illinois, Arkansas, Tennessee, Indiana and Kentucky. According to FEMA, earthquakes are considered a very high risk in nine states, a high risk in 10 states and a moderate risk in 22 states.

Measuring Earthquakes

Over the past 70-plus years, seismologists have been developing ways to mathematically represent the intensity and effects of earthquakes. The most popularly known method of measuring a quake utilizes the Richter Scale, formulated by Dr. Charles F. Richter in 1935. This scale measures the severity of an earthquake by focusing on the amount of energy released at the quake's source. An increase of one whole number on the Richter scale represents an earthquake that is 10 times as strong. It also means that a quake involves roughly 32 times as much energy.

Another popular measuring stick, the Modified Mercalli Intensity Scale, pays attention to the damage actually caused by a quake and represents the extent of that damage in the form of a Roman numeral. A quake ranging from I to IV is only felt by a portion of people in an area, depending on how close they are to the ground. At V, fragile items and windows might break. At VI, furniture might move, and plaster might sustain some damage, and so on. According to the United States Geological Survey, the scale tops out at XII, a number associated with a totally damaged community.

For reasons that are not essential to the purpose of this text, non-scientific media outlets tend to avoid these two specific scales. Instead, they just use a generally accepted measurement to represent an earthquake's magnitude. Under this basic method, magnitudes below 2.5 are not usually felt. Some damage can be seen when magnitude reaches 4. At the top end of the basic scale, a magnitude of 8 would cause what the Associated Press has termed "tremendous damage." The 1906 quake in San Francisco, for example, is believed to have had a magnitude of 7.9 on the media's basic scale.

The Non-Popularity of Earthquake Insurance

Special insurance policies that reimburse people for earthquake-related damage have been sold in the United States at least since the 1920s, but the coverage has struggled consistently to gain acceptance from most of the general population.

Nowhere is the public's relationship with earthquake insurance stranger than in California, where noticeable earth movement is far from out of the ordinary. In 1985, the state passed a law requiring all property insurers to make earthquake insurance available to all of their homeowners insurance customers. Yet the percentage of insured Californians remained surprisingly low over the next 10 years. The Northridge quakes of 1994 shot the take-up rate all the way up to roughly 30 percent for a short period

of time, but that number dipped as the disaster escaped from people's short-term memory. Despite continued earth movement in the state, not to mention state-instituted assistance for high-risk homeowners, only an estimated 11 percent of Californians were insured by an earthquake policy in in 2016, as reported by the Los Angeles Times.

People's reluctance to purchase earthquake insurance in high-risk areas can't be boiled down to any single reason. Rather, insurance professionals who sell earthquake coverage need to recognize many psychological, historical and financial factors that have joined together to form a firm barrier against greater market penetration.

The take-up statistics related to the Northridge quakes are a perfect example of how psychology affects people's perception of risk. Regardless of proximity to a fault line and warnings from scientists that a quake is likely to occur in the near future, homeowners in high-risk communities fall deeper and deeper into denial the longer they go without experiencing a disaster. Conversely, a violent confrontation with Mother Nature in the recent past will often give people the extra push they need to purchase more insurance. Experts have noticed that this latter kind of behavior among insurance customers has a lifespan of approximately two years. After two years have gone by with no significant threats to properties, policyholders reexamine their risk tolerance and usually let their coverage lapse.

Still, a person's choice to spend money on something other than an earthquake insurance policy is not always linked to a poor understanding of the geological risks residing below their properties. Many people are well aware that their house sits near a fault line, but they look at the cost of earthquake coverage and decide that, thanks to state and federal disaster relief programs, buying quake coverage is an act reserved for fools. They might be old enough to remember how, after a 1971 California quake, victims became eligible for low-interest government loans and didn't need to pay back the first $2,500 they received in governmental assistance. Or they might look at an event like Hurricane Katrina and conclude that federal and state lawmakers would be committing political suicide if they didn't adequately assist the uninsured after a catastrophic event. However, the reader will note at a later point in this material that the government isn't legally required to bail out citizens after a natural disaster and usually sets limits on the amount of financial relief it'll give to victims.

There are also several U.S. homeowners who worry about their exposure but believe their location has effectively priced them out of the market for quake coverage. Although California has experimented with limited price controls that benefit some high-risk customers, coverage in the state has consistently been criticized for being overly basic and allegedly not worth its high cost. These criticisms help explain why only 10 to 15 percent of people in the state have purchased the insurance. Yet in Missouri, where coverage costs less, the take-up rate has neared 50 percent in some years.

Though citizens of such countries as Australia and New Zealand are extremely likely to have earthquake insurance coverage, low take-up rates in other nations suggest the people of California and other high-risk states are not just a stubborn bunch of holdouts. Japan, for one, sits on four tectonic plates and represents the biggest earthquake risk on the globe. Every September 1, the country holds a national earthquake drill that commemorates a deadly quake from 1923, and visiting journalists report that some Japanese still keep their bathtubs filled regardless of use, in case earth movement disrupts water service. But despite all this, Japanese insurers have had little success selling earthquake insurance to their own people. At the time of a 7.2 magnitude quake in Kobe, Japan, in 1995, less than 5 percent of residents had coverage.

Earthquakes and Homeowners Insurance

Earthquakes are obviously capable of doing tremendous damage to people's homes. Along with the risk of structural collapse, homeowners in quake-prone communities must face the possibility that earth movement might cause floods by breaking water mains or cause fires by rupturing gas lines. Though basic logic might suggest that these perils ought to be covered under a homeowners insurance policy, the reality is that homeowners insurance generally excludes coverage of quake-related damages.

Policy exclusions of "earth movement," which collectively refers to quakes, landslides, sinking and volcanic eruptions, have been enforced in an increasingly strict manner over the past few decades. Several years ago, some courts awarded insurance payouts to policyholders if earthquake-related damage to a home could also be linked in some way to a cause besides earth movement. The basis for these court-mandated payouts was known as "concurrent causation" and had been practiced as early as the 1906 San Francisco quakes, when Lloyd's of London and other insurers decided to pay all property claims despite exclusions for earth movement. But by the 1980s, insurance companies were getting the legal go-ahead to add "anti-concurrent causation clauses" to their contracts, effectively making it less likely that quake damage of any kind would be covered under a homeowners policy.

Today's homeowners policies might in fact cover some claims when an earthquake is responsible for a fire or a broken pipe, but such coverage is limited to damage that could have only been caused by the fire or burst pipe. Suppose, for example, that an earthquake occurs in a consumer's neighborhood, causing some buildings to partially burn and then collapse from the earth movement and other buildings to simply burn to the ground. If the person's home is one of the buildings that suffered no earthquake damage but burned down because of an ensuing fire, he or she might be able to have the home replaced in full through a homeowners insurance policy. On the other hand, if the person owns one of the buildings that suffered some fire damage and then collapsed, he or she cannot expect homeowners insurance to cover the full replacement of the dwelling.

Working Around Earthquake Exclusions

As a way of expanding business and compensating for the loopholes in homeowners insurance, many carriers sell special earthquake coverage that can either be added as an endorsement to a homeowners policy or be sold as an independent policy. Earthquake insurance can be purchased for commercial buildings, residential buildings and even for mobile homes if people are willing to pay a little extra to insure these relatively unstable dwellings. Like a homeowners policy, though, earthquake insurance contracts might still exclude some forms of earth movement, such as landslides and sinking.

Earthquakes and Mortgage Loans

Consumers have a real choice as to whether or not to insure their dwelling and belongings with an earthquake policy. This choice contrasts greatly with the lack of options people face in regard to homeowners insurance.

Though a prospective homeowner is technically not required to buy homeowners insurance in conjunction with a real estate purchase, anyone who wants a mortgage loan must do so. Since few Americans can pay out of pocket for a dwelling, insurance requirements in the mortgage industry have effectively left most homeowners with at least some financial protection against fire, vandalism, hailstorms and other perils.

Yet lenders generally don't require borrowers to insure mortgaged properties against earthquake damages. Supposedly, this difference in insurance requirements exists because banks and other lenders consider fire risks and earthquake risks to be very different from each other. Whereas fires occur in all kinds of places, significant earthquakes are common only in a small portion of the United States. It's therefore generally believed that, as long as a bank provides mortgage loans to a geographically diverse group of borrowers, it'll be able to diversify its portfolio enough to keep earthquake exposure at a manageable level.

Lenders' ambivalence toward earthquake insurance can create a somewhat interesting situation if a homeowner buys coverage independently and incurs a house-crumbling loss. In the judgment of some courts, a mortgage lender who doesn't order borrowers to purchase earthquake coverage retains no control over how a borrower uses earthquake insurance benefits. This distinguishes earthquakes from the perils that are covered under a homeowners insurance policy. When a mortgaged property is damaged by fire, for example, insurers issue checks in the names of both the mortgage lender and the borrower. This allows the lender to insist that policy proceeds be used either to restore the dwelling or to pay off the outstanding balance on the home loan. If a homeowner files a claim for earthquake damage, he or she has the right to use the insurance money for other purposes without the lender's approval.

Be Aware of Moratoriums

Despite of the insurance industry's desire to sell more earthquake policies, the coverage isn't easy to obtain when it's probably most appealing to the public. For obvious reasons, the uninsured and the underinsured are more likely to inquire about earthquake insurance in the days immediately following major earth movement. Yet a property insurance company is likely to turn these potential customers away for the time being for fear of taking on an undesirable amount of risk.

Once a major quake ends, smaller quakes, called "aftershocks," can rock the same affected area for a while. Before issuing more policies in a victimized community, carriers want to feel assured that these aftershocks have passed and that, at least in the immediate future, earth movement won't produce more damage in the same spot.

In general, the uncertainty surrounding aftershocks is strong enough for an insurer to engage in a one-month or two-month moratorium, which temporarily prevents people from buying new quake policies and from updating old ones. The specifics of these potential moratoriums may differ among insurance companies and are sometimes articulated in a company's "magnitude policy." For instance, a company's magnitude policy might call for a moratorium on earthquake policies within 100 miles of a quake's epicenter if a quake has a magnitude of 4.0 or above. Sometimes, though, moratoriums can be broader and arguably severe. In 1985, two quakes in Mexico were enough to stop some companies from writing new policies entirely as far north as San Francisco and Los Angeles.

How Much Will Coverage Cost?

The average cost of earthquake insurance varies by state and is dependent on the area's susceptibility to major earth movement. Reportedly, coverage is still inexpensive enough in high-risk states like Missouri for some agents to suggest that all homeowners add an earthquake endorsement to their dwelling policies. But further west, where many states are considered very high risks by FEMA, it's fair to say that the insurance, no matter its positive attributes, isn't cheap. From an insurer's point of view, high premiums are often necessary because earthquake policies are most likely to be bought by people in high-risk parts of the country.

Premiums for earthquake insurance may also need to be higher than those for homeowners insurance and flood insurance because, compared to the extensive history of floods and hurricanes around the globe, there have been few major earthquakes. A resulting lack of data makes it more difficult for risk managers to estimate the frequency and potential damage that may be caused by a quake and makes it harder for insurers to offer coverage at a low price.

What About the Deductible?

Like premiums, earthquake insurance deductibles vary depending on where an insured person lives and the amount of risk associated with the area. Low-risk dwellings may be insurable with a 2 percent to 5 percent deductible. Moderate-risk and high-risk dwellings may require a 10 percent deductible. Properties representing a very high risk might need to be insured with a deductible of 15 percent or 20 percent.

The dwelling's deductible, which represents the amount of insured losses for which the insurer is not responsible, is applied to the dwelling's insured value rather than to the value of an insurance claim. In other words, policyholders who insure their homes for $100,000 with a 10 percent deductible would need to suffer $10,000 in damage before their policy benefits could kick in. If a dwelling's insured value is particularly low, the insurer might impose a minimum deductible expressed in dollars. In the event of a total loss, policyholders receive the difference between their deductible and their policy's value. They don't need to physically pay the deductible before receiving policy benefits.

In general, earthquake insurance involves one deductible per occurrence, not one deductible per policy period. So if the policyholders in our previous example had the unfortunate opportunity to live through two major earthquakes in the same year, they would have been looking at a combined deductible of $20,000 instead of $10,000. However, insurance companies usually apply a single deductible to policy benefits when multiple quakes closely follow one another. All earthquakes that occur within a three-day period are usually thought of as a single event for the purpose of deductibles. Some policies have enhanced that provision to include all quakes within a seven-day period.

Earthquake insurance may require a separate deductible for damaged contents. If so, the deductible may be applied to the insured value of the contents. So with $50,000 of contents coverage and a 10 percent deductible, the insured would be looking at a minimum of $5,000 in non-reimbursable losses. Other policies might list a flat dollar amount as the contents deductible. Some policies have no deductible for contents coverage if the dwelling deductible has been met.

Dealing With Additional Living Expenses

Like homeowners insurance, most earthquake insurance policies include some coverage of additional living expenses (ALE), which might arise if a quake makes a home temporarily or permanently uninhabitable. Covered costs usually include those for temporary housing, clothing, meals and laundry services. Additional living expenses don't include those expenses that a person would have incurred regardless of a disaster.

Limits and Exclusions

Because the product was created in response to a major exclusion in homeowners policies, it may seem a bit ironic that earthquake insurance contains many exclusions of its own. Most policies exclude damages caused by earthquake-related fires. These damages should be insurable through a standard homeowners policy. Also, detached structures, including pools, garages, spas and greenhouses, often aren't covered by a basic quake policy. The same might hold true for sidewalks, patios, fences and lawns.

Insurers have sometimes enforced limits and exclusions pertaining to certain kinds of building materials. On occasion, people have had to pay out of pocket for damage to plaster or concrete walls. Sometimes coverage of exterior masonry has been optional, with the additional coverage increasing consumers' premiums and affecting their deductible.

Coverage for Renters and Condo Owners

Earthquake insurance isn't just for people who own houses. It can also be customized to suit the needs of renters and condo dwellers. Quake insurance for renters covers personal property within an apartment or other rented home and also helps disaster victims pay for additional living expenses. Because a renters policy entails no coverage for a dwelling's structure, it tends to be cheaper than a typical earthquake policy and might involve a lower deductible.

Since condo ownership incorporates elements of renting and owning a house, an earthquake policy for a condo owner will be more extensive than a policy for a renter. Unlike a renters policy, insurance for condo owners can help a policyholder pay for interior repairs to the tune of several thousand dollars. However, damage to the exterior, as well as damage to such communal areas as hallways and laundry rooms, isn't covered under a condo owner's policy. It's only covered if the condo association has purchased earthquake insurance for itself.

If the condo association lacks insurance or is faced with a large deductible, unit owners might find themselves looking at some steep assessment fees. Luckily, many policies for condo owners will cover these costs. In some cases, this assessment coverage may be available on its own, meaning that condo owners can purchase it without also needing to insure their home's interior or their personal property. Separate, higher deductibles for assessment coverage may apply.

Earthquake Insurance for Businesses

Earthquake insurance can relieve financial burdens from businesses by covering commercial properties and reimbursing companies for losses that are linked to business interruption. When insurers consider issuing earthquake coverage to a business, they may put special emphasis on a building's contents. Whereas some offices and storefronts are likely to contain little more than standard business equipment and furniture and not seem like a major earthquake risk, an antique store located on a fault presents a problem because one good shake could mean the loss of countless fragile items.

Deductibles for commercial policies might merit special attention, particularly when a policyholder wants to insure multiple structures through a single insurance contract. Suppose, for example, that a restaurant owner operates out of two locations and insures both properties with one $300,000 policy. Assuming a 10 percent deductible, that would leave the owner with at least $30,000 in out-of-pocket expenses if a quake were to destroy both properties. But what would happen if a quake were to damage one location and spare the other? Would the owner still be responsible for a $30,000 deductible, or would the insurer cut the deductible in half? The answers to those questions will depend on the policy language.

Many issues related to business interruption pertain not only to earthquakes but also to other disasters. They will be addressed cumulatively in a later section of this material.

Earthquake Safety Tips for Homeowners

For homeowners, guarding against earthquake risks is arguably more challenging than guarding against wildfire risks. Whereas wildfires can be thwarted when people remove weeds and brush from their property, earthquake risk management generally entails a major construction project or a move to a less risky part of the country.

Effective management of earthquake risks should probably begin when prospective homeowners are shopping for a dwelling. If they want to worry less about earthquakes or at least qualify for lower insurance premiums, home buyers might want to settle on land that is at least 50 feet away from a fault, according to the Insurance Information Institute.

If moving far away from a fault isn't an option, the next best thing a person can do is to pay attention to a home's construction features. Poorly braced houses are difficult to insure in some areas because they're sensitive to lateral pressure. Their lack of horizontal stability prevents them from moving in one piece during a fierce quake and makes it easier for heavy shaking to pull pieces of the dwelling apart.

In general, single-story buildings have a better chance of withstanding an earthquake. "Soft-story structures," which incorporate a parking lot or some other form of open space on the building's first story, are especially risky due to the absence of adequate support. According to the Association of Bay Area Governments, soft-story structures accounted for two-thirds of all buildings that were made uninhabitable by the 1994 Northridge quakes.

For homeowners with the money and the drive to complete a major construction project, retrofitting is an option. In a general sense, "retrofitting" just means upgrading an old structure. From the perspective of earthquake risk management, it often involves tying a tighter knot around a dwelling and its foundation so the building can bend a bit more under pressure without crumbling. Other kinds of retrofitting don't do much for a building's foundation but can help prevent the fires and floods that often follow major earth movement. Water heaters can be clamped down against walls so that they remain stationary after a good shake, and automatic shutoff valves for gas lines can prevent a bad situation from getting worse.

General Disaster Information

Despite our focus on fires, windstorms and earthquakes, there are obviously many insurance issues that pertain to seemingly all

kinds of disasters. The remainder of this chapter highlights several of these topics and concerns.

Keeping Coverage Current

Buying an insurance policy to protect a home and its contents is a major step in the risk management process, but it's not the final one. No matter what kind of disaster they fear the most, policyholders put themselves in a good position when they periodically review their coverage to determine whether their insurance still meets their needs.

Homeowners are usually well-insured right after they purchase their dwelling. If their own risk tolerance doesn't successfully entice them to become adequately covered against various acts of nature, their mortgage lender is nearly certain to step in and mandate proper coverage. Yet as time goes by, a well-covered home can turn into a poorly covered home, and there may be no one but the owner around to take control of the situation.

Admittedly, many property insurance policies feature inflation guards that increase coverage by a few percentage points each year, but this protection isn't always enough to minimize an owner's out-of-pocket expenses. Building costs can easily outpace inflation and are especially likely to rise when a disaster hits a large area. Additional coverage may also be necessary when a policyholder makes major home improvements.

As a way of reducing the amount of underinsured homeowners in the United States, insurance professionals often recommend that buyers review their policies at least once a year. A policy's annual renewal period presents the opportune moment for this evaluation, since the insurer might make noteworthy changes to a policy at this time.

If clients follow this routine and discover that they need more insurance, they're not necessarily stuck with paying more for the additional coverage. They might be entitled to greater benefits if they agree to a higher deductible.

Minding Local Building Codes

When someone buys a home, the building's age hints at more than just the probable progression of wear and tear. It might help the owner decide how much property insurance to buy and could have an influence on the premiums for that coverage.

The building's age is important to insurance carriers because it suggests how fully a home complies with the most recent local building codes. When these safety and energy requirements are updated, they apply to new buildings but often don't require property owners to make changes to older dwellings. However, if an older home is destroyed, an owner who wants to rebuild is required to abide by the current standards.

The insured replacement value of a damaged dwelling is likely to be enough to cover most rebuilding costs if the damaged dwelling was built only a few years ago. On the other hand, people who want to rebuild older homes would have to comply with several years' worth of changes to the rules. Depending on where they live, these owners might need to construct a new home that boasts a fire-resistant roof, an intricate sprinkler system and several other features they had not considered when they first bought their homeowners policy.

If disaster victims are at all surprised by the cost of rebuilding in compliance with local codes, they're also likely to be shocked when they learn that the typical homeowners policy doesn't cover all of these mandatory upgrades. Concerned insurance customers might want to look into purchasing "building ordinance coverage," which can be added to another property insurance policy to help people manage these costs.

From an insurer's perspective, building codes are important because they give underwriters a basic idea of how buildings in a particular area are likely to respond to a disaster. The disaster-prone states California and Florida are known to have two of the strictest building codes in the nation, which might help explain why insurance companies continue to cover properties there. Yet detailed codes, in and of themselves, won't always be enough to secure affordable coverage for local residents. After paying many disaster claims for houses that were built by people who cut regulatory corners and got away with it, insurers started paying closer attention to how strongly communities enforce their codes.

Disaster Insurance for Business Owners

When disasters strike, self-employed people unfortunately have much more to worry about than just the safety of their loved ones and the sturdiness of their home. They will be faced with major business concerns, including how to repair damaged offices and how to make up for lost income.

At least two disaster-related insurance products may appeal to business owners who would not be able to afford an unexpected halt to their productivity. "Business income insurance" is the more popular of the two. Among other things, the coverage can take care of utility bills while work is suspended, pay employees' salaries and reimburse the business owner for lost income after a disaster.

A similar product, "extra-expense insurance," provides benefits to policyholders when they keep their business running after a disaster but incur additional expenses while doing so. For example, extra-expense insurance might cover the cost of special generators or pay for air shipments when road conditions or other factors don't allow a company to ship products via regular mail.

Business income insurance may be cheaper and easier to find if shoppers present a "disaster recovery plan" to an insurance company. This kind of plan involves precautionary steps that ought to get a business back on its feet quickly after a catastrophic event. As part of this plan, the business owner might maintain a record of all employees' contact information and store it in a safe place. He or she might also want to tell workers ahead of time where they ought to report for duty if the business's building ever suddenly becomes uninhabitable. Finally, important computer files should be backed up on a regular basis, and backup copies should be stored in a secure location.

Avoiding Problems at Claim Time

Insurance should be a source of relief for covered disaster victims, not something that amplifies someone's stress level in an already unfortunate situation. Yet as helpful as insurance companies can be during times of crisis, it appears as though every disaster in recent memory has had its share of disgruntled policyholders.

For some people, getting a disaster claim sorted out becomes akin to having a second job. For others, wildfires, earthquakes and other disasters lead to long-term legal battles between consumers and carriers. Sometimes insurers win these battles, and sometimes policyholders claim victory. But no matter how each of these fights plays out, the one-sided wins are effectively in no one's best interest. Rather than strengthening a business-minded bond between insurance providers and private citizens, they nurture a conscious and subconscious sense of distrust

among those consumers and professionals who want nothing more than to be treated fairly by the other side.

Indeed, it may be naïve to suggest that there isn't at least a small minority of policyholders who will use disasters as an opportunity for fraud, and it may be equally naïve to suggest there have not been a few insurance companies that have sacrificed fairness in order to satisfy greed. But it would be unfair to link all property insurance disputes to devious displays of selfishness. In fact, experience tells us there are many things consumers and carriers can do to smooth out the claims process for all affected parties.

Knowing What You Own

Documentation can be one of the keys to a pain-free insurance settlement. People who have kept track of their purchases will be able to pinpoint exactly what they have lost in a disaster and will be more likely than others to receive fair compensation quickly. Homeowners should either list or take pictures of everything they own before a disaster hits and ought to be as specific as possible. Lists or photos of major appliances and other electronics, for example, should include model numbers. Whether in written or photographic form, any inventory of a person's personal belongings shouldn't be kept inside the home. There's little point in keeping an inventory of your belongings if that inventory is likely to burn up in a fire with the rest of your property.

Old receipts for major items can be helpful, too, though a policyholder isn't legally obligated to keep them. A set of house plans might prove to be invaluable if the homeowner wants to rebuild, and copies of all applicable insurance policies might turn out to be great references at a crucial moment. Like one's property inventory, these receipts, home plans and policies belong in a secure offsite location, perhaps in a safe deposit box at a bank.

Evaluating the Damage

After a disaster, it'll be time for the policyholder to prepare a claim and for a claims adjuster to evaluate the damage. If a disaster has only done partial damage to a dwelling and safety officials allow owners to access the property, policyholders can do themselves a favor by evaluating the building several times before filing a claim. People accumulate a lot of personal items over the course of home ownership. It'll therefore be very easy for disaster victims to overlook many losses at first glance. Also, if on-the-spot repairs must be done, the homeowner ought to document them in some way so the damage can be reported accurately to the insurance company.

Today's excellent communication systems have made it possible for claims adjusters to get on the ground and spring into action as quickly as safety permits. Often after a disaster, an insurance company will call on its top adjusters to head to the heart of the destruction as part of a "catastrophe squad." These adjusters are paid by insurance companies to assess insured losses but are also expected to provide honest service to companies' customers.

In most cases, claims adjusters, including those who work on catastrophe squads, must be registered or licensed in the state where they perform their work. On rare occasions though, the severity of a disaster is so high that insurers are permitted to call on out-of-state adjusters to help expedite quality service to victims.

Regardless of who is assigned to an area, people who have lived through catastrophes report that victims prefer to work with one adjuster throughout the claims process. If an insurer pulls its adjusters off of cases and reassigns them to other ones, a claim might get bogged down amid the transfer of responsibility, and the claimant might have to wait longer than expected for a fair settlement.

Disaster victims who believe an insurer's claims adjuster is not playing fairly may want to turn to a "public adjuster."

Public adjusters know how to evaluate damage, but they work for policyholders rather than for insurance companies. In return for serving as the middlemen between the consumer and the insurance company, they receive a percentage of the consumer's insurance settlement.

Reacting to a Proposed Settlement

Once a claims adjuster has evaluated the destruction that a disaster has caused, an insurance company might offer a quick settlement. The claimant can accept the settlement and start replacing items and rebuilding property, but acceptance of a settlement may limit the person's ability to file related claims at a later date. As an alternative, the person can decline the offer and instigate an appeals process.

Earning High Marks for Quick Responses

People who live in disaster areas are likely to note that many insurers assign an array of industry professionals to hard-hit towns. Local insurance workers will typically be putting in overtime to answer claimants' questions, even as many of them worry about the status of their own homes and possessions. In addition to fielding questions, agents and adjusters at bigger companies can hand out checks or debit cards on the spot, so that the newly homeless can immediately pay for lodging, clothing, food and other essentials.

Dealing With Contractors

Unfortunately, disasters have the power to bring out the worst in some opportunistic people. This sad reality has led to occasional law-breaking scams in which unskilled builders have presented themselves to victims as reputable contractors. Concerned policyholders may be able to avoid these frauds if they use contractors who have been recommended by their insurance companies.

Still, claimants are allowed to do business with contractors who haven't been chosen or recommended by a carrier. When claimants go outside of their insurance company to find a contractor, industry professionals and consumer advocates recommend that they take a few preventive steps. These steps include confirming that the contractor has adequate liability coverage and checking to see if anyone has filed a complaint against the contractor through the Better Business Bureau.

Federal Assistance for Disaster Victims

Though federal law doesn't require that the government automatically assist homeowners, renters and businesses after every disaster, it does grant the president the power to declare a community a "federal disaster area." A federal disaster designation makes it possible for affected victims to apply for disaster relief from multiple federal departments.

Federal disaster relief can come from any of the numerous government departments, including the Department of Housing and Urban Development and the Department of Agriculture. Even the Department of Education can get involved from time to time by providing money for the reconstruction of schools. Still, modern disaster relief usually begins at the doorstep of the

Federal Emergency Management Agency, more commonly known as "FEMA."

Once the president has designated a place as a federal disaster area, victims can turn to FEMA for help with their uninsured losses. Upon registering with the agency, a person will receive an application for a federal loan from the Small Business Administration (SBA) and/or an application for a federal grant from FEMA's Individuals and Households Program (IHP).

SBA Loans

Despite its name, the Small Business Administration actually distributes 80 percent of its disaster loans to homeowners and renters. These loans can only be used to pay for the disaster-related costs that are not covered in full by grants or a person's insurance. Homeowners can receive up to $200,000 from the SBA for damages to a dwelling. Owners and renters may be eligible for up to $40,000 to replace or repair their personal belongings. Businesses and non-profit organizations may receive as much as $1.5 million as compensation for lost or damaged assets.

SBA loans must be repaid with interest to the federal government or participating lender, with the first payment usually due after five months. However, the government puts limits on interest charges and offers long-term lending agreements to Americans in order to make the loans reasonably affordable. If a borrower has no other source of credit after a disaster, the interest rate on an SBA loan cannot exceed 4 percent. This rate restriction applies to roughly 95 percent of loan recipients. The remaining 5 percent of recipients, who can obtain credit from other sources, cannot be charged an interest rate higher than 8 percent. Homeowners, renters and some businesses can obtain loans with 30-year terms. A business with available credit will need to repay its loan within a minimum of three years.

The SBA is usually able to evaluate an applicant's creditworthiness and make a decision on a potential loan within three weeks of receiving an application. The SBA says it approves approximately 50 percent of all applicants. The other 50 percent may be referred to the IHP for assistance.

IHP Grants

If a disaster victim doesn't qualify for an SBA loan or has suffered uninsured losses that are too large to be covered by an SBA loan, the person may be eligible for a tax-free grant from FEMA's Individuals and Homeowners Program (IHP). IHP grants, which don't need to be repaid by recipients if used as directed, can amount to roughly $25,000 or so and go to people whose homes have been rendered uninhabitable, unreachable or in need of repair. The home needs to have been situated in a federal disaster area, and the damaged or destroyed dwelling must have been occupied both on a regular basis and at the time of the disaster. Applicants can be turned down for a grant if the damaged property is a vacation home or if they have another unoccupied dwelling that can be used for temporary shelter.

IHP grants must be used for specific purposes. Money applied to a damaged dwelling can only be used to make a home "safe and sanitary," according to FEMA. This contrasts with the many insurance policies that are meant to at least restore a dwelling to its pre-disaster condition.

A grant may also be used to pay for non-dwelling expenses, including medical, dental and funeral bills and the cost of clothes, tools and household items. Recipients are only allowed to apply their grants to these goods and services if the expenses are related to preventing or recovering from a disaster. Funeral expenses, for example, will only be covered by a grant if a disaster is at least partly to blame for a person's death. To ensure that IHP grants are used properly, the government requires that all recipients hang onto subsequent receipts for at least three years.

An IHP grant pays only for expenses not covered by a disaster victim's insurance company. If a person refuses insurance benefits, he or she may be deemed ineligible for a grant. However, the mere fact that a victim has some insurance should not necessarily discourage him or her from applying for IHP assistance. Insured persons may apply for an IHP grant if they have filed an insurance claim and have not been indemnified by their insurer after 30 days. If the insurer honors the claim after more than 30 days have gone by, the IHP grant will be treated like an advance of the person's insurance benefits, and the government will get its money back.

Tax Breaks for Disaster Victims

Property insurance benefits that are meant to replace or repair a dwelling or personal items are tax-free.

A portion of a person's uninsured losses may be deducted on income tax returns. After subtracting an IRS-specified dollar amount from their total uninsured losses, disaster victims can deduct the portion of uninsured losses that exceeds 10 percent of their adjusted gross income. Note, however, that certain criteria might need to be met in order to take advantage of this deduction, such as federal declaration of a disaster.

Additional tax benefits might be made available under special circumstances. In some cases, for example, the IRS may decide that people in a disaster area are entitled to a filing extension for their income taxes. In another possible scenario, the government might decide that victims deserve a quicker refund than usual and will let people work off of a previous year's tax return instead of making them wait for the latest forms to arrive. Insurance professionals and their customers should turn to the IRS if they need specific tax information.

How Disasters Affect Affordability and Availability

Many homeowners in disaster-prone areas worry about the effect a wildfire, hurricane, earthquake or other destructive event may have on their insurance costs. With insurers often using past claims to predict the likelihood of future claims, policyholders are left to wonder if a single catastrophe will be enough to spoil a long, spotless claims history with their carriers. Will one big fire, for example, be responsible for a rate hike, or will an insurer agree to take the bad times with the good ones, accept the fire as a rare, freakish development and resist increasing people's premiums?

For homeowners who are covered by experienced insurers, one disaster should not have a great impact on premiums. The cost of a potential catastrophe will have already been factored into the price of coverage, ensuring that the insurance provider will have enough reserves to handle a significant loss.

Rate increases are more likely when long-term patterns suggest an increase in risk among a particular demographic of consumers. So, while one wildfire might not create a lasting insurance problem for the public, multiple fires occurring within a few years of one another might have a negative impact on homeowners.

Sometimes disaster victims worry that filing a major claim will make them uninsurable when their policy comes up for renewal.

Despite declarations by the industry that only about 0.5 percent of policies are not renewed each year, insiders have asserted that filing as many as three homeowners claims within a five-year span may be enough to eventually sever the relationship between an insurer and an insured.

Catastrophe Models

Risk managers at insurance companies must evaluate, to the best of their ability, the probable maximum loss that a carrier could face at any given time. However, these managers often need more than an insurer's claims history in order to perform a proper, helpful evaluation. Because they occur so rarely in the United States compared to other perils, potential disasters are harder for underwriters to assess. This has led risk management professionals to develop and utilize multi-faceted estimation tools called "catastrophe models," which help insurers predict the likelihood of a catastrophe and its resulting damages.

Catastrophe models do not ignore past insurance data, but they deemphasize that data in favor of computer simulation and widespread expert analysis. When evaluating earthquake risks, for example, an insurer utilizes information from geologists and software from a modeling organization in order to simulate a particular kind of quake and assess how a similar catastrophe might affect a particular area.

In order to produce as accurate an estimate of potential losses as possible, underwriters provide modelers with various pieces of information. If insurers want to determine potential losses from a particular event, they will often do the following:

- Note how many of their policies are held in a particular ZIP code.
- Examine that area's history of catastrophes.
- Study data concerning the structure of the buildings they insure in the area, reporting whether a piece of property is weather-resistant.
- Use documented losses from any similar disasters as guides.
- Consider the specifics of their policies, paying attention to deductibles and to what sorts of damages are actually covered through their contracts.

Catastrophe models had been around since the 1980s, but it took years for insurers to gain enough confidence in the tools to use them in estimating losses. In the summer of 1992, Hurricane Andrew hit Florida and caused $26 billion worth of damage. This catastrophe, the most financially disruptive one in American history prior to September 11, 2001, left 11 insurers insolvent and forced underwriters to admit that modeling was perhaps more reliable than traditional methods of risk assessment.

Still, confidence in the models varies from one insurer to the next. Different modelers can come up with different estimates of potential losses, prompting insurers to not always trust the findings of just one modeling service. Even when the various modeling firms are in general agreement regarding probable catastrophic losses, they can still be collectively streaky in terms of their predictions. Model estimates for the 1994 earthquake in Northridge were nearly 10 times less than the actual damage. Models related to Hurricanes George, Earl and Bonnie generally got the numbers right, but low estimates for Hurricane Katrina caused some insurers to once again question the reliability of modeling techniques.

Others within the industry stress that incomplete data from insurers contributed to the poor estimations. With all of this information in mind, it's perhaps best for an insurer to keep catastrophe models within their proper context and view them for what they truly are: helpful tools but not infallible prognosticators.

Covering Your Car

While a home is almost always a person's biggest financial asset, personal automobiles are usually very valuable, too.

Drivers who want to be covered against disaster-related damage to their car, truck or van can insure their vehicle with a comprehensive auto insurance policy. They should keep in mind, however, that this kind of insurance, unlike auto liability coverage, is not required by law. Some financing agreements require drivers to purchase comprehensive insurance, but most other situations allow owners to skip the coverage at their own risk. Depending on the policy, there may be exclusions that apply to electronic accessories, such as stereo equipment, and to personal belongings stored inside the vehicle.

Liability for Disasters

On occasion, disaster victims decide that the stress and financial losses brought on by a catastrophic episode have been made needlessly worse by negligent people and irresponsible businesses. A homeowner might determine that a dwelling reacted feebly to a force of nature thanks in part to the sloppy contractor who built it. Or a community might find itself surrounded by pollution after a destructive event and place part of the blame on poor planning by a local waste management company. Details about professional liability insurance, directors and officers insurance and environmental insurance are all topics beyond this course's scope, but risk managers should at least realize that products like these are available to help potentially liable parties cope with defense costs, court fees, settlements and monetary judgments.

Conclusion

Disasters, whether they're linked to wind, water, shakes or flames, are a threat to families and individuals in every region of our land. They possess the merciless power to not only threaten our safety but also demolish every material thing that serves as proof of our successes, hard work and good fortune. They incorporate nightmarish risks that can't be managed sufficiently through luck and the average American's often slender emergency fund.

Quick recovery from these perils may only be possible if victims have planned ahead by securing their dwellings. Though a property insurance policy can't perform miracles or control the earth's elements, it might be able to influence a disaster's psychological aftermath for the better. With adequate benefits coming their way, affected policyholders can focus on rebuilding their lives instead of thinking about what they've lost.

CHAPTER 3: HIPAA PRIVACY COMPLIANCE

Introduction

In the mid-1990s, members of Congress generally agreed that health care needed to be administered more efficiently and that delivering it would be simpler if there were a set of national standards for doctors and insurers to follow when handling electronic transactions. But just imposing those standards and encouraging greater utilization of electronic health records wouldn't be enough to please patients and providers.

The concept of the internet was still relatively new to many Americans, and even those who were fine with sending some data through computer networks weren't entirely comfortable

with the possibility of their medical information being intercepted by hackers and identity thieves. If the government wanted sensitive information to be shared in new ways, it would need to ensure that people's privacy would remain intact.

Congress tackled those basic concerns on a bipartisan basis by passing the Health Insurance Portability and Accountability Act of 1996, known more simply as "HIPAA." Full implementation of HIPAA was delayed at first by a rush of public comments about the law and then by changes in leadership at the U.S. Department of Health and Human Services. But by the middle of the first decade in the 21st century, anyone who was providing or receiving medical services was feeling the effects of one our country's most significant privacy laws.

General Overview of HIPAA

So what exactly did HIPAA do? A detailed answer to that question is what this chapter is all about. But as a starting point, here are some of the areas in which HIPAA has had the greatest impact:

- Thanks to HIPAA, new employees and their dependents have the right to join an employer's group health plan regardless of their health status.
- Thanks to HIPAA, people who are insured through a group health plan can be covered for pre-existing medical conditions after a special waiting period has passed.
- Thanks to HIPAA, doctors and health plans generally can't disclose a patient's medical information without the person's consent.
- Thanks to HIPAA, most doctors and health plans are required to take security-related measures to keep medical information safe.
- Thanks to HIPAA, there are uniform procedures for doctors to follow when billing electronically for treatment.
- Thanks to HIPAA, purchasers of long-term care insurance can receive federal tax breaks.

Our focus will mainly be on the third and fourth of those points.

Noncompliance with HIPAA's privacy rules has created unfortunate situations involving either one of two extremes. On one hand, there have been examples of medical personnel being completely ignorant of the rules by posting people's x-rays on social networking websites and selling celebrities' medical information to gossip publications. However, there have also been instances in which a doctor or nurse has leaned too heavily on the law and prevented a patient's loved ones from receiving important information in an emergency. In between those extremes, there are countless cases of professionals who have wanted to do the right thing but have been unsure about what HIPAA allows or prohibits.

Throughout this chapter, we'll try to give you a strong background in your rights and responsibilities under the law in a wide variety of common situations. In some cases, you might be surprised to read about protections you didn't know existed. Alternatively, you might discover that some broad exceptions to these rules leave you with fewer protections than expected.

A Disclaimer About This Chapter

As you review the following information about privacy and security requirements, please be advised that the totality of all HIPAA-related rules could fill several hundred pages. So while you'll find plenty of information here, a course like this can't possibly address all the details and nuances that exist in the actual law and regulations. If you're working with clients and have access to their health information, we strongly suggest you review HIPAA thoroughly on your own or at least consult an expert who is familiar with your specific situation. This chapter is intended to make you knowledgeable about privacy protection requirements but isn't a substitute for legal counsel. Also, be aware that actions not necessarily prohibited by HIPAA might still be illegal under other federal or state laws.

Health Information Privacy Rules

To provide and pay for health care in relatively simple ways, certain people need access to your medical information. If you don't tell your doctor about your medical history, you might end up being misdiagnosed. If your doctor doesn't share information about you with your insurer, he or she might not be compensated for treatment.

Still, most patients seem to agree that details about your health are your own business and should only be disclosed on a need-to-know basis. Since you probably wouldn't want everyone in the world to know what surgeries you've had and what medications you've taken, you expect your physicians to protect your privacy as much as possible.

Laws regarding medical privacy existed before HIPAA, but they were mainly enacted on a state-by-state basis. Through a collection of regulations known as the "Privacy Rule," HIPAA created national standards that dictate what doctors, insurers and other collectors of medical data can do with your information. Those standards also determine your right to access your own medical records as well as your right to correct errors in them.

The authors of the Privacy Rule attempted to promote a balance of confidentiality and efficiency in the health care system. On one hand, they recognized that patients put a lot of trust in their doctors and expect their personal records to be guarded with care. Yet they also knew that putting too many restrictions on the sharing of information could slow the system down and prevent patients from getting treatment in a timely fashion.

Whether the authors ultimately succeeded in finding that balance has been a source of heated debate in the medical community. But no matter which side of the debate you're on, you'll probably agree that complying fully with the Privacy Rule isn't easy. If you aren't careful and well-informed when medical information is being shared, someone's rights could be at risk. Those rights, of course, can include your own.

Kinds of Protected Health Information

HIPAA doesn't allow certain entities (mainly health care providers and health insurance plans) to use or disclose specific medical information about you unless you give your consent or unless the use or disclosure is allowed by the Privacy Rule. This specific medical information is called "protected health information."

One of trickiest parts of HIPAA compliance is figuring out what exactly qualifies as protected health information. The Privacy Rule and HIPAA itself can make this task difficult because they contain many similar terms and definitions. For example, along with the term "protected health information," the Privacy Rule also has separate definitions of "health information" and "individually identifiable health information." We can't understand HIPAA's requirements unless we know what those terms really mean.

To be considered "health information," the information must have all of the following traits:

- It is created by or given to a health care provider, a health plan, a public health authority, an employer, a life insurance company, a school or university or a health care clearinghouse.
- It relates to a person's past present or future medical condition, genetic information, health care provided to a person, or the past, present or future payment of health care for a person.

That definition, though, is just a starting point. Health information, in and of itself, is not the kind of information that can't be used or disclosed without your consent. In fact, some of the entities mentioned in that definition (such as life insurance companies and schools), generally aren't regulated by the Privacy Rule.

Health information isn't protected by the Privacy Rule unless it is considered "individually identifiable health information." To be considered "individually identifiable health information," the information must have all of the following traits:

- It is created by or given to a health care provider, a health plan, an employer or a health care clearinghouse. (Note the absence of life insurers, schools and public health authorities from the definition.)
- It relates to a person's past, present or future medical condition, health care provided to a person, or the past, present or future payment of health care for a person. (Note that this trait is also part of "health information.")
- It either identifies the person or could reasonably be used to identify the person.

That last point is key to HIPAA compliance. A doctor who says something like, "I once treated someone for tuberculosis," wouldn't necessarily be violating the Privacy Rule. But a doctor who clarified that statement by saying, "I once treated Jane Smith for tuberculosis," could be in some legal trouble. With this in mind, information that would normally not seem medical in nature (such as your name, your Social Security number and your address) can be "individually identifiable health information" if it is disclosed along with information about your health, your treatment or your payment for treatment.

The same standard might not apply in regard to information about payments for health care. While a health insurer wouldn't be violating HIPAA by telling a reporter that, "We've paid over $5 million in claims this year," it might be a violation of HIPAA to say, "The policyholder at 123 Main St. has made a $5,000 claim."

But even then, the information might not be considered "protected health information" and therefore might not be subject to the Privacy Rule. In general, "protected health information" is "individually identifiable health information" that is transmitted or stored in any way. However, "protected health information" typically doesn't include information from school records or employment records.

So, why is there a distinction between "individually identifiable health information" and "protected health information"? The short answer is it helps clarify how employers need to follow the law. If you haven't already, you'll soon understand that certain entities need to comply with the Privacy Rule while others don't. Someone who is exempt from the Privacy Rule doesn't need to keep your protected health information confidential.

Employers are in a unique position in that they are generally exempt from the Privacy Rule when acting strictly as your boss but not necessarily exempt when they are acting as the sponsor of your group health plan. Don't be too concerned if this sounds confusing at first. We'll elaborate on the distinction between employers and plan sponsors in a little while.

Now that you know that "protected health information" is basically "individually identifiable health information" with a few exceptions, let's go over some important details by answering some questions.

Does it Matter How Information Is Transmitted or Recorded?

An important element of HIPAA known as the "Security Rule" only applies to information that is stored electronically. However, the Privacy Rule applies to individually identifiable health information in all its forms. The information can be stored electronically, written by hand or spoken.

What Are Some Basic Kinds of Information That Are Protected?

Examples of information protected by the Privacy Rule include:

- Information you discuss with your doctor, a nurse or other health care provider.
- Information in your medical files.
- Information about health insurance claims.
- Information about medical bills.
- Non-medical information (such as your name, address and phone number) if it can reasonably be used to identify you and help people learn something about your health.

Is Information About Relatives Protected?

Information doesn't have to be about you in order to be protected. If you give your doctor some details about your parents' medical history, the doctor needs to treat those details as protected health information. The doctor generally can't disclose them without your consent.

What About Information That Predates HIPAA?

HIPAA's Privacy Rule is retroactive, meaning it protects information that doctors and health insurers currently possess but obtained prior to the law's passage. It doesn't matter, for instance, if you were treated for leukemia way back in 1960. The information is still protected.

Even the deceased retain some HIPAA rights for several years after their death. We'll have more on that topic later.

When Can Protected Health Information Be Shared?

Someone who must follow the Privacy Rule can't share protected health information unless the law provides an exception or you give your consent.

Applicability to Covered Entities

With just a few important exceptions, the only people or entities that need to follow the Privacy Rule and keep your information confidential are "covered entities." A covered entity can mean any of the following:

- A health care provider.
- A health plan.
- A health care clearinghouse.

As you can see, that's a relatively limited list. If you're concerned about your privacy in general, keep the brevity of this list in mind when discussing your medical information with anyone. Though it wouldn't be the nicest thing to do, your neighbor can gossip

with others about your medical history and not be in violation of HIPAA. Businesses that get a hold of your medical information might not be obligated to keep it private if they aren't involved in providing or paying for health care.

Still, each item on the list deserves some clarification.

Health Care Providers

We tend to associate the phrase "health care provider" with doctors. But the true definition of the word is a bit broader and incorporates many other people. According to the Department of Health and Human Services, a provider might be any of the following:

- A doctor.
- A hospital.
- A clinic.
- A pharmacy.
- A dentist.
- A psychologist.
- A chiropractor.
- A mental health center.
- A nursing home.

Providing medical services to patients doesn't necessarily make a person a covered entity. A health care provider is exempt from the Privacy Rule if it never shares health information electronically. Examples of providers who might be exempt from the Privacy Rule include those who don't do electronic billing, don't electronically inquire about patients' insurance coverage and don't electronically authorize referrals. But since most providers do these things (and since there is still no exemption if a provider relies on a third party to do them), there are very few providers who can ignore the Privacy Rule.

Although the electronic transmission of information helps determine if a provider has to follow the Privacy Rule in the first place, it doesn't change the kind of information that is protected. Once it has been established that a provider is a covered entity, that provider must keep all protected health information confidential, including information found on paper and information revealed in conversation. The information doesn't need to be stored electronically for it to be covered by the Privacy Rule.

Again, be careful not to confuse HIPAA's Privacy Rule with HIPAA's Security Rule. Unlike the Privacy Rule, the Security Rule only pertains to electronic information. You'll read about the Security Rule later in this course.

Health Plans

A health plan is basically defined as an individual plan or group plan that pays for health care. Common examples include the following:

- Health insurance companies.
- Health maintenance organizations (HMOs).
- Company health plans.
- Government health plans, including Medicare and Medicaid.

As usual, there are some important details to consider when trying to figure out exactly which health plans need to follow the Privacy Rule.

Is the Privacy Rule Only for Group Plans?

No matter if it sells insurance in the group market or the individual market, a health insurer is a covered entity under the Privacy Rule. This is a big difference compared to HIPAA's rules about portability and nondiscrimination, which often don't apply to the individual market.

Are There Major Exemptions for Health Plans

Some self-insured health plans are not covered entities and generally don't have to worry about the Privacy Rule.

In a self-insured health plan, an employer sets up a mechanism whereby it is responsible for paying employees' medical bills. In a true self-insured plan, coverage for employees is not purchased from an insurance company.

A self-insured health plan is not a covered entity if it has fewer than 50 participants.

What If an Insurer Doesn't Share or Receive Information Electronically?

In the rare event that a health insurance company doesn't share or receive information electronically, it still must obey the Privacy Rule. The exemption regarding electronic information and providers doesn't extend to health plans.

What About Other Kinds of Insurance Companies?

A common misconception about HIPAA is that life insurance companies are covered entities and need to follow the Privacy Rule. The Department of Health and Human Services has concluded that life insurance companies and workers compensation insurers generally aren't governed by the rule. The confusion regarding this issue is understandable because life insurers and other non-health insurers often collect medical information about their customers.

Still, don't assume the Privacy Rule doesn't factor into the way these insurers do business. When a life insurance company decides that it will only sell you a policy after reviewing your medical records, those records typically can't be shared with the company unless you have signed a HIPAA-compliant authorization form. Though the insurer technically still wouldn't be a covered entity at that point, the authorization form might put contractual restrictions on how the company can use your information.

Keep in mind, too, that many life insurance companies have branched out into the health insurance market by offering traditional health insurance, long-term care insurance and other health-related coverage. In its role as a provider of this coverage, an entity calling itself a "life insurance company" might actually be a health plan under the law. It's also important to note that many insurance companies must still comply with privacy laws at the state level even if those companies are technically exempt from HIPAA.

Health Care Clearinghouses

According to the Department of Health and Human Services, health care clearinghouses are entities that take health information in a non-standard format and put it in a standard format or vice versa. Health care clearinghouses rarely have direct relationships with patients, but they play important roles during the health-care billing process.

Applicability to Employees

You may have noticed that most examples of covered entities (with the exception of some health care providers) technically aren't individuals. With this in mind, you might wonder how employees of covered entities fit into the Privacy Rule. If a doctor improperly discloses protected health information but is

employed by a hospital and isn't involved at all in things like electronic billing or insurance inquiries, who is at fault? Would the covered entity (the hospital) be liable for the disclosure, or would the employee (the doctor) be the one in trouble?

How about a customer service representative at an insurance company? Since the representative isn't a health plan on his or her own, might the representative be in legal trouble for failing to keep a customer's information confidential?

Those questions weren't clearly addressed in HIPAA's original form, and the officials in charge of enforcing the law sometimes couldn't agree on the answers.

Congress tried to clear up some of the uncertainty by passing the HITECH Act in 2009. Under the act, an employee who takes or discloses personal health information from a covered entity without proper authorization has violated HIPAA.

Applicability to Business Associates

Whether they realize it or not, some businesses and individuals aren't covered entities but are still indirectly expected to uphold the Privacy Rule. Many of these businesses and individuals are known as "business associates."

Business associates are third parties that are given protected health information in order to provide services to a covered entity. They aren't members of a covered entity's workforce, but they might find themselves acting on a covered entity's behalf.

Examples of potential business associates include:

- Lawyers representing covered entities.
- Health insurance agents and brokers.
- Transcription companies for health care providers.
- Third-party administrators for health plans.
- Third-party billing companies for health care providers or health plans.
- Accountants working with covered entities.

Business associates are impacted by the Privacy Rule through "business associate agreements." A business associate agreement is a contract between a business associate and a covered entity. It explains what the business associate can and can't do with protected health information. The agreement can't allow the business associate to do anything that the covered entity wouldn't be able to do under the Privacy Rule. It can even force the associate to agree to rules that a covered entity wouldn't have to follow.

Until 2010, business associates were only indirectly regulated by HIPAA. Though they couldn't do anything that violated the Privacy Rule, they technically couldn't be charged with HIPAA violations. If you were a business associate and improperly disclosed someone's health information, the victim might've taken legal action against the covered entity that gave you the information. Then, the covered entity might've responded by suing you for violating your business associate agreement. But in the end, the federal government wouldn't have subjected you to any HIPAA-specific penalties.

Like it did for employees of covered entities, the HITECH Act expanded liability under HIPAA to include business associates. If you are a business associate and violate a business associate agreement, you can face the same legal consequences as a covered entity.

Here's some additional guidance to help you understand the relationship between covered entities and business associates.

What If a Business Associate Violates the Law?

Upon becoming aware of a possible HIPAA violation, the covered entity is required to notify the business associate. At that point, depending on the severity and the continuance of the violation, the covered entity might need to help fix the problem or terminate the business associate agreement. The same actions must be taken by business associates if they are aware of violations by covered entities.

Do Covered Entities Need to Have Agreements With All Third Parties?

Business associate agreements are only for third parties who receive or access protected health information from a covered entity. If a covered entity deals with a vendor who doesn't receive or access protected health information, the vendor doesn't need to sign a business associate agreement.

There's also no need for a business associate agreement under HIPAA if it is technically possible for a third party to access protected health information but very unlikely for it to occur. For example, a shipping company or post office can accept a package containing protected health information without having to sign an agreement.

What Happens When Agreements Expire?

If a business associate agreement expires or is terminated, the business associate must do one of the following:

- Return the protected health information to the covered entity.
- Destroy the protected health information.
- If the information can't be returned or destroyed, agree to keep the protected health information private.

Do Covered Entities Need Agreements When Sharing Information With One Another?

Covered entities generally don't need to sign business associate agreements when they share information with one another for the purpose of billing or treating people. If your doctor decides to get the opinion of a colleague about your health, your information can be shared with the other doctor without the need for an agreement. Your doctor is also free to share your information with your insurer in order to be paid for medical services.

If information is shared among covered entities for other reasons, a business associate agreement might be required. According to the Department of Health and Human Services, an outside physician who is hired to train hospital employees would need to sign a business associate agreement before accessing patients' information as part of the training.

What If a Business Associate Decides to Outsource Tasks and Responsibilities to Another Business?

On occasion, protected health information might be given by a business associate to a subcontractor or other entity as a way of completing a business task. For example, an insurance broker might give paper versions of protected information to a shredding company in order for the information to be destroyed.

If protected health information is provided by a business associate to a subcontractor or other entity in order to perform business tasks, the subcontractor or other entity will also be considered a business associate. Therefore, the subcontractor or other entity must abide by the Privacy Rule and any contractual requirements it has agreed to. However, the covered entity who

provided information to the first business associate is not responsible for having a business associate agreement with the subcontractor or other entity and is not responsible for ensuring the subcontractor's or other entity's compliance. Instead, the business associate who gives protected health information to another business associate must obtain reasonable assurances that the information will be protected. In most cases, this will be accomplished by having the two business associates enter into a business associate agreement. The agreement between the two business associates must be at least as strict as the agreement between the first business associate and the covered entity that provided or will ultimately receive the protected health information.

Applicability to Plan Sponsors

"Plan sponsors" are indirectly required to follow parts of the Privacy Rule in certain situations.

A plan sponsor is the entity that arranges for people to join a group health plan. In the majority of cases, it's an employer who decides to have a health plan for employees or a union that decides to have a health plan for its members.

HIPAA affects plan sponsors because it puts limits on the kind of information they can receive from their health plans. It also restricts what sponsors can do with the information once they receive it.

A sponsor usually can't receive protected health information from a health plan unless it signs a special agreement. The agreement will state what the sponsor can and can't do with the information, and it can't let the sponsor do anything that would otherwise be a violation of the Privacy Rule. The agreement will also forbid the sponsor from using the information to make employment-related decisions. (Decisions regarding whether to change or discontinue a group plan are allowed.)

You'll read more about plan sponsors in the section "Sharing Information in the Workplace."

Parties Exempt From the Privacy Rule

Since we've spent so much time going over who is a covered entity and who isn't, it's worth revisiting the basics before moving on to our next topic. Again, with a few exceptions, the Privacy Rule only needs to be followed by covered entities. The list of covered entities is limited to the following:

- Health care providers who engage in certain electronic activities.
- Health plans.
- Health care clearinghouses.

Since HIPAA was enacted, many people have incorrectly assumed that the number of covered entities is larger than those three. Even though they may receive health information on a regular basis, the following entities generally aren't covered entities:

- Life insurers,
- Workers compensation insurers.
- Property and casualty insurers.
- Schools (assuming they don't provide health care on a regular basis and don't engage in certain electronic transactions).
- Law enforcement officials.

But don't forget the main point of the Privacy Rule: A covered entity can't share your protected health information with a non-covered entity unless you or the rule allow it. So while non-covered entities aren't necessarily limited in the ways they can share your information, they may be limited in the ways they can receive it.

Required Authorization and Consent Forms

HIPAA allows covered entities to use or disclose protected health information without your permission in any of the following circumstances:

- The use or disclosure is designed to help treat you.
- The use or disclosure is designed to ensure payment for medical services.
- The use or disclosure is part of "health care operations." (Health care operations are an assortment of tasks that are integral to running a reasonably efficient covered entity. An example would be training employees at covered entities to use computer systems.)

Using or sharing information for other reasons generally can't be done without your consent. The Privacy Rule requires that consent be provided through the use of an authorization form. The form has several mandatory elements to it, and it must be used even if you are the one requesting that information be shared with someone.

Among other things, a HIPAA-compliant authorization form needs to contain all of the following items:

- The kind of information that will be used or shared.
- The person or entity that will be using or disclosing the information.
- The person or entity that will be receiving the information.
- The deadline for the receiving entity to receive or access the information.
- Information about your right to cancel the authorization and how to exercise that right.
- Whether allowing the use or disclosure will affect your right to treatment or insurance benefits.
- Disclosure of the fact that the information might not be protected by the Privacy Rule once it has been shared.
- A place for the date and your signature.

Let's go over some common questions about authorization forms.

Does the Form Need an Exact Expiration Date?

Authorization forms need to mention how long the receiving party can access or receive your protected health information. They don't need to contain an exact date.

For example, if access or disclosure will be allowed on a continuing basis, the form can mention this in place of a deadline. It's also acceptable to use a particular event (such as the end of a medical research study) instead of a specific date.

Does the Government Require the Use of Specific Language in the Form?

The language in an authorization form can be written entirely by the covered entity. The government only requires that it contain the required information and be understandable.

How Do Consumers Remember What's in the Form?

When you sign an authorization form, you are supposed to receive a copy from the covered entity.

Can a Form Allow Covered Entities to Disclose Future Information?

Authorizations can be made ahead of time. If you want someone to receive copies of all your future medical records, you can authorize it by signing a single form.

Permissible Use and Sharing of Protected Health Information

Covered entities can use or share protected health information without your authorization if the use or sharing is done to facilitate treatment, payment or health care operations.

Early drafts of HIPAA regulations didn't allow this to happen, but it was ultimately decided that requiring authorization in these situations would be impractical and potentially harmful to patients. If you were to become very sick and needed immediate medical attention, you'd probably want medical professionals to have easy access to your past and present health records. If you were having important tests done, you'd probably want your doctor to be able to access those tests and report back to you as soon as possible without having to get your signature on something.

You can request that a covered entity not share your information for the purpose of treatment, payment or health care operations, but the covered entity doesn't need to grant your request. Still, if you make the request and the covered entity agrees to it, the entity must stick to the agreement.

Suppose you're concerned about identity theft and don't want your Social Security number shared with anyone. You might ask your doctor to keep the number private, but the doctor might need the number to receive payment from your insurance company. Since this kind of sharing relates to payment, the doctor can refuse your request and disclose the information to your insurer.

These exceptions to the rules about authorization can be very helpful to covered entities, but it's important not to read things into the exceptions that aren't really there. For example, a doctor's right to share information with a business associate for treatment purposes doesn't mean a business associate agreement isn't required.

Also, keep in mind that the exceptions about authorization relate to the covered entity's right to use the information on its own or share the information with a third party. They technically don't give the third party a right to obtain the information, even when treatment, payment and health care operations are involved.

As an example, if your new doctor contacts your old doctor and requests protected health information for treatment purposes, your old doctor isn't required to share it. If he or she wants, the old doctor can refuse to disclose the information until you've signed an authorization form.

In most situations, the only person who can't be denied access to your personal health information is you.

Treatment

Covered entities don't need your authorization to use or share your information for treatment purposes. This allows a health care provider to go through your medical records in order to give you appropriate medical advice. It also lets one provider share your information with another provider so you can get the best care possible.

Disclosures for treatment purposes can sometimes be made to people who aren't medical professionals. Perhaps the most common example of this would be a disclosure of your health status to a friend or family member in an emergency situation. Another would involve allowing a pharmacist to give medicinal information to someone who picks up a prescription for you. In both examples, the relative, friend or other person can be thought of as being involved in your treatment or responsible for it. (There are, however, many restrictions on situations like these. We'll analyze these scenarios again later.)

Treatment can also include contacting patients about appointments and care. But since emails and voicemails can sometimes be accessed by someone other than the intended recipient, many providers are hesitant to leave messages. After all, a statement as simple as "My name is Dr. Smith, and Mary Jones is one of my patients" could be a HIPAA violation, depending on the reason for saying it.

HIPAA doesn't prevent your doctor from leaving you a message even if the message is left with another person. What matters are what is said and why. If the intent is treatment-related (such as to confirm an appointment or go over your test results), a message of some kind is allowed. A message would also be allowed if it relates to payment or health care operations.

It might be impossible for the doctor to avoid disclosing some protected health information in the message (such as your name and the fact that you're a patient), but that's not a HIPAA-related problem if the disclosure is as limited as possible. So, if the message is meant to confirm an appointment, the doctor might say the scheduled time but not disclose the reason for the visit. If the doctor is trying to reach you to discuss a medical issue, the message might simply say to call the provider's office.

If you're concerned about communication from a covered entity falling into the wrong hands, you can request that covered entities only contact you in certain ways (such as only by phone or only at a certain number). As long as your preference is reasonable, the covered entity needs to honor it.

Payment

Covered entities can use or disclose your protected health information to ensure they are properly paid for their services. This allows doctors to send your information to your health plan and vice versa. If someone else is responsible for paying your medical bills, your information can be given to them, too.

The HITECH Act created some new restrictions in regard to payment-related disclosures. To properly understand them, we should briefly recall some basics about disclosures to covered entities.

In general, a covered entity can share information with another covered entity without authorization if the sharing is done for reasons of treatment, payment or health care operations. Even if you ask a covered entity not to engage in this kind of sharing, the entity doesn't need to honor your request.

As of 2010, you can ask your doctor not to share information with your health plan for purposes of payment or health care operations, and the doctor must agree if you pay for treatment entirely out-of-pocket. This consumer protection is expected to be utilized by patients receiving particularly personal kinds of care, such as abortion services and treatment for sexually transmitted diseases.

Health Care Operations

Covered entities can use and disclose protected health information while conducting health care operations.

The term "health care operations" is probably one of the most difficult HIPAA concepts to grasp. It's an admittedly vague phrase but is generally used to describe reasonable activities that would be expected to be done at a covered entity. Some major examples include employee training and the underwriting of health insurance by an insurance company.

For clarity's sake, here's the exact definition from the Privacy Rule:

- *Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:*

  (1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

  (2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

  (3) Except as prohibited under §164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;

  (4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

  (5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

  (6) Business management and general administrative activities of the entity, including, but not limited to:

  (i) Management activities relating to implementation of and compliance with the requirements of this subchapter;

  (ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.

  (iii) Resolution of internal grievances;

  (iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

  (v) Consistent with the applicable requirements of §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

Incidental Disclosures

The authors of the Privacy Rule understood that preventing every single kind of unauthorized disclosure would be impossible. Whether patients and policyholders like it or not, some protected health information is inevitably going to be available to complete strangers.

Covered entities aren't expected to prevent this sharing from happening at all costs. They just need to protect it in reasonable ways and implement common-sense safeguards.

Minor disclosures that occur despite reasonable actions by covered entities are known as "incidental disclosures." These disclosures are either accidental or practically necessary to facilitate treatment, payment or health care operations. They're bound to happen from time to time, and they aren't examples of HIPAA violations.

Our previous discussion of phone messages and email ought to help you understand incidental disclosures. If your doctor leaves you a message on your answering machine and you play it when someone else is in the room, the disclosure of your health information to the other person is considered incidental. If your doctor or insurer communicates with you via email, the covered entity wouldn't be violating HIPAA if you open up a message and the text is seen by someone looking over your shoulder.

Other incidental disclosures commonly occur at hospitals and medical offices. A provider can call out your name in a waiting room without violating HIPAA, and your doctor can discuss your health with you even if you're sharing a hospital room with another patient.

In another example, a nursing home or hospital can choose to put your name by the door to your room. The fact that visitors can see it is outweighed by the way it makes treatment and health care operations simpler for the covered entity.

The Minimum Necessary Rule

HIPAA sometimes grants covered entities the power to use and disclose protected health information without consent, but that power is far from absolute. Even in cases where use or disclosure is allowed, the covered entity needs to follow the "minimum necessary" standard.

Under the minimum necessary standard, protected health information can only be used or disclosed to the extent that the information is needed to complete a task allowed by HIPAA. In other words, if only a portion of your information is needed to do a particular act, a covered entity should only share that portion and keep the rest confidential.

The minimum necessary standard might be best understood by considering how providers share information with health plans. If you visit your doctor for a broken leg, the doctor can send protected health information to your insurance company for billing purposes. This disclosure is allowed without your authorization since it relates to payment. But since things like your weight, your blood pressure and your family's medical history probably aren't needed for the insurer to make payments for a broken leg, your doctor isn't supposed to share them.

Similarly, while a psychologist might need to share a general diagnosis of your mental health with your health plan, disclosing the specifics of what you discuss in therapy would probably violate the minimum necessary standard.

The minimum necessary standard is about more than just disclosures to outside individuals. It also controls how information can be accessed or shared within a single covered entity. To comply with the standard, a covered entity needs to identify all of the following:

- The people within the organization who will have access to protected health information.
- The kinds of personal health information that those people will be able to access.
- The circumstances under which those people will be allowed to access the information.

To demonstrate how this might work, let's think of a family doctor working out of a small office. The doctor might determine that her office assistant (but not her office's janitorial and maintenance staff) ought to have access to patients' protected health information. Then she might decide that the assistant should only be able to access patients' contact information, basic insurance information and their general reason for making appointments. Finally, the doctor might believe that the assistant should only be allowed to access the limited amount of protected health information in order to make appointments, make insurance inquiries and prepare visitors for examinations.

Based on the doctor's decisions, the assistant would be following the minimum necessary standard if he accessed a patient's general information to confirm an appointment. But let's assume one of the assistant's close friends came in for treatment, and the assistant accessed the friend's health records out of personal curiosity and concern. In that case, the assistant likely wouldn't be abiding by the standard.

Right to Your Own Information

A law mandating privacy of your information wouldn't be very significant if you didn't have a way of knowing what your information actually contains. For all its focus on disclosures to third parties, HIPAA still gives you several rights involving access to your own records. These rights include:

- The option to receive copies of your medical records.
- The option to correct errors in your records.
- The option to know if your information is being shared without your authorization.
- The option to let a friend or family member control access to your records.

Let's take a closer look at each of those rights.

Obtaining Copies of Medical Records

You have a right to know what pieces of information a covered entity has about you. Probably the easiest way to find out is to contact the entity and request a copy of your protected health information.

You can receive a copy of any protected health information that has been recorded by the covered entity and included in a "designated record set." (Keep in mind that information you convey in conversations might not be recorded and, therefore, might not apply to this portion of the Privacy Rule.) The Privacy Rule defines "designated record set" in the following manner:

- *Designated record set means:*
  (1) A group of records maintained by or for a covered entity that is:
  (i) The medical records and billing records about individuals maintained by or for a covered health care provider;
  (ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
  (iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

Covered entities are required to give you a copy of your protected health information if you request one. Even if you have unpaid bills from the covered entity, you still have a right to the information. A covered entity can't charge you anything for the copy other than the reasonable cost of labor, postage and supplies that are associated with the copying.

The rules about cost apply to you and a person known as your "personal representative," but some covered entities have been known to charge more when information requests come from third parties, such as attorneys and insurance companies. (We'll go into detail about personal representatives later.)

In general, you're supposed to receive a copy of your information within 30 days after making a request. A one-time, 30-day extension is possible if proper notice is given to the person making the request.

You can have your records given to you in any form that is reasonable for you and the covered entity. For example, you might receive them in the mail, via fax or in an electronic format if the covered entity is set up to provide them in those ways. However, under the HITECH Act, if your records are stored electronically by the covered entity, they must be made available in an electronic format to you as well.

There are very few occasions when a covered entity can turn down your request for your records. An example would be a request for copies of psychotherapy notes. These notes don't need to be shared if a therapist doesn't store them in your medical records.

If a covered entity is refusing a request for your records, it might be because the request is coming from your personal representative rather than from you. Your personal representative is very similar to someone who has medical power of attorney and is often a family member who is responsible for your health care.

Your personal representative has the general right to access your protected health information in the same way you do, but a covered entity might determine that disclosing certain information to the person isn't in your best interest. This sometimes occurs when a physician suspects a personal representative of committing spousal or child abuse.

If a covered entity denies you or your personal representative access to your information, you can appeal the entity's decision. In this case, the decision to share your records or keep them confidential will often be made by an impartial health care provider.

Making Changes to Medical Records

If you access your protected health information within a designated record set and notice an error, the covered entity that gave you the information is responsible for correcting it. Errors usually need to be fixed within 60 days after a request, but covered entities can get a 30-day extension if they give notice to the consumer.

After a covered entity has corrected the records in its possession, it may be required to send the changed data to other companies and individuals. At the consumer's request, corrected information must be given to anyone who has received the person's protected health information from the covered entity and who would reasonably benefit from knowing about the correction.

Sometimes, a consumer and a covered entity will disagree about whether information is accurate and whether a change should be made. If a covered entity doesn't believe an error exists, it can refuse to make a correction. The denial must be stated in writing, along with the reason for the denial and an explanation of how the consumer can file a complaint. At your request, the fact that you are disputing the accuracy of the information must be added to your records.

Accountings of Disclosures

When covered entities disclose your protected health information, they are required to keep records of the disclosure. These records must be made available to you if you request them.

At your request, you can receive information about these recorded disclosures if they were made in the previous six years. The information must be given to you within 60 days after your request and generally needs to include the following:

- Who received your disclosed information.
- What information was disclosed.
- When the disclosure occurred.
- Why the disclosure was made.

Let's answer a few questions about the tracking of disclosures.

Is Information About Disclosures Free to Consumers?

You can request a free accounting of disclosures once each year. If you make additional requests, you might have to pay a reasonable fee.

Are Covered Entities Required to Maintain Protected Health Information for a Set Period of Time?

HIPAA doesn't force covered entities to keep your protected health information for any length of time. It only requires that they keep records of disclosures.

Rights of Your Personal Representative

Nearly the same rights that you have under HIPAA (including the right to receive your information, correct errors in it and authorize disclosures of it) also belong to your "personal representative." Your personal representative is anyone who has the legal right to make health care decisions on your behalf.

By default, the person who can make medical decisions on your behalf is determined by state law. For most children, the person would be a parent. For most married adults, it would be a spouse, and for most unmarried adults, it might be a parent, a sibling or a grown son or daughter. By signing power-of-attorney documents, you can designate someone as your representative regardless of state law.

The rights given to personal representatives can be extremely important because they can be used to give loved ones critical information in serious situations. For example, if you are your elderly mother's personal representative and she goes in for emergency surgery, you can access her medical records before making difficult treatment decisions for her. If you are the one in serious condition and are incapacitated, you can rest assured that timely and informed choices about your health can still be made by someone close to you.

Since they tend to be utilized in emergency situations, the rights of personal representatives should be made clear to patients and providers sooner rather than later. Answers to the following questions might come in handy at the right time.

Can a Covered Entity Refuse to Give Information to a Personal Representative?

As you'll note later in this course, covered entities have the option to share your information with your family and friends without your authorization, but they aren't required to do it. The opposite is true regarding your personal representative.

Because your personal representative is acting in your place, a covered entity generally can't refuse to give the representative access to your protected health information. The exception would be a case in which the entity believes giving information to your representative would reasonably result in harm to you. In practice, this exception is used when you are in danger of being physically abused or neglected by your representative.

However, depending on the law and various agreements that you may have entered into, someone can be your personal representative in one situation but not in others. If the specifics of a situation mean that the person doesn't have the right to make a particular medical decision for you, the person isn't your representative and can't control or use your information. This point is clarified in answers to the next few questions.

Is the Same Person My Representative Whenever I'm Incapacitated?

Whether someone's role as a personal representative applies to all cases of incapacitation will depend on what state law says and what extra legal protections you've put in place. If you've gone beyond state law and delegated medical decision-making to another person in limited situations, that person is only your personal representative in those limited situations.

For a practical example, imagine you have gone beyond state law and given your best friend the power to make decisions about life support. Your other medical decisions will be made on your behalf by your sister.

In this example, your best friend would only be your personal representative if a decision needs to be made about your life support. If you aren't on life support but are otherwise incapacitated, your friend wouldn't be your representative and wouldn't be able to access your information. On the other hand, your sister would be able to access your information in the second case but not the first.

Can Someone Be My Personal Representative If I'm Not Incapacitated?

Someone is your personal representative when they have the legal right to make health care decisions for you. Unless you or a court make some unconventional arrangements, this right is only given to someone if you are physically or mentally incapable of making your own choices. If you want someone to receive your information but aren't incapacitated, you might need to sign an authorization form first.

An exception to this rule allows parents to access a child's protected health information even if the child can think and communicate. Since there are other special guidelines for the use and disclosure of children's information, we'll address this issue in another section.

Do Non-Medical Powers of Attorney Make People a Representative?

You can arrange for someone to make financial decisions on your behalf, but that alone doesn't make the person your personal representative. Unless the person has the power to make health decisions for you, a covered entity isn't required to give the person your information without your consent.

You'll recall, however, that covered entities have the option (not the obligation) to share your information without consent for the purpose of payment. If you are responsible for paying your father's bills, his insurance company might be able to send you his financial statements without violating HIPAA.

Sharing Information in an Emergency

There's hardly a more important time to understand HIPAA than in an emergency.

Suppose you're with your brother, who suddenly collapses. You rush to the emergency room and are told to wait outside by yourself while the medical staff tries to revive him. An hour later, you finally track down a doctor. But when you ask the physician about your brother, she refuses to give you any information. She tells you that since you aren't your brother's personal representative, she can't tell you anything about his condition, including where he is or how he's feeling. After all, she says, giving you that kind of information without your brother's authorization would violate HIPAA.

Though a health care provider might have an internal policy that prevents employees from giving information to a patient's loved ones, HIPAA doesn't prohibit this form of sharing.

If you are not available to give your consent or if you are incapacitated, a covered entity can share some of your protected health information with family members and close friends. Covered entities are allowed to disclose information under these circumstances if they believe doing so is in your best interest and that you probably wouldn't object to it. Based on their professional judgment, they can share information in these situations to the extent that the recipient is involved in your care.

So getting back to our example, it's reasonable to assume that giving you information about your brother's condition would be in his best interest. (Even if you aren't the one who can make medical decisions for him, you might be in charge of contacting the person who fits that description.) And since you were the one who made sure he got to the hospital in the first place, you've become involved in his care. While the doctor would be out of line if she were to tell you information that didn't relate to your brother's collapse, HIPAA generally still allows her to give you some information about his current condition.

The same standards apply to information shared over the phone. If you have an accident and aren't capable of telling medical personnel who to contact, your doctor or your hospital can use professional judgment to contact a friend or family member on your behalf. The covered entity doesn't need to worry about whether the contacted person is your personal representative.

If you are available to your health care provider, your information can be shared with friends or family if the provider believes doing it would be in your best interest and you don't object. So if you are in the emergency room but are still competent and able to communicate, your doctor can simply say something like, "I'll go tell your son what's going on." By saying nothing to stop the doctor, you would be giving him consent to share at least some of your information with your son. You don't need to sign an authorization form for this kind of sharing.

Sometimes your consent can be implied. For example, if you invite someone into a treatment area while you are being examined, your provider can infer that talking about your condition in front of that person is acceptable.

Here are some other situations in which a covered entity might be able to use professional judgment and disclose some of your protected health information without your consent to friends or family:

- Someone is picking you up from treatment and would benefit from knowing how to transport you safely.
- Someone is going to be looking after you while you are sick or injured and would benefit from knowing how to keep you safe or provide basic treatment.
- Someone is helping you pay your medical bills and needs protected health information for financial reasons.
- Someone is picking up medication for you and would benefit from knowing about dosages, side effects and other drug-related matters.

Because this aspect of the Privacy Rule is so important yet so misunderstood, we'd be foolish if we didn't explore it in greater detail.

Are Covered Entities Required to Share Information With Friends or Family Members in Emergencies?

HIPAA gives covered entities the option of sharing your information with these people without your authorization. However, covered entities aren't obligated to share your information with anyone other than you or your personal representative.

Health care providers might have internal policies that prevent your friends and family members from receiving any protected health information under any circumstances. These policies are generally allowed, but they aren't required by HIPAA.

How Is My Personal Representative Different From Other Friends and Family Members?

Your personal representative can act on your behalf to make medical decisions and take several actions in regard to your protected health information. This person can access all of your protected health information, request amendments to it and authorize disclosures of it on your behalf. Practically the only time a covered entity can refuse to give information to your representative is when there is a reasonable chance that the representative will abuse you.

Other friends and family members don't have any rights to your information under HIPAA. Without your authorization, they can't access your information unless a covered entity believes disclosing it would be beneficial to you. The covered entity can pick and choose what to tell these people about your health status, and unless they're your personal representative, they can't amend your records or authorize disclosures. They can't make medical decisions for you.

Sharing Information in the Workplace

Despite not being covered entities, employers deal with HIPAA indirectly when they act as "plan sponsors."

A plan sponsor is essentially any entity that decides to create a group health plan for itself. A sponsor can choose to fund its group's health care independently (in an arrangement known as self-insuring), or it might decide to purchase coverage for the group from a health insurance company.

A plan sponsor's involvement in HIPAA compliance will depend on how its plan is structured and what information the sponsor receives from the plan. If an employer offers its plan entirely through an insurance company and only receives a limited amount of health information from its insurer, its participation in HIPAA compliance won't be particularly complicated. (In this case, the employer's insurance company will probably be charged with handling HIPAA's administrative requirements.) But if the employer is self-insuring, it will be at least partially responsible for ensuring that its plan is following HIPAA's many privacy requirements.

Before going into too many specifics about different kinds of health plans, we need to emphasize that there are plenty of situations in which medical information provided at work has nothing to do with HIPAA. Even as the Privacy Rule regulates the instances in which your health plan can give information to your employer, it doesn't always stop your employer from getting your information from other sources and using it inappropriately.

In general, HIPAA has little or no power over information that companies obtain in their role as employers. For example, when you request a medical leave of absence, your employer can require that you give a reason for your request. When you attempt to take a sick day, your supervisor can still demand to know why you won't be in the office.

Since medical information in those situations would be coming from you rather than from the health plan, your company would be receiving it as an employer, not as a plan sponsor. Nothing in HIPAA would force your employer to keep your medical information private in either of those examples. (Of course, your employer might be required to follow other laws that restrict the use or disclosure of your information. For simplicity's sake, we'll only concern ourselves with HIPAA requirements here.)

Similarly, since it would need the information for payroll purposes, your employer can receive information about whether you are enrolled in its plan and how much of your paycheck is supposed to be earmarked for premiums. And though your doctor might not be allowed to disclose the results of a drug test to your employer without your consent, you can still be turned down for a job if you don't let your employer access the information.

Fully Insured Plans vs. Self-Insured Plans

HIPAA compliance can be relatively simple for employers when they sponsor a fully insured plan. A fully insured plan is a group health plan in which coverage is secured entirely through an insurance company or HMO.

The opposite of a fully insured health plan is a self-insured plan, in which the employer pays members' medical bills partially or entirely on its own. In general, self-insured plans are more popular among large employers than among small employers.

Since employers are usually the ones who sponsor health plans, it's easy to assume that they are responsible for keeping their plans HIPAA-compliant. But if an employer sponsors a fully insured plan and its insurer doesn't give the employer any information about employees other than enrollment information and "summary health information," most of HIPAA's administrative responsibilities will be handled by the insurance company.

Summary health information is health information about the benefits provided under the employer's plan, including the plan's claims history. This information may disclose the kinds and costs of treatment that group members have received, but it won't include data that can be used to identify a particular employee, other than five-digit ZIP codes. A plan sponsor can only receive summary health information (without members' consent) for limited purposes, such as shopping around for lower premiums and making changes to its health plan.

Fully insured plans that don't let employers access other information generally just need to ensure that their plan doesn't retaliate against people for exercising their HIPAA rights and doesn't force members to waive any of those rights. Other administrative duties can be handled by the employer's insurance company.

To keep this straight in your mind, you might find it helpful to view these kinds of plans as two separate plans. One plan is at the employer level and is the employer's responsibility. Another plan is at the insurer's level and is the insurer's responsibility. For the fully insured arrangements that we've been discussing, the administrative requirements for the plan at the employer's level are minimal.

If a plan is self-insured or lets the plan sponsor receive protected health information other than enrollment and summary health information, the sponsor will have more responsibilities. Even though the employer would still technically not be a covered entity, the portion of its business that is administering the health plan would be acting as one. As a covered entity, this portion of the employer's business needs to do the following:

- Not retaliate against employees for exercising their HIPAA rights.
- Not force people to waive their HIPAA rights.
- Create and maintain a privacy notice.
- Provide the privacy notice to group members in the manner described in the section "HIPAA Privacy Notices." (If the plan is fully insured but receives or

creates protected health information besides enrollment and summary health information, the notice only needs to be provided upon a member's request.)
- Appoint a privacy officer who will be in charge of keeping the health plan compliant with the Privacy Rule.
- Create internal privacy policies that address who can access or use protected health information, what information they can use or access, and the circumstances under which use or disclosure will be allowed.
- Have a written or electronic copy of its internal privacy policies.
- Establish a process for members to file privacy complaints.
- Implement safeguards to prevent unauthorized or unintentional uses and disclosures.
- Train employees to follow privacy practices and procedures.
- Require third-party administrators and other service providers to sign business associate agreements before obtaining protected health information from the plan.

If a health plan is going to be sharing information with its sponsor besides enrollment and summary health information, the legal documents establishing the plan must be amended. Among other things, the following points must be made clear in the amended documents:

- The sponsor can't use or disclose protected health information in ways that are prohibited by the plan documents.
- Any agent acting on the sponsor's behalf must follow the same privacy rules as the sponsor.
- The sponsor needs to contact the plan if it knows of any improper use or disclosure of protected health information.
- If possible, the sponsor needs to get rid of or return protected health information when the information is no longer needed.
- The sponsor can't use protected health information to make employment-related decisions.
- The sponsor will only allow certain people to access protected health information on its behalf. (These people must be identified in the plan documents.)

Understand that this is only a summary of a plan's main requirements at the employer level. For additional requirements impacting employers and other plan sponsors, see the Privacy Rule.

Exemptions for Some Group Plans

Though HIPAA's rules about insurance portability and nondiscrimination still need to be followed, the Privacy Rule doesn't apply to self-insured health plans with fewer than 50 participants. Group plans that only offer life insurance, disability insurance or some other non-health kind of coverage are also exempt.

Using Information for Marketing Purposes

Covered entities can't use or disclose your protected health information for marketing purposes without consent. A covered entity is marketing to you if it is communicating with you about a product or service and encouraging you to purchase or use the product or service. A covered entity is also generally forbidden from selling your information to a third party, including situations in which the third party just wants to market to you.

There are, however, some cases in which a covered entity can promote goods and services and not be marketing to you. For instance, no marketing is going on (and no authorization is required) if a covered entity is promoting a product or service as part of legitimate treatment. If you phone your doctor and complain of certain symptoms, your doctor generally can recommend a particular drug to you as a way of relieving those symptoms. Also under HIPAA, marketing is not necessarily going on when a covered entity is using your information to promote a health-related product or service that it provides.

A covered entity doesn't need your authorization before marketing products and services to you in a face-to-face conversation or when giving you a small promotional gift.

Marketing Rules Under the HITECH Act

Through the HITECH Act, Congress tightened and clarified the HIPAA marketing rules for covered entities and their business associates. Among other things, the law added the following rules:

- If a covered entity or business associate is disclosing your protected health information in exchange for compensation, the authorization form that you sign must state whether the party receiving the information can resell it.
- If you receive communication from a covered entity for the purpose of fundraising, you need to have a way to opt out of future fundraising communications.

Even if a covered entity is marketing products or services to you that are provided by that entity, your authorization might still be required. Much will depend on whether a third party is paying the covered entity to do the marketing. (As an example, think of a health plan that's being paid to advertise a particular benefit, or a doctor who's being paid by an equipment manufacturer to market certain procedures to all patients.)

Sharing Information With the Government, the Courts and Other Authorities

There are plenty of times when government authorities and courts could benefit from having protected health information. The information might help the government detect illegal activity, assist people in defending themselves or assist local health officials in the containment of infectious diseases.

Covered entities can disclose your information to the government, the courts and other authorities without your authorization. We'll summarize how these disclosures are allowed, but be aware that the Privacy Rule has many specific requirements that will depend on a given situation. If you find yourself in a position where you feel obligated to give health information to a lawyer, a government representative or a police officer, you'll probably want to review the Privacy Rule first or consult an attorney.

The Government

Covered entities can give your protected health information to the government if the information is required by law. They might also share your information as a way of cooperating with regulatory investigations.

The Courts

Whether information can be shared as part of a lawsuit will depend on who's involved in the suit and who's asking for the data.

Covered entities can disclose protected health information if they are a plaintiff or defendant and the information relates to their case. If you are suing your doctor for malpractice, the doctor doesn't need your permission to use your medical records as part of a defense. If your health plan has taken legal action against you for nonpayment, your payment information can be used against you without your consent.

When they aren't plaintiffs or defendants, covered entities can share information without your consent in accordance with a judge's order. When a judicial request is made by a party other than a judge, covered entities can share your information without your consent in either of the following situations:

- The covered entity or the person requesting the information has made a reasonable attempt to contact you and given you a reasonable chance to object to the disclosure.
- A court has issued a protective order that sets privacy restrictions on your information.

Law Enforcement

Law enforcement entities occasionally use protected health information to prevent and solve crimes. Here are a few instances in which sharing information with law enforcement would generally be allowed:

- The sharing is required by law.
- The sharing is done to protect someone from immediate harm.
- The sharing is requested by law enforcement to help identify or locate a criminal. (The Privacy Rule has special limits on the kind of information that can be shared in this scenario.)

Public Health Authorities

Covered entities can share your information with a health authority if the disclosure is made with the intent of protecting the public. Like most other kinds of disclosures, this sharing still needs to be compliant with the aforementioned minimum necessary rule. In other words, if a piece of information isn't needed to fulfill a particular purpose, it's supposed to be kept confidential.

Other Assorted Privacy Requirements

Regardless of whether any protected health information has been shared yet, covered entities need to comply with the Privacy Rule's administrative requirements. You already read about some of these requirements in the section "Fully Insured Plans vs. Self-Insured Plans."

Other than some fully insured plans at the employer level, all covered entities must follow the Privacy Rule by doing the following:

- Appointing a privacy officer to oversee compliance with the Privacy Rule.
- Providing appropriate privacy-related training to employees.
- Applying sanctions against employees and business associates who violate privacy rules.
- Documenting any sanctions against employees and business associates who violate privacy rules.
- Implementing appropriate safeguards to keep protected health information private.
- Creating a process that allows the public to file privacy complaints.
- Documenting any privacy complaints.
- Creating procedures that minimize the harmful effects of privacy violations.
- Not intimidating, threatening or discriminating against people for exercising their HIPAA rights.
- Not forcing people to waive their HIPAA rights for the purpose of treatment, payment, eligibility for benefits or enrollment in a health plan.
- Keeping a written or electronic copy of privacy practices (for at least six years after they are no longer in effect).

Relationship to Other Privacy Laws

We're just about ready to turn away from the Privacy Rule. But before we do, we ought to reiterate that HIPAA's privacy requirements are minimal standards and aren't the only medical privacy rules in existence.

People who aren't covered entities need to understand that being exempt from HIPAA requirements doesn't exempt them from other laws regarding health information. Covered entities need to know that uses and disclosures that HIPAA allows might be prohibited by other laws. In general, if a law provides greater privacy protection than HIPAA, that law must be obeyed.

Health Information Security Rules

The Privacy Rule isn't the only collection of standards that covered entities need to follow. A covered entity and its business associates also need to comply with HIPAA's Security Rule.

Whereas the Privacy Rule deals mainly with how protected health information can be used or disclosed, the Security Rule addresses how the information needs to be guarded. It contains a number of administrative, physical and technical safeguards that need to be implemented whenever protected health information is stored or transmitted in an electronic format.

Information stored on a server or on a desktop computer is considered to be in an electronic format, and so is data that's stored on a removable disk. Information that's transmitted over the phone or via fax generally isn't in an electronic format.

When it was enacted, the Security Rule was applicable only to covered entities (health care providers, health plans and health care clearinghouses). Because of the HITECH Act, business associates are now required to obey it too.

A business associate's obligation to follow the Security Rule's requirements needs to be part of a business associate agreement. If a plan sponsor wants to receive protected health information in an electronic format, the sponsor must agree to implement a security plan of its own.

Implementing a Security Plan

Ever since it was proposed, the Security Rule has made some covered entities nervous. Under the impression that the rule's requirements are too complicated and costly, many providers and plans remain noncompliant with this part of HIPAA.

In reality, the Security Rule was written with flexibility in mind. The people drafting it understood that no two covered entities are exactly the same and that they all have different amounts of technical and financial resources available to them. The rule is intended to be used as a general set of standards that can be followed at all levels of the health care industry without becoming outdated.

So before diving into too many details, we should clarify some basics about what the Security Rule requires and what it doesn't.

Contrary to popular belief, it doesn't force anyone to utilize any particular kinds of software or other computer-related technology. It doesn't even force covered entities or business associates to encrypt electronic health information.

Instead, the Security Rule sets several broad security-related goals and expects covered entities to achieve them in whatever way seems reasonable. In return for being able to choose the specifics of their security plan, covered entities are required to reevaluate that plan if their exposure to security risks ever changes.

When deciding how to implement the standards set by the Security Rule, covered entities are allowed to take the following factors into consideration:

- The covered entity's exposure to security risks.
- The cost of implementing particular security measures.
- The covered entity's existing security measures and how they accomplish the goals of the Security Rule.

Required Safeguards and Addressable Safeguards

The specific safeguards mentioned in the Security Rule are either "required" or "addressable." If a safeguard is required, covered entities must implement security measures that satisfy it. If a safeguard is addressable, covered entities need to at least determine whether the safeguard is reasonable or appropriate for them.

When covered entities believe an addressable Security Rule safeguard is reasonable and appropriate, they need to implement it. When an addressable safeguard isn't reasonable and appropriate, covered entities can ignore it by doing all of the following:

- Documenting that the safeguard isn't reasonable and appropriate.
- Documenting why the safeguard isn't reasonable and appropriate.
- Implementing an alternative safeguard that is reasonable and appropriate.

The required and addressable safeguards are divided broadly into three categories: Administrative safeguards, physical safeguards and technical safeguards. Within those broad categories, you'll often see subgroups of safeguards. These subgroups are known as "standards."

In the next three sections, we've summarized the standards and safeguards and identified which ones are required and which ones are addressable.

Administrative Safeguards

- **Standard:** Security Management Process (Create and implement procedures to protect information, detect security problems and fix security problems.)
    - Safeguard: Risk Analysis (Identify the risks to your electronic data and the size of those risks.) REQUIRED
    - Safeguard: Risk Management (Take steps to bring your identified security risks down to a reasonable level.) REQUIRED
    - Safeguard: Sanction Policy (Create penalties for employees who violate security rules.) REQUIRED
    - Safeguard: Information System Activity Review (Regularly monitor the security of information systems.) REQUIRED
- **Standard:** Assigned Security Responsibility (Choose someone who will be responsible for picking and implementing security measures.) required
- **Standard:** Workforce Security (Take steps to ensure that authorized employees can access information and unauthorized employees can't.)
    - Safeguard: Authorization and/or Supervision (Implement procedures to determine if people should have access to information and how they should be supervised.) ADDRESSABLE
    - Safeguard: Workforce Clearance Procedure (Implement procedures to prevent unauthorized people from accessing information.) ADDRESSABLE
    - Safeguard: Termination Procedure (Implement procedures to ensure that once people lose access, it stays lost.) ADDRESSABLE
- **Standard:** Information Access Management (Determine how access to information should be achieved.)
    - Safeguard: Isolating Health Care Clearinghouse Functions (If you have a department that acts as a health care clearinghouse, take steps so that information from that department isn't shared improperly with other departments.) REQUIRED
    - Safeguard: Access Authorization (Determine how people should be able to access information.) ADDRESSABLE
    - Safeguard: Access Establishment and Modification (Document, review and modify [if needed] how access to information is allowed and achieved. ADDRESSABLE
- **Standard:** Security Awareness and Training (Create training for people within the organization.)
    - Safeguard: Security Reminders (Keep the workforce appraised of security procedures.) ADDRESSABLE
    - Safeguard: Protection From Malicious Software (Protect your system from viruses and similar problems, and train employees about this risk.) ADDRESSABLE
    - Safeguard: Log-in-Monitoring (Take steps to monitor situations in which people attempt to access information but don't succeed.) ADDRESSABLE
    - Safeguard: Password Management (Make procedures for creating, changing and safeguarding passwords, and communicate password policies to employees.) ADDRESSABLE
- **Standard:** Security Incident Procedures (Decide what should be done when there's an issue with information security.)
    - Safeguard: Response and Reporting (Implement procedures for identifying security problems when they occur and minimizing their impact.) REQUIRED
- **Standard:** Contingency Plan (Have a plan for situations in which normal access to information is lost.)
    - Safeguard: Data Backup Plan (Make copies of electronic information for emergency access.) REQUIRED

  - Safeguard: Disaster Recovery Plan (Have a plan for restoring lost access to information.) REQUIRED
  - Safeguard: Emergency Mode Operation Plan (Make sure an emergency doesn't jeopardize the security of information.) REQUIRED
  - Safeguard: Testing and Revision Procedures (Periodically test contingency plans, and revise them as needed.) ADDRESSABLE
  - Safeguard: Applications and Data Criticality Analysis (Determine which computer programs are most important to the handling of protected health information.) ADDRESSABLE
- **Standard:** Evaluation (Evaluate all security plans periodically to address risks and compliance with the Security Rule.) REQUIRED
- **Standard:** Business Associate Contracts and Other Arrangements (Don't share information with business associates unless you believe they'll keep it protected.)
  - Safeguard: Written Contract or Other Agreements (Document a business associate's obligation to keep information safe.) REQUIRED

Physical Safeguards

- **Standard:** Facility Access Controls (Implement procedures that limit access to information and to the facility housing the information.)
  - Safeguard: Contingency Access Controls (Have a way to make information secure and/or adequately accessible when a contingency plan is underway. ADDRESSABLE
  - Safeguard: Contingency Security Plan (Take steps to address theft, tampering or unauthorized access of electronic information at the facility.) ADDRESSABLE
  - Safeguard: Access Control and Validation Procedures (Determine who at the facility should have access to areas where information is accessible.) ADDRESSABLE
  - Safeguard: Maintenance Records (Document any repairs and modifications that relate to the physical security of the facility.) ADDRESSABLE
- **Standard:** Workstation Use (Implement policies explaining how devices related to electronic information are to be used, including devices used outside of the facility.) REQUIRED
- **Standard:** Device and Media Controls (Develop policies regarding how information should be received, handled and disposed of on hard drives or portable storage devices.)
  - Safeguard: Disposal (Implement procedures regarding how to dispose of information and the items on which it's stored.) REQUIRED
  - Safeguard: Media Reuse (Require that media storage devices can't be reused unless old information is deleted from them.) REQUIRED
  - Safeguard: Accountability (Document cases in which information is moved from place to place.) ADDRESSABLE
  - Safeguard: Media Backup and Storage (Ensure that information has been copied before moving the equipment that stores it. ADDRESSABLE

Technical Safeguards

- **Standard:** Access Control (Create methods and controls to ensure that information is only accessible to authorized personnel.
  - Safeguard: Unique User Identifier (Be able to track users of information systems by name or identification number.) REQUIRED
  - Safeguard: Emergency Access Procedure (Implement ways for information to be accessible in emergency situations.) REQUIRED
  - Safeguard: Automatic Logoff (Use a system that logs people off after an extended period of inactivity.) ADDRESSABLE
  - Safeguard: Encryption and Decryption (Figure out how to encrypt and decrypt information.) ADDRESSABLE
- **Standard:** Audit Controls (Implement procedures for recording activity on systems.) REQUIRED
- **Standard:** Integrity (Take steps to ensure information can't be improperly changed or deleted.)
  - Safeguard: Mechanism to Authenticate Electronic Protected Health Information (Monitor whether information has been inappropriately altered or destroyed.) ADDRESSABLE
- **Standard:** Person or Entity Authentication (Take steps to ensure that people trying to access information are who they say they are.) REQUIRED
- **Standard:** Transmission Security (Take measures to prevent unauthorized access while information is being transported through a network.)
  - Safeguard: Integrity Controls (Make sure information isn't modified or destroyed during transmission.) ADDRESSABLE
  - Safeguard: Encryption (Use a system that encrypts data when appropriate.) ADDRESSABLE

Dealing With Security Breaches

The Privacy Rule and Security Rule made covered entities responsible for the proper use and disclosure of protected health information. But until 2009, nothing in HIPAA or its related statutes guaranteed that a victim of a serious privacy breach would ever be alerted to the situation. While some states had laws requiring breach notifications, many others didn't address the issue and let covered entities make up their own minds about whether contacting affected persons was appropriate.

One of the most significant changes brought on by the HITECH Act was the requirement that covered entities notify individuals of security breaches. The law also forces business associates to alert covered entities when protected health information has been used or shared in unauthorized ways.

Breach notifications only need to be made when the wrongfully used or disclosed information was "unsecured." For data that is stored electronically, information generally is unsecured when it has not been destroyed or encrypted. For data stored on paper, information generally is unsecured when it has not been destroyed or shredded.

Under the law, breach notifications are required unless the covered entity can demonstrate that an individual's privacy was

probably not compromised. If a disclosure is technically a HIPAA violation but isn't likely to compromise someone's privacy, a covered entity isn't obligated to contact the victim.

When deciding whether a notification is necessary, covered entities are advised to consider both the kind of information that has been breached and the person who gained access to the information. If covered entities determine that notification isn't necessary, they still need to document the unauthorized use or disclosure and their reason for not notifying anyone.

There doesn't need to be proof of a breach for the notification requirement to go into effect. If a situation suggests there might have been a breach, it needs to be treated as though one actually occurred.

Breach Notifications

A notice to an affected individual must contain the following:

- The date when the breach occurred (if known).
- The date when the covered entity became aware of the breach.
- The steps that have been taken to minimize harm to the individual.
- The steps the individual can take to minimize harm.
- Contact information that can be used to find out more about the breach.

Breach notifications need to be made to affected individuals no later than 60 days after a covered entity either knows of a breach or reasonably should have known about it. This includes any time when an employee or agent of a covered entity knew about a breach but didn't report it.

Covered entities can delay notifications if they receive a request from law enforcement. If the request is made orally, an entity can delay notification for 30 days. When the request is in writing, the entity can wait until the time specified in the request. The law allows these delays in order to keep notifications from compromising criminal investigations.

Breach notifications should be made via first-class mail and sent to the individual's last known address. A covered entity can notify people by email if they have already agreed to be reached that way, or by phone if other forms of communication are too slow to prevent harm. If an affected individual has died, the covered entity can send the notice to the person's personal representative or next of kin.

When a breach involves 10 or more people whose contact information is unknown, the covered entity has two options. Notification of the breach to those people can be made on the home page of the entity's website for 90 days, or it can be made through a toll-free telephone number that is active for 90 days. The entity is required to advertise the phone number in the local print and broadcast media.

Breaches that require notifications also need to be reported to the Department of Health and Human Services. Breaches involving less than 500 people in a state or other jurisdiction need to be reported to the government in annual reports within 60 days after each calendar year. For larger breaches, a covered entity needs to notify the government at the same time that affected individuals are given notice, and advertising must be done in print and broadcast media.

Criminal and Civil Penalties

The HITECH Act increased the size of penalties for HIPAA violations and made them applicable to covered entities, business associates and employees. The severity of a penalty will depend on the violator's history of compliance, the violator's knowledge of the law and the violator's intent.

Civil monetary penalties range from $100 for a single mistake to $1.5 million for repeated serious offences. Criminal offences can land a violator in jail for as long as 10 years if the person broke the law with malicious intent or for financial gain.

Conclusion

HIPAA remains an important law for anyone who is concerned about medical privacy. Students who are interested in potential changes to HIPAA should periodically contact the Department of Health and Human Services or visit the department online.

CHAPTER 4: FIGHTING INSURANCE FRAUD

Introduction

Insurance fraud is a costly and even dangerous crime, but it can easily slip down our list of priorities. Outside the insurance industry, the public often fails to see the harm in this form of financial deceit. And even inside the insurance business, the tasks of monitoring, identifying and stopping insurance fraud have an unfortunate tendency to get pushed aside by busy sales personnel and left for claims specialists who can only take action against a scam after it has occurred.

This chapter encourages greater fraud prevention efforts at every stage and from every player in an insurance transaction. As an insurance producer, you'll learn how to frame the goals of anti-fraud endeavors in ways that should bring consumers to the right side of the issue so that the average insurance buyer recognizes his or her vested interest in reporting possible wrongdoing. You'll also discover how some common insurance frauds work, and you'll be challenged to spot potential warning signs before an insurance product is ever issued to a seemingly shady applicant.

How Big Is the Problem?

For a variety of reasons, measuring the size and frequency of insurance fraud isn't a simple task. Perhaps the largest barrier to calculating firm statistics is that the only indisputable numbers about these crimes are from cases in which criminals became sloppy and didn't get away with a scheme. We can't determine with absolute certainty how often the more careful crooks cheat an insurer out of money and walk away undetected.

Another problem with measuring insurance fraud relates, frankly, to the sometimes conflicting ways in which insurance carriers and the public define the crime. Consider, for example, the differences between cases of what is sometimes called "hard fraud" and instances of what is sometimes called "soft fraud."

In hard fraud, the primary motive is to enrich oneself via insurance money, such as by staging an auto accident or setting insured property on fire. In soft fraud, however, people may have suffered a legitimate loss or purchased insurance for legitimate reasons and only later given in to the opportunistic temptation of lying to an insurance company. Depending on how broadly, the term is used, examples of soft fraud might include lying about the value of personal belongings destroyed in an accidental fire, exaggerating the amount of damage to a vehicle in an auto accident, intentionally misrepresenting the ZIP code where a car

is principally garaged in order to save a few dollars on auto insurance or not disclosing tobacco use to a life insurance agent.

To most insurance companies, the invisible lines separating hard fraud from soft fraud might be irrelevant or nonexistent. Those companies and the people who work for them take both types of fraud extremely seriously and would probably prefer that consumers and law enforcement do the same. For them, any estimate of fraud and its consequences must include not only the most egregious attempts at hard fraud that occur every once in a while but also the myriad examples of soft fraud that occur every day.

To consumers, though, the separation between hard fraud and soft fraud is much more pronounced. In fact, many insurance buyers don't consider soft fraud to be fraud at all. The general public might not condone padding an insurance claim after a fire, for example, but they're likely to view it less seriously and not support heavy punishment—if any at all—for people who engage in it. For them, policyholders who commit soft fraud might be unethical but aren't necessarily deserving of being called criminals. Therefore, consumers with this mindset might believe that estimates of fraud should only include instances of hard fraud.

Despite those challenges, the insurance industry and some of its partners have still attempted to arrive at some fraud-related statistical conclusions:

- The Coalition Against Insurance Fraud estimates that, for all lines of insurance combined (not including government insurance programs), insurance fraud costs insurance companies $80 billion per year.
- The Insurance Information Institute has estimated that 10 percent of property and casualty insurance losses involve some element of fraud.
- According to a survey conducted by the Fair Isaac Corporation (FICO) in 2013, nearly one-third of U.S. and Canadian insurers said they believed fraud accounted for more than 10 percent and, in some cases as much as 20 percent, of claims costs.
- According to the Michigan Fraud Awareness Coalition, at least one in six residents in that state claimed to know someone who had committed insurance fraud.

Consequences of Insurance Fraud

For the person who engages in insurance fraud, the consequences of getting caught include having his or her insurance policies voided by the carrier, not being eligible for future insurance and perhaps even facing legal prosecution.

But fraud's impact extends beyond the perpetrator. No matter if we're the producer selling insurance or just an insurance prospect going about our daily life, we should care about insurance fraud because it has the potential to harm all of us.

Since the estimated amount of money lost to insurance fraud is so large, insurance companies cannot be expected to merely write off those losses as the cost of doing business. Instead, innocent, law-abiding consumers can rely on having those losses passed down to them in the form of higher insurance premiums. For example, several regulators from a variety of states agree that the average American family pays approximately an extra $1,000 per year due to fraud. Similarly, anti-fraud advocates stress how fraud committed against government insurance programs, such as Medicare, can result in wasted tax dollars and higher cost-sharing requirements (in the form of larger deductibles, premiums and copayments) for patients.

Although their impact is not as widespread, certain insurance fraud schemes must be rooted out in the name of public safety. For example, complex scams involving staged auto accidents have occasionally gotten out of control and harmed not only insurance companies and their premium-paying customers but also innocent bystanders who have been injured or killed while crossing the street or otherwise minding their own business.

For only a small sample of cases in which insurance fraud caused legitimate physical harm to victims, consider the following items compiled from Coalition Against Insurance Fraud, the National Insurance Crime Bureau and assorted news publications:

- An Indiana man caused a natural gas explosion in his home for the insurance money but damaged approximately 80 neighboring properties, killed two of his neighbors and injured roughly a dozen others in the process. Security cameras recorded one of the victims pleading for help from emergency workers as he died.
- A Virginia doctor allegedly lied to several of his patients, claiming they had skin cancer, just so he could perform unnecessary procedures on them and bill their insurance companies.
- A Florida eye doctor needlessly stuck needles into patients' eyes and performed botched laser surgeries in a scam that bilked insurers out of more than $130 million.
- A pet store owner committed arson for insurance money while leaving nearly 30 dogs in their cages.
- A Michigan spinal surgeon performed negligent and unnecessary surgery on several patients, leaving some of them with permanent injury and disfigurement, while collecting more than $30 million from medical insurers.
- A Minnesota father beat his son to death and hurled him into a nearby river in an attempt to obtain a $50,000 death benefit from a life insurance company.
- Physicians in Illinois preyed on the homeless community, drug addicts and the elderly, bribing them with food, money and cigarettes to complain of heart ailments and ultimately undergo pointless heart catheterizations, angioplasties and expensive tests.

In addition to containing the common theme of greed, these stories and countless others like them highlight the danger of setting our suspicions about fraud aside. Rather than viewing insurance fraud as a white-collar crime, we must remember how it can do real harm to real people.

Public Perceptions of Insurance Fraud

The public's tolerance for insurance fraud and for the people who commit it is mixed at best. Whereas a 2013 survey conducted by the Insurance Research Council found that more than 80 percent of people agree that insurance fraud can negatively impact the size of premiums, studies conducted by the Coalition Against Insurance Fraud suggest that too many consumers will look the other way when they suspect fraud. In 1997 and again in 2007, the organization surveyed the public and ultimately grouped each respondent into one of four categories based on his or her reaction to fraud-related questions. Overall, during the 10-year gap between the initial and follow-up study, the public's tolerance for fraud increased. Other troubling findings from the follow-up study appear next:

- The number of "moralists," who have no tolerance for insurance fraud and view it as a punishable offense, dropped from 30 percent to 26 percent.

- The number of "realists," who have a low tolerance for insurance fraud but say they understand why it might be committed, remained consistent at 21 percent.
- The number of "conformists," who don't really care about insurance fraud and assume nearly everyone does it, ticked up from 25 percent to 26 percent.
- Perhaps most discouragingly, the number of "critics," who believe insurance fraud is justified, rose from 20 percent to 26 percent.

No matter the age of the data, the two main reasons why a sizable portion of the population will either support or at least ignore insurance fraud don't seem to change. First, compared to other crimes, insurance fraud is viewed as relatively harmless, impacting an impersonal corporate entity rather than hurting everyday people. Second, too many consumers see insurance companies as villains, particularly when the cost of insurance goes up and/or when an insurance claim is not handled to the policyholder's satisfaction.

Not surprisingly, according to a 2010 report from Accenture Research, more than half of adults believe poor service from an insurance company will increase the chances of someone committing fraud against that company. Similarly, in its 2016 annual report, the Coalition Against Insurance Fraud stressed that better service is a fraud deterrent and that policyholders who have a positive experience with an insurance claim are less likely to tolerate insurance fraud.

In an effort to enhance public support against fraud, the coalition has also made the following basic recommendations, among others, to the insurance industry:

- Work to attach a greater social stigma to insurance fraud, so people who might otherwise entertain fraudulent activity will be too ashamed to act on their plans.
- Make it simple for consumers to report suspected fraud rather than requiring significant evidence for an investigation.
- Keep promoting the connection between insurance fraud and higher premiums.
- Maintain a zero-tolerance message against fraud rather than making distinctions between, for example, the aforementioned "hard fraud" and "soft fraud."
- Pressure insurance companies to act as good corporate citizens.

Government Responses to Fraud

Like insurance companies, state regulators generally understand that insurance fraud can cost consumers significant money. Several states have carved out spots within their insurance department specifically for the purpose of fighting fraud. And according to the Coalition Against Insurance Fraud, by 2015, more than 40 states mandated that insurance companies report suspected fraud to regulators or other authorities. Still, particularly in cases of elaborate schemes committed by groups of criminals, fighters against fraud sometimes worry that as one state decides to devote more resources to the problem, gangs committed to hurting insurers will simply move elsewhere and continue their illegal efforts.

Insurer Responses to Fraud

When confronted with the possibility of consumer fraud, insurance companies must choose essentially between two basic options: Fight it or forget about it.

As much as the industry might want to weed out every instance of dishonesty by an applicant or policyholder, it must also cope with the realities of limited resources and possible public relations nightmares. Spending several thousands of dollars to catch and ultimately help prosecute someone whose alleged act of fraud only amounted to a few hundred dollars certainly sends a strong statement, but it might not be the most cost-efficient response. Meanwhile, a carrier with its sights set on building a positive image with the public might decide to pick its fraud-related battles carefully in order to avoid being perceived as a stingy corporate citizen that victimizes its own customers.

But for those cases in which fraud seems too big, too obvious or too important to ignore, carriers continue to add to their arsenal in the battle against crime. It's not uncommon for an insurer to maintain an anonymous hotline via which suspected dishonesty can be reported for further investigation. Many companies take fraud prevention seriously as part of their sales training and emphasize the ways in which even one insurance agent can spot major warning signs. Evolving technology, too, has sometimes been an insurance company's indispensable ally in opposition to fraud, with GPS devices, social media networks and even heartbeat-measuring tools all validating suspicions about claims that couldn't have been investigated effectively in previous decades.

Let's look more carefully at fraud-fighting resources available at the carrier level.

Special Investigation Units

Most insurance companies utilize a "special investigation unit" (SIU) when their claims division detects a high probability of fraud. The SIU operates as a subdivision within the insurer's claims department or as an independent entity that the carrier can utilize on an as-needed basis.

In addition to understanding important aspects of insurance, members of SIUs typically have experience within law enforcement. Some, for example, are likely to be former police officers or private investigators. They understand not only how to sniff out suspicious activity but also how to investigate it in an efficient way that will produce credible evidence of wrongdoing.

Although it lacks police powers, such as the ability to arrest a suspect, an insurer's SIU can often perform limited types of surveillance (such as noninvasive monitoring of a claimant who is suspected of falsifying a disability or workers compensation claim) and often takes steps to enforce the insurance company's rights found in the applicable policy language, such as the right to require submission of detailed documentation and the right to require sworn statements from a claimant. If an investigation strengthens the case against an alleged criminal, the SIU will refer the case to the appropriate law enforcement agency, including local police, state prosecutors or even (in cases involving possible money laundering, terrorism or other dangerous crime) the Federal Bureau of Investigation.

Due to the enhanced skills and deeper analysis conducted by an SIU, the costs associated with utilizing this team aren't always justifiable. Therefore, an insurer typically won't refer a case to its SIU unless red flags about a claim are too prominent to ignore.

In addition to the enhanced costs, the insurer must also consider whether the likelihood and degree of fraud is high enough to justify the enhanced pressure that an SIU's investigation might put on a claimant. Even though an insurer hopes to eliminate fraud, there is always the possibility that a thorough investigation will amount to no further action by the carrier, as well as the

chance of the carrier being sued for failure to pay a legitimate claim.

Social Media Tools

Ever since the widespread utilization of Facebook and other social media networks, insurance companies have been able to catch fraud participants by monitoring claimants' online activities. According to data reported in 2017 in the Journal of Internet Law, two-thirds of insurers use social media to investigate possible fraud.

Simple examples of fraud detection via social media include cases in which people receiving disability insurance payments post public photos of themselves rock climbing, skydiving or engaging in other physically strenuous activities. In another scenario, thrill-seeking drivers who engage in drag racing or intentional car crashes will sometimes post videos of these events in an attempt to gain fame with their online communities but will forget that those same incriminating videos might be publicly viewable by an auto claims adjuster. In one of the more amusing cases of a social media gaffe, as reported by the San Gabriel Valley Tribune, a woman who received insurance assistance after a supposedly serious back injury faced fraud allegations when she posted a video of herself hurling a heavy, several-gallon bucket of ice water onto a colleague in an attempt to raise awareness for Lou Gehrig's Disease.

A more complex use of social media as an antifraud tool might involve tracking the connections within social media networks, such as noting when witnesses to auto accidents are identified online as friends of the drivers in those same accidents.

No matter its effectiveness, social media's role in fighting insurance fraud can raise ethical and legal concerns. For example, although most insurers are likely to agree that a consumer's public posts on social media are fair game as evidence for a fraud investigation, what about social media posts with privacy settings that limit access to just a person's social media connections (such as Facebook "friends")? If fraud is suspected, should an insurance investigator pretend to be an alleged criminal's friend in order to gain valuable access to those posts? Given the privacy and compliance issues they raise, questions such as these should be addressed carefully at the carrier level with help from competent legal counsel.

Fraud Analytics in Insurance

While it's still possible for an experienced claims adjuster to review a set of facts surrounding a loss, notice that they don't make much sense and identify a probable instance of insurance fraud based purely on professional experience, a more efficient method for separating legitimate claims from questionable ones will involve data analytics. According to a November 2016 report from the Coalition Against Insurance Fraud, 75 percent of insurers use automated systems to analyze claims information in an attempt to detect false claims.

Automated systems at many carriers can predict inaccuracies in a claim, connect the dots between multiple claimants who might be working together in fraudulent activities, flag when the same party is constantly named as part of an insurance claim and point toward curious irregularities that should at least lead to further investigation by properly trained insurance professionals.

For example, data analytics at some health insurance companies and in the Medicare system have been effective at flagging scenarios in which a pharmacy consistently bills insurers for a hugely disproportionate amount of uncommon drugs. In auto insurance, organized crime was detected by analytics after more than 30 people within the same California county appeared frequently in accident reports (serving in various roles and all claiming to have spilled coffee on themselves) soon after buying their cars.

Producers and Antifraud Efforts

Previous perceptions of insurance fraud focused almost entirely on the claims stage in the transaction. Today, insurance companies realize fraud can also occur—but perhaps be prevented—in other phases, too, such as during the application process or while underwriting is underway. Suspicious activity during those earlier points can hint at future attempts at claims fraud. They can also relate to fraud that has less to do with claims, such as fraud designed to help someone get insurance either at a lower rate or for a risk that a carrier would otherwise deem uninsurable.

By emphasizing the possibility of insurance fraud during every stage of a transaction, and by enlisting producers and underwriters in the fight against consumers' deceptions, insurance companies become more likely to stop illegal behavior. Meanwhile, this broad approach to attacking fraud can show the public that a distaste for insurance fraud—not a resistance to paying legitimate claims—is the motivating factor behind a carrier's sometimes tough actions.

No matter the line of insurance in question, producers must understand that they are almost always the most human link between an insurance customer and the insurance company. If a consumer has any kind of relationship with an insurance professional at all, the relationship likely exists with the person selling and serving the policy rather than with an underwriter or a claims representative.

This position puts producers in the front lines against insurance fraud because they are more likely than other insurance professionals to know details about a consumer's situation and character. Such personal knowledge can be critical to not only identifying warning signs of fraud but also helping others within an organization collaborate on next steps regarding the odd information or strange behavior. A watchful and engaged insurance producer has the potential—albeit not the sole responsibility—to flag peculiarities that a disengaged insurance person would never see. Similarly, that same careful producer might be able to provide helpful feedback that prevents an innocent situation from evolving into a needlessly costly and intrusive investigation. Like claims adjusters, producers shouldn't be expected to deal with fraud detection on their own, but they are integral to an insurer's crimefighting team.

Many worrisome signs related to potential fraud are specific to a certain type of insurance. For now, though, it's important for us to point out some basic behaviors that might cause a producer to pause and think about what's really taking place, regardless of the coverage being sought.

Possible signs of fraudulent behavior at the application stage across practically all lines of insurance are listed below:

- The applicant comes to you for insurance advice in an unconventional way. For example, if your entire business is built around referrals and centered on clients who reside within a certain geographic range, should you be suspicious when someone from a faraway community wants to do business with you and has no connections to any of your existing or former clients?

- The applicant demands that coverage be issued as soon as possible.
- The applicant insists on paying all premiums upfront and in cash, no matter the amount.
- The applicant provides a strange mailing address (such as a PO box in another state) or a suspicious phone number that no one ever seems to answer.
- The applicant has no special insurance training but somehow clearly understands how insurance claims are processed. This might seem like an even bigger red flag if the applicant expresses concern about how a particular carrier processes claims compared to competitors and if the person has already accumulated a spotty loss history.
- The applicant's previous loss history (if known) seems disproportionately weighted toward suspicious claims, such as multiple fires at different properties or multiple children with life insurance all dying at early ages.
- The applicant seems abnormally concerned about issues other than the coverage itself, such as any "free-look" or cancellation opportunities or whether the transaction will require reporting to the IRS or some other regulatory body. Like insisting on cash-paid premiums, such behavior might be a sign of attempted money laundering.
- The applicant is unreasonably combative when asked for basic information.
- The applicant openly admits to experiencing major financial difficulties.

These behaviors don't guarantee that a prospect intends on committing fraud or doing harm, but they certainly should prompt an experienced insurance professional to connect the situation's dots and utilize sound judgment.

Examples and Red Flags of Insurance Fraud

Having mentioned warning signs that could occur in a wide range of insurance transactions, let's drill down into fraud awareness in specific lines of insurance.

Property Insurance Fraud

Unfortunately, myriad opportunities exist for property owners to commit fraud. For example, the Insurance Fraud Bureau of Massachusetts, created by the state's legislature and funded by the state's insurance companies, has identified the following activities as the most common types of property insurance fraud:

- Bogus reports of property theft.
- Exaggerating the value of stolen goods or the amount of insured property damage.
- Intentional damage to insured property.
- Concealment of how insured property is used (for example, hiding the fact that a building is used as a rental property rather than as the owner's residence, or not disclosing that property is used for business rather than for personal purposes).

The probability of these or similar fraudulent actions might be higher in cases where the policyholder has experienced financial problems, such as looming foreclosure on a home or the likely closure of a failed business.

Let's look at more specific types of property insurance fraud in greater detail. Some frauds are perpetrated by property owners, whereas others actually victimize consumers and are masterminded by unethically opportunistic contractors.

Fraud by Property Owners

Scenarios in which property owners commit insurance fraud include (among other schemes) arson, faked burglaries (where allegedly stolen property is actually stored at an alternate location) and the padding of otherwise legitimate claims (such as claiming to lose more property than is truly the case after a break-in or fire).

Some possible warning signs related to property insurance fraud by property owners are listed below:

- A claim involves personal property that had been added very recently to the owner's insurance policy.
- A claim involves a major loss that would not be covered in full if not for recent increases in the policy limits.
- A claim involves a structure that was on the verge of being lost by the owner, such as a home facing foreclosure or a commercial building nearing condemnation.
- A claim involves expensive items that have mysteriously disappeared. (This red flag helps explain why most insurance companies either don't cover certain items when they simply can't be found or at least why certain items—such as jewelry—might only be covered against this risk for a limited amount or for an extra charge.)

Arson

Arson is the act of intentionally starting a fire in order to cause physical damage or physical harm. Although arson is associated mostly with burning buildings, it can also be committed to damage an automobile. According to the National Fire Protection Association, more than 250,000 arsons occurred annually from 2007 to 2011, causing an estimated $1.3 billion in property damage.

Arson demands special attention in a course about insurance fraud because it doesn't just result in unfair financial losses for insurers but also has great potential to be linked to dangerous crimes, such as attempted murder. Even when arson is committed for insurance money, plenty of those intentional fires have gotten out of control, harmed neighbors' property, put firefighters at significant risk and killed innocent victims. The aforementioned four-year period studied by the National Fire Protection Association (and reported subsequently by the insurance trade publication "Risk Management") included more than 400 civilian deaths related to arson and more than 1,300 civilian injuries.

Some signs that might point to arson in a fire insurance claim include:

- The fire occurred while the property owner (or, in commercial insurance, the business owner) was experiencing serious money problems.
- The owner had time to save an extraordinary number of valuables from the fire, rather than the few items that a person might be capable of carrying away in a truly unexpected emergency.
- Multiple fires have occurred at the same location during a short stretch of time.

Fraud by Contractors

In some cases following significant property damage (and often after a natural disaster), insurance companies are victimized not by their customers but by contractors who claim to have done repairs for those customers and who want substantial reimbursement.

Sometimes those contractors intentionally overbill an insurance companies for repairs actually completed. In extremely unethical scenarios, a contractor might actually cause damage on purpose, without a homeowner's knowledge, in order to inflate the amount of insurer-paid compensation. In either case, these contractors often believe that an insurer will be either too swamped with claims after a disaster to spend time fighting an inflated claim or will at least be hesitant to fight a claim out of fear of seeming stingy after widespread tragedy. Unfortunately for the insurance industry, these guesses are frequently correct.

For contractor-initiated scams to work, the policyholder must "assign" his or her insurance benefits to the contractor. In other words, the insurance customer must actively agree that any insurance money that would ordinarily be owed to him or her will instead go directly to the contractor for services rendered. This is often possible via an "assignment of benefits clause" in a property insurance policy.

Although some carriers have derided the existence of assignment of benefits clauses, these provisions in insurance policies aren't entirely without value. In legitimate instances, they can help an insured person receive services from a third party even if the insured person can't pay upfront for the work. The clauses, when not abused, can also sometimes result in smoother claims processing, since the service providers typically have more experience dealing with insurance claims than the average consumer. In fact, assignment of benefits is a common and often encouraged practice in health insurance, where patients sign forms at a medical office so that their doctors can bill insurance companies directly rather than forcing the patient to fill out and send complicated paperwork on their own.

No matter the arguments and counterpoints related to assignment of benefits, property owners should take precautions to ensure that the contractors who approach them are likely to treat them and insurance companies fairly.

Common recommendations for homeowners who want to avoid doing business with unethical contractors appear next:

- Confirm that the contractor is licensed and has proof of insurance.
- Ask the contractor for references from previous customers.
- Be careful when a contractor seems to overemphasize the need to assign benefits. (Assignment of benefits should always be the policyholder's choice and not mandated by the contractor.)
- Research whether the contractor has a publicly advertised business address and phone number.
- Although typically not required, consider using contractors recommended by the insurance company.

Auto Insurance Fraud

With so many cars on the road, it's perhaps not surprising that auto insurance fraud has taken many forms. Whereas some fraud-related techniques tend to dominate in states where no-fault auto insurance systems exist, others occur throughout the nation, no matter a particular state's approach to accident liability.

Some common examples of auto insurance fraud committed by an individual driver (rather than by a group of organized criminals) are as follows:

- A driver suffers legitimate damage in an accident but bills an insurer for repairs of pre-existing damage unrelated to the accident.
- A driver lies about where a vehicle is principally garaged. (With auto insurance premiums influenced heavily by ZIP codes, the distance of a few miles can make a significant difference in the cost of coverage. In general, urban areas with more traffic or instances of auto theft tend to correspond with higher insurance rates than rural areas.)
- A driver fails to disclose whether a personal automobile is also used for business.
- A driver fails to disclose the amount and identities of others who have regular access to the insured vehicle.
- A driver intentionally underestimates how frequently a car is driven.
- An uninsured driver suffers property damage in an accident, buys insurance quickly and then claims that the accident occurred after the policy had been issued. (This attempt at fraud is known as "crash and buy.")
- A driver reports a vehicle stolen even though it has actually been dismantled and sold for parts.
- A driver's account of an accident is in conflict with data available to the insurance company (such as weather reports on days when an accident is alleged to have been caused by slippery roads, or data from insurer-installed devices that monitor an insured driver's speed and other behind-the-wheel activities).
- An accident occurs very soon after coverage is issued.
- The location where a vehicle will allegedly be garaged does not match the driver's mailing address or public records.
- A driver asks if coverage can be backdated so it can go into effect retroactively.
- The number of drivers insured under a policy is in conflict with what the driver has told an insurance professional about the size of his or her household.

Staged Auto Accidents

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 utilizes 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, tow-truck operators, repair shops, 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 that want to keep their money out of crooks' hands. 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 functions:

- 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 roads in an area where reasonably high speed limits are permitted but where twists and turns make driving a bit more challenging, 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.

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. Or perhaps they decide to racially profile a victim. A seemingly foreign-born person who might be an undocumented immigrant and worried about being reported to authorities would be a good target because he or she might be less likely to call police or more easily intimidated into going along with whatever story Rob and his friends concoct.

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 a 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 the 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 already 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, they would probably threaten to expose the whole operation. But on second thought, 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 persistence to get the insurance companies to pay the claims.

With any luck, the fraud will be executed without causing any serious injury to victims, unlike the one in which a scam artist hit and killed a 71-year-old grandmother named Alice Ross and the one in which a driver who was supposed to hit another vehicle accidentally hit a telephone pole and killed 64-year-old Altagracia Arias, who allegedly had been drafted into serving as a witness to the staged crash.

Rob might think about those two cases of organized auto insurance fraud gone wrong and feel sad for a moment or two, but this feeling would likely go away when he is reminded of the insurance checks that will soon be provided 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.

According to the National Insurance Crime Bureau, common methods for staging auto accidents and preying on innocent drivers include the following:

- A "swoop and squat," in which a car cuts off a driver in front of a victim and forces the victim to slam on the brakes.
- A "drive down," in which a victim gets a signal to merge into a lane from a criminal, only to have the criminal slam into the victim's car.
- A "panic stop," in which a criminal acting as a passenger keeps staring at the car behind him or her, waits until that driver seems distracted and then orders a partner to slam on the brakes.

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 wait 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 necessarily 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.

With all these complexities and consequences in mind, here are some warning signs of possible auto insurance fraud committed by organized criminals:

- Databases show that the same people tend to be involved in multiple accidents, often playing different

roles. (For example, the driver in one accident was a witness in a second accident and a passenger in a third.)
- Evidence suggests that someone involved in the accident was reluctant to notify police and file a report.
- The amount of alleged physical injury seems disproportionate to the amount of physical damage to the vehicles.
- An alleged accident victim receives an abnormally high amount of treatment from one medical provider and is never referred to a specialist.
- The number of passengers in the alleged accident was significantly higher than the car's capacity. (Extra passengers might've been stuffed into the car to allow for more claims of physical injury.)
- Injuries sustained by victims are "soft-tissue" injuries—such as back pain or whiplash—that can't easily be proven or disproven by x-rays, body scans or other standard medical tests.
- Alleged accident victims are frequently utilizing a medical clinic with connections to their attorney.
- Alleged accident victims frequently report being struck by a hit-and-run driver or a vehicle that "came from out of nowhere."

Fraud by Body Shops

As if being in an auto accident weren't stressful enough on its own, some accident victims will unintentionally become paired with unethical collision-repair shops that have no problem committing insurance fraud. Along with stealing money from insurers, some of these unethical shops put their customers' physical safety at risk. For example, according to the National Insurance Crime Bureau, a shop might replace an airbag or other critical parts with used or defective materials obtained at a discount and bill for the replacement as if everything were brand new and of the highest quality. Alternatively, it might bill for services never performed and repairs never made.

To reduce the risk of unwittingly using an unethical body shop, drivers are encouraged to seek written warranties for installed repair parts and to consider using collision-repair service providers recommended by an insurance company. (Note, however, that some states have made it illegal to make the payment of an auto insurance claim contingent on the driver's use of an insurer's favored service provider.)

Workers Compensation and Disability Insurance Fraud

Faked or exaggerated physical accidents related to disability insurance or workers compensation have become stereotypical examples of insurance fraud committed by consumers. But although a 2014 report published by the trade publication Best's Review estimated that roughly a quarter of workers compensation claims involve fraud, it's important to understand that costly untruths can come not only from a worker but from an employer, too. Let's look at disability and workers compensation fraud from both types of sources.

Fraud by Workers

If a workers compensation claim doesn't seem to make sense, some kind of investigative team will likely 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.

As part of an investigation, 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 during free time 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 can 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 a 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 three years.

Fraud by Employers

When business owners commit insurance fraud with respect to workers compensation, their goal is usually to reduce their insurance premiums and tax-related responsibilities. Through a method called "misclassification," businesses might lie about their number of employees—as opposed to independent contractors—or aim to convince an insurance company that some of their workers with high-risk jobs are actually doing low-risk tasks. For example, a construction company might claim its roofers are actually engaged in general carpentry, or a manufacturer might declare that its warehouse employees are clerical workers. Some entities will even go so far as to establish

shell companies abroad to make it appear as though they have significantly fewer employees on their books. While lowering their workers compensation premiums, many of these schemes also aim to reduce a business's payroll tax liability.

In addition to harming insurers and indirectly raising insurance costs for honest businesses, companies that engage in intentional misclassification victimize their workers. Following an occupational accident, a laborer who should be considered an employee but is instead paid under the table as an independent contractor will struggle to obtain the quick and relatively inexpensive medical care mandated by workers compensation laws. Unless the employer agrees privately to arrange for adequate and free care, the harmed worker might have few options other than to either pay out of pocket for expensive care or sue the business owner.

Life Insurance Fraud

Despite occupying a juicy spot at the center of crime novels and a few classic films, life insurance fraud—at least compared to fraud in the health, property and casualty sectors of the industry—is thankfully rare. Rather than sensational cases in which beneficiaries murder their loved ones for a death benefit, most cases of major life insurance fraud involve faked deaths, often by policyholders in dire financial straits. A husband, for example, might purchase several small term life insurance policies from several companies, list his wife as the beneficiary and then have his surviving spouse claim that he died in a third-world country where autopsies are uncommon or where falsified death certificates can be obtained easily on the black market. Unethical opportunists even took advantage of national sympathies and falsely claimed to have died in the terrorist attacks of 9/11.

Tragically, when murder is a motive for purchasing life insurance, the victims are often innocent children. Many life insurance professionals believe insurance on a child's life can serve a legitimate purpose, perhaps as a savings component for a college fund or as a safeguard against future health conditions that could ultimately impact a young person's insurability. Yet it's still important to carefully analyze a parent's stated reasoning for wanting the coverage. Here are some red flags to consider in this admittedly uncomfortable scenario:

- Parents want life insurance on a child but have no life insurance on themselves.
- Parents claim to be interested in the savings component found in some life insurance products but are asking for term life insurance (which has no cash value).
- Parents want to insure a child for an irregularly high amount. (In response to fraud-related concerns, many carriers put limits on death benefits when life insurance is issued on a child.)
- Parents want to insure a child and disclose that they need something inexpensive due to major financial difficulties.

Health Insurance Fraud

Because so many bills submitted to health insurance companies are from doctors rather than patients, the current fight against health insurance fraud is focused largely on identifying and stopping bad behavior by medical providers. The National Health Care Anti-Fraud Association, the National Insurance Crime Bureau and other sources have identified the following types of medical provider fraud:

- **Billing for medical services never actually performed:** Sometimes this will be done through "upcoding," in which a provider will provide one type of cheaper medical care but bill an insurer for a more expensive procedure. In other scenarios, a medical provider will have performed no care at all but will be able to use a patient's insurance information through threats or intimidation. For example, some providers have taken advantage of opioid addiction in the United States by recruiting addicts, dangling medication in front of them in exchange for their health insurance information and threatening to cut off their drugs if they don't cooperate.
- **Performing unnecessary procedures:** In another example of abuse related to drug addiction, at least a few doctors have performed painful yet totally unnecessary surgeries on patients in exchange for medication.
- **Misrepresenting an elective medical procedure as medically necessary:** For instance, perhaps sympathetic to a patient's concerns about large medical bills, a plastic surgeon might claim that someone who wants a nose job for cosmetic reasons is actually suffering from a deviated septum.
- **Unbundling various medical charges that should ordinarily be combined into one:** Rather than billing a flat rate for a common annual checkup, a doctor might bill one amount for checking a patient's vital signs, another amount for making a visual observation of the patient, another amount for answering a patient's basic medical question, etc.
- **Employing unqualified (and perhaps unlicensed) medical staff to treat patients and billing the insurer under the doctor's name:** In an effort to spot this activity, insurance databases should be capable of flagging scenarios in which the volume of provided medical care stretches the limits of mathematical credibility. For instance, doctors have been caught claiming to have seen patients for more than 24 hours per day.

Although patients cannot be expected to understand the complexities of medical billing, the insurance industry encourages them to look carefully at any statements and report any obvious irregularities.

Even if a patient shares none of the cost for a fraudulent claim, cases of medical identity theft can create errors in a victim's medical records, such as incorrect blood types, bogus prescription histories and more. When relied upon in an emergency, those compromised records can put a patient's health at risk.

Conclusion

As easy as it is to view fraud prevention as something the claims department should handle, the consumer probably does not have a trusting relationship with a claims adjuster. Nor is the person likely to have a relationship with the top-level insurance executives or the trade groups that have traditionally been the ones to make the case for greater fraud awareness.

Producer training is key to making any progress on the issue. If the industry wants to reach its customers and convince them that insurance fraud is a problem worth tackling, agents and brokers might be some 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. Term life insurance is the opposite of _____.
   A. funeral insurance
   B. level term insurance
   C. credit life insurance
   D. permanent life insurance

2. Decreasing term insurance is life insurance with a death benefit that _____.
   A. doesn't change as premiums decrease
   B. increases at the same rate as the owner's income
   C. goes down over the course of the policy period
   D. grows in value despite downturns in the owner's health

3. Whole life, universal life and variable life are only three of the many forms of _____ life insurance.
   A. tax-favored
   B. mutual
   C. survivorship
   D. permanent

4. Employer-sponsored life insurance is almost always term life insurance that is _____.
   A. combined with long-term disability coverage
   B. funded entirely by the employer
   C. medically underwritten based on each employee's health
   D. renewable by the employer on an annual basis

5. _____ life insurance tends to involve little or no medical underwriting.
   A. Term
   B. Whole
   C. Group
   D. Second-to-die

6. One-year term insurance, known as _____, was fairly common several decades ago and suited consumers whose need for life insurance was very temporary.
   A. freely renewable term
   B. annual renewable term
   C. funeral and burial insurance
   D. contingent beneficiary coverage

7. A life insurance company's willingness to offer a lengthy term and/or a renewal option will largely depend on the insured's _____.
   A. age
   B. gender
   C. income
   D. occupation

EXAM CONTINUES ON NEXT PAGE

8. Compared to permanent life insurance, term life insurance usually allows buyers to _____.
   A. obtain the largest amount of living benefits
   B. exchange coverage from a broader range of insurers
   C. purchase the largest death benefit for the least amount of money
   D. build an insurer-assisted savings component for possible retirement

9. Premiums for term life insurance are usually _____.
   A. increased during each year of the contract
   B. approved on an individual basis in all states
   C. level throughout the policy's term
   D. negotiated by experienced insurance agents

10. Most people who buy term life insurance _____.
   A. already own permanent insurance from an employer
   B. are a few years away from qualifying from Medicare
   C. do not die during their policy's term
   D. purchase it through a bank or credit union

11. Term life insurance provides basic coverage without any _____.
   A. non-taxable death benefit
   B. chance for renewal
   C. cash value
   D. upfront premiums

12. The relatively low cost for term life insurance makes the product fairly attractive to _____.
   A. estate planners
   B. seniors on fixed incomes
   C. young adults
   D. securities dealers

13. Policyholders who wish to keep their term life insurance beyond the initial term usually can extend their coverage for at least one more term _____.
   A. at the same price
   B. at a lower price
   C. at a higher price
   D. by passing rigorous health tests

14. Buyers who choose reentry term insurance have the ability to pay comparatively low premiums upon renewal if they _____.
   A. have been a policyholder for several years
   B. satisfy certain health-related requirements
   C. allow the insurer to pick the death benefit
   D. make the switch within 90 days of a renewal

15. A family income policy includes both permanent and decreasing term life insurance on the life of a family's _____.
   A. surviving spouse
   B. oldest child
   C. youngest child
   D. main income earner

16. Additions to a carrier's standard life insurance policy are known as "_____."
   A. assignments
   B. declarations
   C. riders
   D. exclusions

EXAM CONTINUES ON NEXT PAGE

17. Challenges in modern wildfire prevention have been compounded by homeowners' increased movement into the _____.
    A. major cities
    B. suburban communities
    C. urban wildland interface
    D. Deep South

18. The most common type of _____ insurance policy covers removal of debris after a storm.
    A. business interruption
    B. professional liability
    C. flood
    D. homeowners

19. Windstorm deductibles are typically listed as a _____.
    A. flat dollar amount
    B. coinsurance calculation
    C. set percentage of a dwelling's insured value
    D. set percentage of the policy's liability coverage limit

20. Subsequent to a widespread loss, at least a few insurance companies might _____ on sales of various products, including life, auto and homeowners insurance.
    A. decrease premiums
    B. loosen underwriting guidelines
    C. institute a moratorium
    D. pay out more dividends

21. HO-1 and HO-2 policies, rarely sold these days, are known as "_____" policies because they only provide financial protection against those dangers that are specifically mentioned in the insurance contract.
    A. all-risk
    B. multi-peril
    C. named-peril
    D. predetermined peril

22. The _____ policy is the standard product for modern homeowners and is known as an "all-risk" policy.
    A. standard fire
    B. dwelling
    C. HO-3
    D. HO-4

23. From the standpoint of homeowners insurance, the policy's _____ is the amount of otherwise insurable losses, expressed in dollars, that will not be covered under the insurance contract.
    A. insured value
    B. coinsurance clause
    C. deductible
    D. face amount

24. Most insurers will not pay an entire claim for partial damage to a home unless the policyholder has insured the property for at least _____ of its replacement cost.
    A. 50 percent
    B. 75 percent
    C. 80 percent
    D. 90 percent

EXAM CONTINUES ON NEXT PAGE

25. The limits of extended replacement cost coverage, as well as those of actual cash value and regular replacement policies, ought to give homeowners an incentive to _____.
    A. have all of their personal property valued by a professional
    B. review their policies on a regular basis
    C. allow their mortgage lender to suggest an appropriate carrier
    D. insure all items for their original market value

26. The typical homeowners policy includes _____ equal to a certain percentage of the dwelling's insured value, often within the range of 50 percent to 75 percent.
    A. attached structure coverage
    B. personal liability protection
    C. contents coverage
    D. flood insurance

27. Homeowners insurance reimburses policyholders for _____, which may be defined as costs the homeowner incurs as a direct result of not being able to live in his or her dwelling.
    A. actual cash value
    B. contents coverage
    C. additional living expenses
    D. disaster recovery planning

28. When weather damages an apartment building or a rented home, structural damage should be covered by the _____ insurance policy.
    A. tenant's
    B. landlord's
    C. building association's
    D. real estate agent's

29. Like homeowners insurance, renters insurance can cover a dwelling's contents on either a(n) _____ basis or an actual cash value basis.
    A. replacement cost
    B. extended replacement cost
    C. market value
    D. depreciated value

30. Although most buildings that are compliant with modern building codes are eligible for federal flood insurance, a building cannot be covered if it is _____.
    A. in a high-risk state
    B. occupied by a business
    C. used as a warehouse
    D. principally below ground level

31. Policy exclusions of "_____," which collectively refers to quakes, landslides, sinking and volcanic eruptions, have been enforced in an increasingly strict manner over the past few decades.
    A. earth movement
    B. volcanic action
    C. sinkhole collapse
    D. shaking

32. In general, earthquake insurance involves one deductible per _____.
    A. year
    B. occurrence
    C. policy period
    D. government-declared disaster

EXAM CONTINUES ON NEXT PAGE

33. Business income insurance may be cheaper and easier to find if shoppers present a(n) _____ to an insurance company.
    A. ultimatum
    B. claims history
    C. personal check
    D. disaster recovery plan

34. Disaster victims who believe an insurer's claims adjuster is not playing fairly may want to turn to a(n) _____.
    A. public adjuster
    B. licensed underwriter
    C. limited lines agent
    D. actuarial professional

35. _____ know how to evaluate damage, but they work for policyholders rather than for insurance companies.
    A. Public adjusters
    B. Independent adjusters
    C. Property underwriters
    D. Insurance brokers

36. Drivers who want to be covered against disaster-related damage to their car, truck or van can insure their vehicle with a(n) _____ auto insurance policy.
    A. named risk
    B. comprehensive
    C. collision waiver
    D. extended warranty

37. Thanks to HIPAA, new employees and their dependents have the right to join an employer's group health plan _____.
    A. immediately upon employment
    B. regardless of their health status
    C. at reduced premium rates
    D. at the employer's consent

38. Laws regarding medical privacy existed before HIPAA, but they were mainly enacted _____.
    A. at the federal level
    B. on a state-by-state basis
    C. to protect insurers from liability
    D. with no specific penalties attached to them

39. Health information isn't protected by the Privacy Rule unless it is considered _____.
    A. anonymous health information
    B. individually identifiable health information
    C. unrelated to mental health
    D. substantive health information

40. With just a few important exceptions, the only people who need to follow the Privacy Rule and keep your information confidential are "_____."
    A. health plan sponsors
    B. life insurance companies
    C. covered entities
    D. doctors who don't store information electronically

41. No matter if it sells insurance in the group market or the individual market, a health insurer is a _____ under the Privacy Rule.
    A. business associate
    B. plan sponsor
    C. personal representative
    D. covered entity

EXAM CONTINUES ON NEXT PAGE

42. In a self-insured health plan, an employer sets up a mechanism whereby it is responsible for _____.
    A. paying employees' medical bills
    B. paying employees' insurance premiums
    C. establishing a wellness plan
    D. designating an approved third-party administrator

43. When covered entities disclose your protected health information, they are required to _____.
    A. inform you of the disclosure
    B. seek retroactive permission
    C. keep records of the disclosure
    D. alert privacy regulators

44. A _____ is essentially any entity that decides to create a group health plan for itself.
    A. personal representative
    B. health care clearinghouse
    C. plan sponsor
    D. third-party administrator

45. The opposite of a fully insured health plan is a _____.
    A. private plan
    B. self-insured plan
    C. association health plan
    D. government insurance program

46. Covered entities can't use or disclose your protected health information for _____ without consent.
    A. treatment purposes
    B. payment purposes
    C. marketing purposes
    D. health care operation purposes

47. Whereas the Privacy Rule deals mainly with how protected health information can be used or disclosed, the Security Rule addresses how the information needs to be _____.
    A. pre-identified
    B. guarded
    C. sold
    D. updated

48. In _____, the primary motive is to enrich oneself via insurance money, such as by staging an auto accident or setting insured property on fire.
    A. hard fraud
    B. soft fraud
    C. premium fraud
    D. money laundering

49. 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

50. When business owners commit insurance fraud with respect to _____, their goal is usually to reduce their insurance premiums and tax-related responsibilities.
    A. commercial property
    B. workers compensation
    C. product liability insurance
    D. surety bonds

END OF EXAM

Turn to page 117 to enroll and submit your exam(s)

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CHAPTER 1: RISK MANAGEMENT FUNDAMENTALS

Introduction

A lot can go wrong on any given day. We might oversleep and be late for an important meeting. Slick roads and irresponsible drivers might cause us to be the victims in a costly car accident. Our newest employee might make an innocent mistake that ends up costing our business thousands of dollars. Customers might opt to leave us and obtain products or services from our competitors. Exhaustion might contribute to a testy conversation with our significant other and lead to an ugly shouting match. Distracted by our foul mood, we might unintentionally cut ourselves while making dinner and require medical attention.

But no one knows for sure. We can't predict the future, and life offers few guarantees.

Every moment comes loaded with many different risks, and we can neither fully ignore nor become completely consumed by them. To be productive and even the least bit happy, we must be mindful of our own safety without letting uncertainty paralyze us with fear. In both our personal and professional lives, we need to engage in risk management.

The good news is we already have some experience at managing risk, even if we haven't acknowledged it yet. For example, you might already set an alarm clock so you wake up on time. You probably have insurance in case you're ever in an auto accident or need emergency medical care. You almost certainly treat your customers well in order to earn their loyalty. If you hire a new worker, you might place limits on the person's authority until he or she demonstrates sufficient competency and judgment. And if you're in a bad mood, maybe you try your best to avoid confrontation by thinking before you speak.

We can become even better at managing risk by reviewing some of the formal, systematic procedures that experienced risk managers often use to identify, lessen and cope with the unknown.

As an insurance professional, you already understand how the products you sell can address major risks. This chapter is intended to let you build upon that existing knowledge. It will help you see the bigger, broader picture of risk management, where insurance appears in it and—despite our potential biases—why insurance might not be the only solution to a problem.

The Money-Making Argument for Risk Management

Given all the other demands on our time and wallets, many people might dismiss risk management too quickly and view it as a waste of resources. However, greater attention to this discipline doesn't necessarily come at greater expense. In fact, risk management can often be part of a smart financial strategy for the following reasons:

- Investing in non-insurance forms of risk management—such as burglar alarms, sprinkler systems, wellness programs and employee training—can make insurance applicants more attractive to insurance companies and thereby result in lower insurance costs.
- Thinking ahead about how to handle risks that could result in significant losses can reduce the severity and duration of those losses. For example, a business that already has a disaster plan in case of fire is likely to reopen quicker after a blaze than a business that remains oblivious to this risk.
- Knowing more about the risks involved with a proposed new venture can actually make people more comfortable pursuing the opportunity. For example, an investor who has extensive knowledge about the economy might actually feel more comfortable taking chances in the stock market than someone who knows nothing about current financial issues.
- Worrying about risk can create tremendous stress, which can distract people from important goals, including those that could lead to greater wealth. Similarly, if people are forced to constantly react to the negative consequences of small risks due to poor planning, they might not be able to devote adequate resources to bigger problems that are more worthy of their attention.

Although taking risk management to an extreme can produce inefficiencies and diminishing returns, most of us—not to mention your insurance customers—can benefit from more education about risk and how to handle it.

Risk Management vs. Insurance

In general, the risk management process involves identifying risks, measuring those risks and figuring out what to do about them. Based on that description, you can probably already see why there is a strong link between risk management and the insurance industry. You'll be reminded of those important connections at various points in this chapter, but let's first highlight the important differences between the two fields.

Risk management has always been practiced to some degree, but its roots as a formal discipline reach into the corporate environment and the challenges faced by commercial insurance buyers in the mid-twentieth century. Crises involving safety, pollution, natural disasters, lawsuits and financial busts caused tightening in the insurance market, with higher prices and shrinking coverage. Awakened to new threats to their livelihood, business owners turned to their organizations' insurance experts and hoped to uncover solutions to problems that even a good insurance policy was unlikely to fix.

Risks might be uninsurable for any of the following reasons:

- The size or likelihood of losses associated with the risk cannot be calculated by insurance actuaries. (This is common when relatively new risks emerge and tends to last until insurers have enough time and experience to gather sufficient loss-related data.)
- The probability of losses associated with the risk is too high. (This explains why insurance applicants with a spotty claims history often struggle to obtain good coverage.)
- The size (as opposed to just the probability) of potential losses is considered too high. (This concern is at least partially responsible for the non-competitive insurance market for property situated in coastal areas or on fault lines, where natural disasters are abnormally possible.)
- The risk cannot be spread or diversified across a broad enough range of policyholders. (This is demonstrated by the way insurance companies often use standard coverage forms rather than rewriting their policy language for each customer. Similarly, it somewhat explains why tailor-made insurance solutions might only be available to an applicant at a significant, added cost.)
- The risk could result in a gain rather than just a loss. (This explains why it's nearly impossible to insure against an unwise business decision and is what

separates the uncertainties in insurance from the uncertainties in gambling. Risks that can result in a gain are called "speculative risks" and will be addressed in greater detail later in this course.)

As highlighted by author and risk management expert Emmett J. Vaughan, the evolution toward modern-day risk management was also prompted by changes at business schools, where concepts such as cost-benefit analysis gained greater emphasis. Upon being charged with managing risk, former students from those schools realized that if organizations have a limited budget for insurance, those dollars should be spent as efficiently and thoughtfully as possible.

Risk management still values, respects and often utilizes insurance, but it doesn't assume that buying insurance is the starting point for handling all uncertainty. Instead, it treats insurance as one critical tool among many others. It recognizes that insurance products have a needed role in the lives of businesses and individuals, but it also emphasizes enhanced safety measures, careful research, detailed contingency planning and constant teamwork.

Many insurance professionals find that knowing more about risk management strategies lets them offer increased services and advice to clients. Particularly among agents and brokers in commercial lines of insurance, professional designations associated with risk management expertise might be essential to standing out from the competition.

Of course, providing different services can also expose insurance producers to additional professional liability. Yet for those licensees who don't wish to expand into offering risk management services and prefer to remain safely in their lane of selling insurance products, studying risk management still has its benefits. By exposing yourself to alternate ways of handling uncertainty, you might actually gain a keener sense of what your products are really designed to accomplish. If nothing else, you can become more confident that you are truly selling insurance based on someone's needs rather than because it's all you can offer.

Understanding Risk

Now that we've explained some of risk management's background and basics, it will probably be helpful to consider a few definitions of "risk.' In addition, we'll explain the many different types of risk, including some that can be managed well by insurance and some that commonly call out for non-insurance expertise.

Risk Defined

"Risk" can be defined as the uncertainty surrounding either the likelihood or impact of an event. Outside of insurance, risk might involve a range of possibilities that includes something good possibly happening, something bad possibly happening or something neutral possibly happening. However, at least one of the possibilities must be less desirable than the rest.

In insurance, the same principle generally applies, but the range of possibilities must include only something bad happening (such as becoming ill) or something neutral happening (such as maintaining current health). As a result, we can say that a more specific definition of risk within an insurance context is the uncertainty surrounding a potential loss. The uncertainty surrounding a potential loss may be tied to any of the three following questions:

- Might a loss occur at all?
- When will a loss occur?
- How big might a loss be?

Note that a risk can still exist even if one or two of those questions are already answerable. For example, insurance companies already know losses will occur among their mix of customers and that they will ultimately need to honor some claims. So, the risks that insurers face are more focused on when and how big those losses will be rather than whether they will occur at all. Specifically, uncertainty for insurers relates to whether actual losses will ultimately be in line with an actuary's data-driven estimates and whether the premiums charged to customers by underwriters will be enough to adequately offset claims.

What's a Loss?

"Loss," within an insurance context, may be defined as an expense or decrease in value that occurs at an unpredictable moment. (By contrast, decreases in value at predictable times—such as property's natural depreciation—are not usually intended to be addressed by insurance.) Losses might be direct, such as theft of or damage to property. Alternatively, a loss can be indirect, such as the extra cost of childcare that a stay-at-home parent might need to pay upon being forced into the workforce by a spouse's unexpected death.

Risk vs. Uncertainty

If you find a definition of risk, it's a safe bet that it will include the word "uncertainty." However, some scholars who specialize in risk management believe terms like "risk" and "uncertainty" shouldn't be used as synonyms for each other. Risk, as distinguished by University of Chicago economist Frank Knight and explained further by author and risk manager J. Davidson Frame, deals with unknowns that can be estimated based on statistical probability. Uncertainty, on the other hand, might describe unknowns that cannot be estimated with the help from data and mathematics.

Although this difference might seem impractical or overly academic, it's still worth mentioning here in order to reemphasize how insurance is intended to only manage risks that can be assessed through sufficient loss-related data and statistical estimates. If data about a risk either doesn't exist or can't be plugged into statistical formulas, the risk typically can't be managed through insurance.

Informal Definitions of "Risk"

We've already made some distinctions between how risk is defined inside and outside the insurance community, yet it's worth noting that some insurance companies and insurance professionals tend to define risk in additional ways depending on the conversation. For example, some companies and individuals might use the word "risk" loosely to mean an applicant for insurance ("That person is a good risk.") or as a synonym for a peril. ("We insure against the risk of fire.")

Hazards and Perils

Since we're already examining definitions and terminology, let's review a few more words that tend to come up in discussions about risk.

What's a Peril?

A "peril" is the cause of a loss. Examples of perils include fire, flood and illness.

Insurance companies are concerned about the risk of perils. In fact, insurance policies will either list the perils that can result in

post-loss compensation to the carrier's customers or at least include a special section that explains any excluded perils. If a peril is excluded from a policy, losses caused by it will not result in any insurer-provided compensation for the insurance customer.

What's a Hazard?

A "hazard" isn't the cause of a loss but is something that increases a loss's likelihood or scope. This can be important in insurance underwriting because an applicant who is surrounded by too many hazards can struggle to find affordable insurance even if that applicant has not yet suffered any losses.

The broad category of hazards can be broken down into at least three subcategories:

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

Physical Hazards

A "physical hazard" is an environmental factor that increases the likelihood or severity of a potential loss. Simple examples of physical hazards include frayed wiring (which increases the likelihood and severity of loss by fire) and either poor lighting or wet floors (both of which increase the likelihood and severity of loss by slip-and-fall accidents). Eliminating as many physical hazards as possible can significantly reduce risk and make insurance more affordable.

Moral Hazards

"Moral hazards" are character issues that make people more likely to cause a loss on purpose, such as dishonesty that temps them to commit insurance fraud. These hazards are often carefully monitored by the insurance community and have resulted in several long-standing practices within the industry. Several techniques employed by insurance companies to manage moral hazards appear next:

- Requiring policyholders to have an "insurable interest" in the people or things they intend to insure. (An insurable interest is a desire for a person or thing to remain unharmed.)
- Constructing insurance contracts so policyholders are made financially "whole" again after a loss, but not any better than they were prior to a loss.
- Refusing to cover damage caused intentionally by an insured.
- Enforcing suicide clauses, which typically prohibit a beneficiary from receiving life insurance benefits if an insured takes his or her own life within two years of purchasing a policy.

Morale Hazards

"Morale hazards" (not to be confused with moral hazards) are cases of indifference that make a consumer not care about preventing or reducing losses. Morale hazards don't involve deception or evil intent, but they foster an environment in which people act irresponsibly without considering how their attitudes or inaction might negatively impact others. In a business environment, this might be seen when an employee doesn't bother to report a potential problem because he or she views the task as someone else's job. In an insurance example, a homeowner might believe he or she doesn't need to worry about maintaining property because any eventual damage is likely to be covered by a generous insurance policy.

Insurance carriers have attempted to manage morale hazards by incorporating cost-sharing requirements (such as deductibles, copayments and coinsurance fees) into their products rather than paying for insured losses in full. The assumption is that if the insured is required to pay out of pocket for at least a small portion of a loss, the person will work a bit harder to prevent the loss from occurring (such as by reducing physical hazards and engaging in other risk management strategies).

Types of Risk

The next several sections explain many different categories of risk. You should pay particular attention to how each mentioned type might or might not fit into the way insurance companies view risk. In some cases, you'll clearly see that certain risks are compatible with the purpose of insurance products. In others, it will be obvious that risks can't be managed well entirely by insurance and that other solutions, mentioned later in this chapter, might be better options.

Pure Risks

A "pure risk" is a risk in which none of the potential outcomes are beneficial. At best, this type of risk will result in either a loss occurring or no loss occurring. Unlike with some other risks, there cannot be a chance of gain. Pure risks are generally what most people think of when the subject of risk comes up.

Examples of pure risks include the potential for fire, flood, death, liability and accidents. At worst, these risks will lead to perils and ultimately result in a loss. At best, these risks will merely remain possibilities, won't lead to perils and won't ultimately result in a loss.

The concept of pure risks (and, in particular, their lack of potential gain) is important within the context of your profession because pure risks are generally the only risks that can be managed by traditional insurance products. Many business risks—such as the risk of a new product being either successful or very unsuccessful—have the potential for gain and, therefore, are not insurable.

A Few Side Notes on Pure Risks

Despite the connection between pure risks and insurance, two additional points about that connection deserve to be made here.

First, although a risk generally must be a pure risk in order to be managed by traditional insurance, not all pure risks will be acceptable to an insurance company. For instance, although the risk of terrorism is a pure risk, many insurance companies initially deemed it uninsurable in the months following the World Trade Center attacks on September 11, 2001. Only government intervention and the establishment of a government-backed safety net for catastrophic losses eventually made this pure risk an insurable one.

Second, just because a risk is considered a pure risk doesn't mean it can't also be included within another category or subcategory of risk. For example, you'll soon learn about personal risks, property risks, liability risks and many other risk groupings. Some risks that might fall into those groupings can also be considered pure risks, even if some others cannot.

However, recognize that a pure cannot also be what's called a "speculative risk."

Speculative Risks

Speculative risks are the opposite of pure risks because, although they involve uncertainty, there is a chance of success

or gain rather than just the chance of a negative or neutral outcome. In some circles, speculative risks are also known as "opportunity risks."

Some examples of speculative risks are listed below:

- The risk of gambling at a casino.
- The risk of investing in the stock market.
- The risk of introducing a new product.
- The risk of changing jobs.
- The risk of committing to a romantic partner.

Although bad outcomes are possible in the above scenarios, the possibility for good outcomes exists, too. These risks are actually very common in life, but they don't receive much attention from the insurance community because they typically cannot be managed through traditional insurance. Instead, a risk manager who is tasked with managing speculative risks might recommend other solutions, such as risk avoidance or risk reduction. You'll learn more about these and other non-insurance techniques later in this chapter.

As insurance professionals, we might be biased against speculative risks and view them in an entirely negative light. But taking the occasional speculative risk breaks us away from stagnation, boredom and even depression. If we want to grow, we honestly must avoid the extremes of taking on too many risks or too few.

With all this in mind, risk managers who are charged with evaluating speculative risks shouldn't necessarily discourage their employers from pursuing every risky opportunity. Instead, they can help decisionmakers understand the many possible outcomes and then design a plan based on the chosen path. In these cases, it's possible that a risk management plan will attempt to find a balance between maximizing the profits that are possible from a speculative risk and minimizing (but not necessarily eliminating) the impact of potential losses.

Of course, this doesn't mean a risk manager should go against his or her educated guesses and not firmly advise against taking certain risks. Not taking a risk, a method actually known as "risk avoidance," has an important role in maintaining personal and business stability and will deservedly get more attention here in a later section.

Dynamic Risks and Static Risks

"Dynamic risks" are risks that are tied to the economy and are largely beyond a person's or business's control. These risks are speculative to a large extent because changes in the economy (such as movements in interest rates, employment rates or the supply and demand for a product) might help the person or business or might produce negative outcomes. Like other speculative risks, dynamic risks usually can't be managed via traditional insurance and instead require careful attention to other risk management tools.

By contrast, "static risks" are risks that aren't tied to the economy and are comparatively more within a person's or business's control. Some static risks will be pure risks and can be managed with insurance. Others will be speculative and should be viewed through a non-insurance lens.

Personal Risks

"Personal risks" are risks to your body and well-being, such as the risks of illness, injury and unexpected death, as well as the risk of financial loss tied to those negative events. Insurance is often used to help manage the risk of the financial consequences surrounding personal risks, but other risk management strategies—such as risk reduction techniques linked to eating a good diet, getting enough exercise and having regular medical checkups—might also be encouraged. In some contexts (but not in this course) personal risks might have a broader definition that includes all risks faced by individuals, as opposed to those risks faced by businesses.

Property Risks

"Property risks" involve the potential that something owned will be lost, stolen, damaged or otherwise subjected to a decrease in value. Insurance commonly plays a role in managing property risks because the severity of property losses can be easier to estimate than other losses, such as those related to being sued. Meanwhile, engaging in non-insurance forms of risk management—such as using locks, burglar alarms, sprinkler systems and various other safety and security measures—can make property insurance more affordable.

Liability Risks

"Liability risks" involve uncertainty surrounding whether a person or entity will be held legally responsible for someone else's losses or for unlawful activity. These risks can be particularly challenging for risk managers because there might not be limits on potential legal judgments or fines, thereby making liability's financial consequences nearly incalculable. In addition, most risk managers lack a legal background and therefore must rely on help from other experts to identify, reduce and otherwise manage these risks effectively.

Risks Related to Public Relations and Perceived Character

Particularly among businesses, risk management might focus not only on preventing and controlling direct losses to property and earnings but also on avoiding harm to an entity's internal and external reputation. A business that wants to recruit and retain the best workers will likely want to promote a safe and stable work environment where everyone can focus on the tasks at hand. Similarly, a business that wants to project a positive message to customers will likely want to seem like a responsible, welcoming participant in its community and will certainly want to avoid being the subject of embarrassing reports about accidents, financial infractions or managerial chaos.

Although risk management tools like insurance, hold-harmless agreements and even a good attorney might shield a business from suffering direct financial loss after a crisis, those tools can't change perceptions of how the crisis was handled. For example, a business that successfully avoids legal liability for a serious injury at the workplace must still consider how the incident might impact staff morale. Likewise, a business accused of pollution violations might technically be able to blame a vendor for the problem, but this shedding of responsibility is unlikely to foster good relationships with current and potential customers.

Just as risk managers might consider consulting with a legal team to address liability risks, advance assistance from human resource and public relations professionals might be in order so that negative events aren't exacerbated by risks associated with slow or incoherent communication. In most cases, failing to be transparent with employees or the public about relevant, obvious problems will only expose the business to even greater risk.

Particular Risks

"Particular risks" are uncertainties that are likely to only impact one person or a relatively small group rather than the larger society. Examples include the risk of a single business failing or the risk of a close family member passing away. Although these risks might be scary for the small group who could be effected by them, they don't spell potential trouble for the broader population.

Since particular risks don't have a societal impact, they tend to be managed—if at all—by either one person or a small team. If a team is used, specially trained professionals (such as insurance producers, risk managers and attorneys) might be consulted in exchange for compensation. Free or partially subsidized risk management assistance from the local or federal government might not be available.

Fundamental Risks

"Fundamental risks" are the opposite of particular risks and involve uncertainties that are more likely to impact society. Examples include the risk of unsafe food manufacturing, the risk of unclean water and the risk of widespread poverty in retirement.

Because fundamental risks can cause serious problems for a broad population, they are often managed via public policy rather than just by buying insurance or employing a risk management team. For example, the government might respond to fundamental risks by employing the following types of risk management:

- Enforcing laws and rules that prohibit risky activities.
- Implementing government insurance programs (such as Medicare and Social Security).
- Providing incentives (such as tax credits) to encourage certain behaviors.
- Offering educational opportunities (such as information sessions or free online resources) to individuals who want to learn more about a risk.

Although we'll go into slightly more detail about fundamental risks, these risks generally aren't a professional risk manager's main focus and therefore won't receive significant emphasis in this chapter.

Internal Risks vs. External Risks

The ability to carefully manage a risk will depend partially on whether the risk is internal or external.

"Internal risks" can generally be defined as those that exist within someone's own environment, such as a person's own body, own home or own business. Although internal risks can't always be fully controlled, they allow for more careful and flexible planning than external risks.

"External risks" exist largely within an environment that is beyond a person's control. Examples of external risks are as follows:

- Risks associated with third-party vendors used by a business.
- Risks associated with new regulations that could impact current or future goals.
- Risks associated with a competitor's unknown plans.

Despite being harder to manage, external risks can still be addressed successfully. For example, concerns about a particular external risk might prompt a business to create a detailed contingency plan in case an outside event occurs. More broadly, a business that is flexible and careful to not rely too much on one client, one vendor or the success of one product will likely be more capable of confronting external risks than a business that operates in a more rigid and narrow manner.

Managing Risk

We've spent significant time reviewing the many types of risk and how they might relate to insurance. Now let's learn about what risk managers do and the various strategies they often employ.

Goals of Risk Management

At its simplest level, risk management is an attempt to identify potential losses, determine the likely cost of those losses and create a path toward recovering from them. Alternatively, we can view risk management as a multi-faceted method for maintaining stability despite the presence of loss or uncertainty.

Some slightly more specific goals of risk management are listed next:

- Making losses less common and/or less impactful.
- Minimizing the likelihood of catastrophic events.
- Devising ways to further important goals while avoiding major setbacks.
- Combatting threats in an efficient, cost-effective manner.
- Implementing procedures that help an entity uphold its ethical and legal obligations to workers, customers, regulators and the general public.
- Creating an environment where decisionmakers aren't distracted by constant problems and breakdowns and are, instead, allowed to focus on what matters most to them.
- Putting people in a position to be resilient and proactive in response to losses.
- Understanding how seemingly small issues can lead to serious stress.

Role of Risk Managers

As mentioned earlier, a risk manager's role within a business has evolved from a time when companies employed someone to focus mainly on purchasing commercial insurance products. Today, someone in this position will also be required to plan around risks that either can't be managed affordably through insurance or aren't insurable at all. Analyzing available insurance options will certainly still be part of a risk manager's job, but it won't necessarily be the person's primary focus.

Large businesses can sometimes afford to employ one or several people whose tasks are dedicated solely to risk management endeavors. However, smaller entities will typically need to wrap the responsibilities for risk management together with a worker's other job functions and have the person serve in a dual role. By default, and whether they realize it or not, owners at smaller companies typically act as risk managers themselves.

Availability of Risk Management Services

If an organization lacks the budget to employ a dedicated risk manager, risk management evaluations and related services can be provided by third parties for a fee. Interested businesses can find qualified professionals by searching databases available through risk management trade associations. These associations typically require advanced training as a condition of membership. Alternatively, risk management services are often available to a commercial insurance company's customers. Whether they provide those services for an additional charge or at no extra cost, insurers partner with risk managers because they

understand how promoting safety and preparedness can reduce their own risk and prevent insured losses.

Bringing in a risk manager from outside an organization can sometimes be helpful because the person will be able to view risk with a fresh yet professional set of eyes and won't have the same unconscious biases that can infect someone who is comfortable with an entity's longtime procedures. Still, it's important for businesses to assist third-party risk managers enthusiastically so that the outsider will be able to understand all relevant particulars and what makes each business unique. If a risk manager encounters resistance to receiving data or other information from a business's leaders, the risk manager won't be able to make solid recommendations, and the money spent on the outside risk manager will be wasted.

The Risk Management Process

Let's look more deeply at the common steps in the risk management process. The process must be a proactive one that anticipates potential problems and then looks to halt those problems if they ever actually arise.

Prior to a loss, the risk management process involves spending wisely on insurance and non-insurance safeguards, reducing stress about uncertainty for others in the organization and perhaps even considering how to comply with legal, ethical or company-set standards of practice. Since no entity will have unlimited resources to manage risk, this pre-loss portion of the process will undoubtedly require careful compromises along the way.

After a loss, the risk management process incorporates short-term and long-term plans for an entity to recover quickly, such as how a business can stay open after major damage to its building or how a family can pay its bills after a wage earner's sudden death. As mentioned earlier, this phase in the process might also include a public relations strategy if the loss is likely to harm someone's reputation. Finally, the process should require a review of what happened and whether changes should be made to the existing risk management plan as a way of avoiding future losses.

No matter the stage in the process, a good risk manager's focus will be not only on all the things that could go wrong in a situation but also on all the things that must go right.

Identifying Risks

The first step in the risk management process is identifying potential risks. At first glance, this might seem like a task that could involve an hour or two of brainstorming and creating a checklist. But for this step to be effective, more discipline, patience and communication are required.

This step must be designed so that major categories of risk aren't accidentally dismissed. Although it might be easy enough to identify major yet basic risks, such as losses from a fire or weather-related disaster, other risks often get ignored until losses are already occurring. For example, many businesses don't consider the impact that a key employee's death, disability or departure can have on the organization until the person suddenly becomes unavailable. Similarly, external risks—such as uncertainty surrounding an entity's relationship with an important client, regulator or vendor—tend to be addressed uncomfortably late in the process rather than being addressed early through proactive contingency planning.

Identifying risk also requires broad participation across an entire organization so that possible losses and their potential severity can be understood from different perspectives. Rather than merely requesting input from an entity's top management team, a risk management plan should incorporate detailed feedback from mid-level players and even entry-level team members. Whereas top management might have a general idea of a risk and where it exists, individuals at that level might not be in positions to understand all the daily nuances of procedures, including any specific inefficiencies or red flags that could make a risk even bigger than top management expects.

Organizations that want to manage risk well can benefit from holding regular meetings with representatives from all major departments. By talking about each department's goals and current projects, members from other parts of the organization can better understand how their own work fits into a team concept and, especially, how the seemingly small problems noticed by them can actually indicate bigger concerns for other participants. At the same time, even if a risk-heavy task has been assigned primarily to one department, other attendees at these meetings might have feedback or suggestions that can lighten the burden.

Despite generally being considered the first step in the risk management process, risk identification should remain a nearly constant task. With every change—be it a change in projects, a change in personnel or a change in procedures—comes a different set of risks. Therefore, risk managers must be flexible in their planning and make it a point to encourage continued communication about an organization's new challenges.

Determining Frequency and Severity

Once a risk has been identified, a risk manager should analyze it to determine the possible frequency and severity of a loss. Depending on the type of risk, the type of organization and the budget allowed for risk management, this might incorporate some complicated math, loss-related data and even loss simulations, in which computer programs estimate the cost of losses that are likely to occur from a particular peril. (Such modeling is particularly useful among property and casualty insurers when determining their exposures to natural disasters.) But if the risk manager lacks access to enough data for any reason, educated guesses will need to suffice.

Detailed analysis of frequency and severity should consider losses that could occur at different times. For example, rather than merely considering the general impact that a power outage might have on a business, the analysis might include estimating the frequency and severity if the outage were to occur during the business's busiest season compared to a slower period. The variables to explore during this process are seemingly endless, so the risk manager must prioritize what to examine and keep the overall plan moving forward.

To aid in this step, many risk managers will create a matrix showing where each risk essentially ranks with respect to frequency and severity. Picture, for example, a graph that shows a loss's likelihood on the horizontal "x" axis and the loss's severity on the vertical "y" axis. The resulting graph provides a visual representation of the overall threat of each risk. For example, each potential loss resulting from an analyzed risk might be graphed and thereby identified as follows:

- Low frequency and low severity.
- Low frequency and high severity.
- High frequency and low severity.
- High frequency and high severity.

Seeing potential losses identified in this way can help risk managers ultimately determine what to do about the corresponding risk:

- Losses that are likely to be low in both frequency and severity might result in an entity merely accepting those risks and deciding not to worry too much about them.
- Losses deemed low in frequency but high in severity are sometimes best handled with insurance because coverage is likely to be available and affordable.
- Losses shown to be high in frequency but low in severity might indicate internal problems with administration or procedures that could benefit from some adjustments.
- Losses considered high in both frequency and severity are less likely to be insurable and might be best handled by not exposing the entity to a risk at all.

Even if a risk manager has a strong bias that favors insurance, determining frequency and severity can increase someone's chances of spending their insurance money as efficiently as possible. This is possible by calculating both the "maximum probable loss" and the "maximum possible loss." Whereas the maximum probable loss considers a loss's likely severity, the maximum possible loss considers the absolute worst-case scenario.

With respect to insurance, picking a coverage limit equal to the maximum probable loss can allow a consumer to get efficient use out of his or her insurance budget but will still expose the consumer to some potential uninsured losses. On the other hand, picking a coverage limit equal to the maximum possible loss will shield the consumer from losses in one area but could result in that person not having enough financial resources left over to manage risks in other areas. Even for an experienced risk manager, walking the fine line between being potentially underinsured and potentially over-insured requires delicate balance.

Risk Management Strategies

After identifying risks and analyzing the likely frequency and severity of possible losses, a manager must choose an appropriate technique to manage each risk. In general, those techniques fall into the following categories:

- Risk avoidance.
- Risk retention.
- Risk reduction.
- Risk transfer.

Note, however, that the same risk can be managed by employing multiple strategies at once. For example, consider the risk of burglary at your home. To manage this risk, you might purchase homeowners insurance (which is a form of risk transfer). At the same time, you might also lock your doors after you leave (which is a form of risk reduction).

Let's go through each risk management strategy in more detail.

Risk Avoidance

"Risk avoidance" is a risk management strategy in which a person entirely eliminates a risk by choosing not to engage in an activity. For example, someone who wants to avoid the risk of dying in a plane crash can refuse to ever fly. Someone who wants to avoid the risk of losing money in the stock market can refuse to invest in it. Someone who wants to avoid the risk of putting money into a business and then watching the business fail can choose to always work for someone else rather than being his or her own boss. A company that wants to avoid burdensome regulation in a particular industry can choose not to branch out into that industry in the first place.

Risk avoidance is often employed as a risk management strategy when losses related to a risk are likely to have both a high frequency and a high severity. Few people will feel comfortable accepting those types of risks on their own, and no reputable insurance company is likely to cover them. Risk avoidance is also commonly used when the likely frequency is low but the likely severity is still high enough to keep risk managers in a panic.

Although risk avoidance can literally be beneficial to our survival, it has its limits. Avoiding some risks is natural and wise, but avoiding too many risks can result in someone passing up too many opportunities and not getting enough satisfaction from life.

For instance, avoiding planes can prevent someone from traveling to a desired destination where no other transportation options exist. Avoiding business opportunities can prevent people from reaching their fullest financial potential. In moderation, there's certainly something to be said for overcoming our fears and accepting some risks.

In other cases, risk avoidance might not be an option at all. For example, we'd all presumably like to avoid the risk of becoming disabled or of dying prematurely. Yet we only have limited control over our health and can only manage that aspect of our lives via risk reduction (not avoidance), such as by exercising and maintaining a healthy diet.

Risk Retention

"Risk retention" (sometimes called "risk assumption") occurs when someone decides to accept a risk and to essentially live with the consequences. For example, a driver might choose to retain the risk of damage to his or her old car by not buying collision coverage for the vehicle. Someone might choose to retain the health risk of eating red meat by enjoying a steak whenever he or she chooses and deciding not to worry about the potentially negative dietary effects.

Risk retention is a common strategy when both the likely frequency and likely severity of a loss are low. Putting together safeguards to minimize these losses might not be an efficient use of time, and paying money to transfer these risks—such as by purchasing insurance—might not be the best use of an entity's limited budget.

Often, risk retention is forced upon people in conjunction with another form of risk management, such as risk transfer. This commonly occurs when risk transfer involves insurance. Although a consumer will pay premiums to transfer most of a risk to an insurance company, the insurer will require that the policyholder retain some risk via deductibles, copayments and coinsurance fees. By combining mandatory risk retention with insurance, policyholders are expected to be more risk-conscious and more careful. In other words, this required risk retention helps minimize some of the moral and morale hazards mentioned near the beginning of this chapter. Some retention, in theory, should also reduce the cost of insurance, since higher deductibles and copayments typically translate to lower premiums.

Some risk managers believe retention is the most common form of risk management because it can be done either by choice or by accident. In the latter case, people and organizations might retain risks unknowingly by not recognizing that a risk even exists, such as by not understanding that they might be breaking a law or by not knowing that their insurance is subject to a

particular exclusion. For professional risk managers, this subconscious type of risk retention should be avoided whenever possible by enlisting help from assorted experts, such as attorneys, engineers and insurance professionals.

Although risk retention might seem like a scary solution, it can be a valuable tool when other strategies seem unrealistic or unreasonably expensive. However, before recommending risk retention, a risk manager should do his or her best to calculate how much risk should be retained and how much should be addressed via other options. It is sometimes possible to retain a portion of a risk but still manage the remaining fraction in another way.

Risk Reduction

"Risk reduction" (sometimes known as "risk mitigation") occurs when steps are taken to reduce either the likely frequency or severity of a potential loss with the understanding that the risk can't be entirely eliminated. Although risk reduction is commonly recommended when losses are likely to have a high frequency and low severity, it can be employed in several other scenarios, too. Some common examples of risk reduction are listed next:

- Performing preventive maintenance on a house so it is less susceptible to major damage.
- Locking doors and installing alarms so property is less susceptible to burglary.
- Installing sprinkler systems, smoke alarms and fire extinguishers so small fires are less likely to turn into unmanageable ones.
- Diversifying financial investments so downturns in the stock or bond markets don't entirely wipe out someone's savings.
- Implementing mandatory procedures, adequate training and reasonable safeguards at workplaces to reduce human error.
- Exercising and eating well to fight against illness, disability and premature death.
- Setting an alarm clock to reduce the chances of oversleeping and being late for an important appointment.
- Adding warning labels to products in order to reduce lawsuits from a business's customers.

Risk reduction also provides positive outcomes from an insurance standpoint. The more an applicant can show a dedication to risk reduction, the easier it will be to obtain affordable coverage. Similarly, an entity that implements extensive risk-reduction methods might be able to get away with buying less insurance than an entity that pays little attention to safeguards.

Contingency Planning

Many aspects of risk reduction involve taking care before a loss is capable of occurring, but other parts should address how to handle losses that are already in progress. To manage risk effectively, consideration should sometimes be given to "contingency planning."

In essence, contingency planning entails having a backup procedure in place so that important work toward goals can resume soon after a loss. Basic examples of contingency planning include the following:

- Deviating from your usual route when a car accident ahead of you has already made you a bit late.
- Establishing a temporary business location or work-at-home arrangement when a fire, flood or other peril has already caused a business to unexpectedly close its doors.

Risk Transfer

"Risk transfer" (sometimes called "risk shifting") occurs when the consequences stemming from a risk are taken from one party and moved to another. Although risk transfer doesn't eliminate risk, it absolves the original party from certain responsibilities and can let that party concentrate on other goals. Risk transfer is often recommended when potential losses are expected to be low in frequency but high in severity. For other risks, risk transfer can be financially inefficient or hard to accomplish because few candidates will want to receive the transferred risk.

As an insurance producer, risk transfer is probably the method of risk management with which you have the most familiarity. In fact, insurance is one of the most common forms of risk transfer. The policyholder is allowed to transfer the financial risk of premature death, bad health, property damage, costly legal bills and several other possible problems to an insurance company in exchange for paying premiums. Other common examples of risk transfer include warranties, hold-harmless agreements and other contracts.

As demonstrated by insurance, risk transfer can sometimes be done entirely by choice or sometimes by force. For example, some people choose to buy life insurance because it helps them feel better about their family's financial situation, whereas others might buy life insurance because it is mandated by a divorce settlement or child-support arrangement.

Risk Transfer and Contracts

Contracts that bestow certain responsibilities and liabilities on each party by mutual consent are perhaps the earliest example of risk transfer. If something goes wrong and results in a loss, a well-written contract gives the harmed party a way to possibly be made whole again, either through a court proceeding or via an out-of-court settlement. However, anyone who has ever puzzled over the language in an insurance policy can attest to the fact that contracts aren't always clear. Interpretations of contractual provisions—and even whether those provisions are enforceable—will sometimes depend on the legal authority reviewing the language, as well as on the state or other jurisdiction in which legal action is taken.

In short, although getting contractual agreements in writing is often an extremely wise method of risk transfer, risk managers should consider other safeguards, too, in case those agreements don't withstand unexpected legal scrutiny.

The Role of Insurance

Given your professional experience, you probably don't need to be told how insurance can be a great tool for dealing with many risks and losses. Although some emotional risks (such as the pain of losing a loved one or the discomfort of dealing with an illness) can't exactly be transferred to insurance companies, the right insurance product has a chance at relieving the money-related burdens imposed by those unwanted events.

For a risk manager charged with helping a business or other organization, insurance responsibilities are likely to include consultations with agents and brokers, along with completing the following tasks:

- Determining which specific risks should be transferred by insurance.

- Determining which producers and carriers to engage in insurance transactions.
- Determining preferred dollar limits, deductibles, copayments and coinsurance fees that simultaneously satisfy the organization's risk tolerance and fit within the allowed budget for risk management.
- Determining whether existing insurance arrangements should be terminated, altered or kept in place.
- Reporting losses to insurance companies.
- Deciding whether insurance represents the best way to manage a risk.

If a loss seems highly likely, buying insurance to manage the relevant risk might seem like an obvious decision. However, as mentioned earlier in this chapter, some risks will not be acceptable to an insurance company. As a reminder, a risk will generally not be considered insurable if it fits into any of the following categories:

- The size or likelihood of losses associated with the risk cannot be calculated by insurance actuaries.
- The probability of losses associated with the risk is too high.
- The size (as opposed to just the probability) of potential losses is considered too high.
- The risk cannot be spread or diversified across a broad enough range of policyholders.
- The risk could result in gain rather than just a loss.

Implementing the Program

Upon identifying risks, determining the likely frequency and severity of losses and then picking the best plan of attack, a risk manager will focus on implementing his or her plan. This might seem like an obvious step in the process, but it deserves special mention here because implantation is sometimes treated too casually. The result is often a lot of wasted time and an ultimately ineffective approach to risk management.

Supporting the Risk Management Program

Compared to merely buying insurance, implementing a risk management plan will require greater involvement across an organization and some collaborative responsibilities. Expecting a single risk manager to understand all potential risks and to be on high alert for every single warning sign of potential loss is both unfair and impractical. A risk manager can lead the risk management process but must receive support from an organization's leaders.

In addition to providing the necessary attention, funding and information to help facilitate a smooth risk management process, an organization's leaders must work at creating a culture where sensitivity to risk becomes common. No matter where a team member falls within an entity's hierarchy, he or she should be made to feel comfortable reporting problems to supervisors without fear of being reprimanded, ignored or embarrassed. Similarly, when lower-ranking individuals are asked to participate in identifying or evaluating risks, upper management must make them feel empowered to share honest feedback and should not sway them to agree with whatever their supervisor believes. Again, because upper management is sometimes distant from the day-to-day processes within their organization, contributions from workers at other lower levels are often essential to identifying and solving problems.

The Human Factor in Risk Management

We live in an increasingly technological society that is placing more and more importance and reliance on automation and other forms of non-human contact. And even before this major shift toward technology, some risk managers spent considerable time focused primarily on risks related to engineering, natural disasters and equipment breakdown.

Those concerns should certainly remain high among a risk manager's priorities, but they should not distract a risk management professional from also considering the human element in avoiding and controlling losses. Innumerable problems can still be traced back to human error, so any organization that wants to manage risk properly must be mindful of who it invites in as members, including employees, volunteers, business partners and vendors.

An entity is more likely to assemble an appropriately risk-sensitive team if it keeps the following realities in mind:

- Noticing the potential for risk requires attention to detail. Someone who cannot grasp how seemingly minor issues can mutate into huge problems might lack the necessary skills for monitoring risk.
- Significant investment in training can lead to significant risk reduction. However, this correlation is more likely to be achieved if education is provided on a continuing basis rather than during a one-time session.
- Unfortunately, sometimes all the training in the world cannot compensate for incompetence. At a certain point, leaders must honestly evaluate whether poor-performing individuals are truly the best people for their assigned tasks.
- Distraction or boredom can reduce our ability to spot and react to increased risk, including something as simple as poor data entry that could lead to an inaccurate assessment of risk. Eliminating unnecessary stimuli and keeping a team motivated can help keep everyone alert.
- Having rules or policies about how to perform tasks and how to report problems won't be of much help if those rules and policies aren't enforced. Leaders who react casually when rules aren't obeyed will subconsciously encourage those who follow them to act in a dangerously casual way toward risk.
- Even the most skilled people will sometimes freeze or panic in an emergency. Having emergency plans already in place—and conducting periodic training about the agreed-upon procedures—can minimize these understandable lapses in action and can get an organization closer to managing a realized loss.

Evaluating the Program

Identifying risks, determining the frequency and severity of losses, choosing a risk management strategy and implementing a risk management plan can't be one-time occurrences. Effective risk managers must reevaluate their work and their decisions on a regular basis so important adjustments can be made before a new loss arises. Commitment from upper management is essential so that risk managers have the time and resources to identify and make those adjustments as quickly as needed.

As part of the evaluation process, a risk manager should at least consider the following questions:

- Have we encountered risks that we failed to identify during the planning stage?

- Have losses been as severe and as frequent as expected?
- Have changes in our organization (such as different personnel) created or eliminated some risks?
- Have changes in our procedures, goals or customers' expectations created or eliminated some risks?
- When losses occurred, did training and contingency planning reduce those losses to a satisfactory degree?
- Were the chosen strategies for each identified risk (avoidance, retention, reduction, transfer) suitable for that risk, and should they continue?
- Should the pool of participants who contributed to previous risk management planning be deepened or reduced?

Risk Management Principles in Insurance

Throughout this chapter, we've attempted to emphasize the links between risk management and insurance. Let's spend some time making more specific connections between those topics and highlight some areas in which insurance companies apply risk management principles for their own protection. For example, we'll explain concepts such as the pooling of risks and the law of large numbers.

Pooling of Risks

The "pooling of risks" is a method by which insurance companies (as well as any other entity running an insurance program) attempt to spread either the same or similar risks across a larger group. For instance, rather than insuring just one person against the risk of premature death, an insurance company will insure several similar people against that risk. Pooling of risks rather than insuring just one person allows the insurer to be less reliant on the not-entirely-predictable mortality of that one person. In property insurance, the same concept is applied so that damage to a single property doesn't cause catastrophic loss for the carrier.

Often, each group of insurance customers who are pooled together will be put into the same "rate class," with all members of the rate class being charged a similar amount.

The pooling of risks is tied closely to a mathematical concept known as the "law of large numbers."

The Law of Large Numbers

Insurance companies try to measure risk and more closely predict losses by applying the law of large numbers to their business. 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 large number 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 how many customers who will suffer a fire-related loss.

Risk Management and Government

Although this chapter has focused largely on risk management in the private sector, it's worth noting that innumerable government efforts have been instituted to manage larger societal risks. For example, laws are a form of risk management designed to guard against losses caused by people who behave without enough respect for others. Programs such as Social Security and Medicare are government-run examples of the pooling of risks, where the risk of poverty and illness among senior citizens is spread and shared across the broader population. And of course, some government attempts at risk management have encouraged the private purchase of insurance, such as requirements to have auto liability insurance, workers compensation insurance and health insurance.

OSHA

In some corporate environments, a risk manager may be tasked with monitoring OSHA compliance. Under laws and rules enforced by the federal Occupational Safety and Health Administration, most private-sector employers must provide a safe workplace for their labor force. If a work environment becomes hazardous, employers must first take reasonable steps to remove hazards rather than exposing their employees to unsafe conditions. For example, if an environment could result in major head injury, the employer should first try to remove the source of potential injury before making workers wear protective headgear.

OSHA regulations also require that employers report workplace deaths and injuries that reach a certain threshold of severity. Workers who wish to report unsafe work environments must be allowed to do so without facing discipline from their employer.

Conclusion

As you can see, there's much more to risk management than simply buying insurance. But because many risks are best handled by transferring them to an insurance company, insurance producers will likely forever be an important piece of the risk management puzzle.

CHAPTER 2: LIFE INSURANCE CONCEPTS

Introduction

In early America, many people could provide posthumous financial support to their heirs merely by relying on wills and common law and passing farmland along to their descendants. As prized as real estate inheritances might be today, these kinds of property transfers were even more important to beneficiaries 200 years ago.

In Jeffersonian times, farmland symbolized more than a neat asset that could be sold for residential, commercial or industrial purposes. It was often a multi-dimensional safety net for families who had depended on loved ones for financial security. Heirs could have certainly tried to make up for the deceased's income by selling the property, but they also had the attractive option of living on the land for as long as they wished and growing various crops to sustain themselves and sell to neighbors. In short, a fortunate beneficiary could receive a home, potential nourishment and a potential source of income for the rest of his or her life, all in the form of a few acres.

The 19th century's Industrial Revolution instigated a slow, steady movement away from these resourceful farming communities and toward the cities. Along with that movement came a change in the way breadwinners managed risks related to untimely death.

With fewer people possessing assets that could be transferred and used on as many levels as farmland, Americans needed to find a new way to protect their loved ones from tragic, financial disaster. This desire for risk management has ultimately led millions of men and women to purchase what is still one of your industry's most popular and, perhaps, most beneficial products: the life insurance policy.

If we wish to validate how highly the public regards life insurance, several studies can provide us with evidence. The Life Insurance and Market Research Association (LIMRA) has reported that 68 percent of Americans have some form of this coverage. Other reports put that number even higher, at 80 percent or so.

As much as the public seems to like life insurance, the product's policy language often confuses prospective buyers. As a contractual agreement between the policyholder and the insurance company, a life insurance policy frequently contains commonly misunderstood passages and incomprehensible legalese. This is often true even in cases when an insurer claims to have presented its terms and conditions in plain English.

Legal disputes between policyholders and insurers confirm that the public is occasionally perplexed by language pertaining to policy loans, investment features and other contractual provisions. Insurers, too, are sometimes surprised by courts' interpretations of policy terms and conditions and sometimes find themselves having to honor claims that were never meant to be covered in the first place.

In order to minimize ugly and costly disputes between the customers they encounter and the companies they represent, insurance producers must know more about contractual terms and conditions than just what is spelled out in a sales brochure. They must school themselves in the details of provisions and restrictions to the point where they can answer any questions they would have about a policy if they were the ones shopping for coverage.

While exploring many common life insurance contractual features in this material, students will learn or be reminded of what these policy elements mean, why they exist and how they have been interpreted by courts in various circumstances. Readers will also review the various kinds of life insurance products and the importance of analyzing each prospect's unique needs.

The reader should note, however, that insurance texts, longtime agents and other reputable sources often contradict one another when listing the most common policy components and the ways an insurer can properly word a policy. These contradictions arise for several reasons.

The insurance industry's state-level regulatory structure represents the most obvious cause of conflict, with insurance laws in California differing from those in Illinois, with Illinois insurance laws differing from those in Indiana and so on. In states where a particular insurance law is less stringent than other states or does not exist at all, each individual insurance company might have its own way of wording and interpreting a particular clause in the insurance contract.

Market demands play a role in non-conformity, too, as companies go beyond a law's minimum requirements in order to attract preferred policyholders. Meanwhile, new products can influence even the most basic policy provisions and have, in fact, been created over the years in response to popular demand for improved policy features.

With all this in mind, preemptive apologies might be in order for the student who wants absolute answers about how policy provisions are written, interpreted and applied. The main point to derive from the following factual presentation is not that a court with jurisdiction in another region of the country ruled in favor of or against an insurer in a specific policy-related case. Instead, we hope you are reminded of how important these contractual elements can be and that you always consider this importance when working with customers, colleagues and supervisors.

Why Buy Life Insurance?

Modern insurance companies offer several kinds of life insurance policies with numerous product features. Offering policies with various provisions and riders makes good business sense because different people buy life insurance for different reasons. Even when two prospective buyers articulate the same general reasons for wanting life insurance, each person might have ordered those identical reasons differently on their individual lists of priorities.

For the sake of review, we should briefly mention some of the important roles a life insurance policy can play in people's lives.

Historically, people have bought life insurance in order to ensure that a dependent or other loved one will not suffer financial hardship after a death. Sometimes, the death benefit—the amount paid to a beneficiary—is helpful because it allows an otherwise independent person (such as a working spouse) to adapt to life without a shared income. More importantly, life insurance can create adequate income for those dependents who either need even longer periods to adjust to a devastating financial reality or might otherwise never be able to adapt to such a major change.

Examples of possibly needy beneficiaries might include a stay-at-home spouse who would suddenly need to find a job with competitive pay in order to make ends meet, a child who would need such essentials as food, clothing and a decent education, an elderly parent who would need to hire someone to help with various household tasks or any disabled loved one with special needs.

Life insurance can also help beneficiaries pay specific expenses in either a short-term or long-term capacity. A policy boasting significant benefits could help satisfy a mortgage loan on a family home or free a spouse from other debt obligations. A small policy might be enough to ensure that a low-income family will not need to lose thousands of hard-earned dollars in order to cover the cost of a respectable funeral.

No matter if their child is a few days old or has already spent years in the school system, middle-class parents might want to eventually borrow money from a life insurance policy and create a substantial college fund for a son or daughter, thereby making the policy not just a risk management tool but also a source of investment gains and savings.

That last example can help us bridge the gap between traditional views on life insurance, which center on death benefits, and current views on the policies, which treat life insurance as yet another wise addition to a diversified financial plan. Following the

annuity's lead, some life insurance policies have been marketed as smart investments for eventual retirement. Customers have been told about the various tax incentives that some life policies might provide. Even businesses have noted the financial flexibility of the product by taking out policies on valued employees and using life insurance as a prominent feature in buyout agreements.

Needs Analysis

On average, according to Advisor Today (the official publication of the National Association of Insurance and Financial Advisors), agents will handle 10 death claims during their time in the business and will therefore have at least that many chances to witness what life insurance can do for beneficiaries.

Those occurrences are bound to bring positive or negative "what if" scenarios to mind. Agents might recognize a death benefit's positive effects on a grieving family and think, "Thank goodness! What if that person had not bought this policy?" Or, in a more troubling scenario, they might meet people whose lives are unnecessarily worse due to either a bad policy or no policy at all. In these instances, they might think, "How awful! What if this person had been properly covered?"

These examples of good and bad experiences help explain why all people who express interest in buying life insurance need more than just a salesperson. Customers deserve a knowledgeable insurance representative who takes the time to understand their unique needs and who attempts to sell them only the products that could reasonably meet those needs.

In keeping with this service attitude, insurance producers can help reduce the millions of underinsured and over-insured people in this country by performing a "needs analysis." A needs analysis tries to determine how much insurance a person ought to possess. This analysis should be influenced by each individual applicant's concerns and risk potential.

For many years, life insurers pounded home the idea of purchasing coverage equal to five times one's income. These days, the five-year standard conflicts with the advice of insurance representatives who say people should buy coverage that is equal to eight, 10 or even 12 times their income.

Depending on the customer, the old five-year figure might be too high, or the 12-year figure might be too low. Although software programs and worksheets can help buyers and sellers arrive at a potentially adequate amount of death benefits and assist the two parties in policy selection, the numbers used to calculate a suitable death benefit are unlikely to protect the insured's present and future interests unless the seller raises important issues and receives honest responses from the applicant.

A proper needs analysis analyzes a customer's death-related risks and insurance objectives. When calculating a dollar amount for a proper death benefit, the producer and the applicant might find it helpful to ask and answer the following questions:

- How much money will dependents need in order to maintain their current standard of living and keep up with inflation?
- How much money will dependent children need for school tuition and basic necessities?
- How long is a person likely to remain a dependent and rely on income from a policy?
- How much money should beneficiaries receive—regardless of need—as a gift from the deceased?
- If the insured is in training for a potentially lucrative career, how much money should dependents receive in order to offset the loss of expected high earnings?
- How much money should beneficiaries receive in order to offset debts (such as a mortgage loan) that the insured person 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 the insured person's death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?

A needs analysis can lead buyers and sellers to the best kind of life insurance policy for a given situation. For instance, a high-income applicant might prefer a policy that could maximize the amount of death benefits without causing major estate tax problems. Middle and low-income applicants, on the other hand, are less likely to need this same kind of policy because their estates do not commonly face significantly negative tax consequences upon death. Instead, their financial situations might call for a traditional policy that guarantees necessary death benefits to children, spouses and other dependents in as simple a manner as possible.

A needs analysis might weigh the cost of a proposed policy against its potential benefits. This will be a particularly important consideration if a low-income buyer would need to make significant financial sacrifices in order to pay premiums. The insurance community remains divided, if not evenly so, in its approach to these low-income customers. Whereas some agents and brokers are likely to convince people with modest incomes that purchasing a policy with decent, nearly guaranteed death benefits is well worth the expense, others will appeal to these consumers by highlighting policies that offer extremely affordable premiums in exchange for few benefits.

A final factor to consider in a needs analysis is the potential buyer's eligibility for a particular policy. The good and bad news for buyers in this regard is that eligibility requirements will probably differ depending on the insurer, with the only near certainties being that someone who has been diagnosed with an aggressive terminal illness, such as AIDS (as opposed to someone who is merely HIV-positive) and certain cancers, has probably waited too long to pursue coverage.

The task of understanding industry-wide eligibility guidelines is made even more complicated by non-uniformity among the 50 states and their respective insurance laws. Though many companies will disclose the exact reasons for rejecting a life insurance applicant, insurers have not always needed to do so in every part of the country.

Note, however, that life insurers are concerned with life expectancy rather than pure health. As long as a person is likely to live long enough for an insurer to make a profit on a policy, a pre-existing condition that is not known to be life threatening will not necessarily disqualify someone for coverage.

Regardless of their exact criteria for eligibility, life insurers have traditionally placed healthy, low-risk applicants in a "preferred" or "preferred-plus" class and granted lower premiums to those customers. People with smoking habits, weight problems, high cholesterol and a record of personal or family health problems have found themselves paying higher premiums as part of a "standard" or "substandard" class.

Addressing Business and Tax Issues

Before moving further toward our course objectives, we ought to address two topics that appear frequently in trade literature but do not fit into our particular educational agenda. These topics—corporate-owned life insurance and tax issues—will certainly be relevant to some producers and their careers, but only a few specifics about them exist in the main body of this text. The following summaries are intentionally basic and have been included merely for background purposes so that the reader will more easily comprehend some concepts and facts discussed later in this chapter.

Corporate-Owned Life Insurance

Some companies purchase life insurance that protects their financial interests in the event of a key employee's death. In its traditional form, "corporate-owned life insurance" pays no death benefit to an employee's family or to any other worker-designated beneficiary. Proceeds from the policy go to the company, which may use the money in several ways, including as a subsidy for the business while it searches for a replacement, or as a source of funding for employee benefit programs.

A "corporate split-dollar policy," allows the company and the employee to share life insurance benefits as stipulated in the contract. Typically, upon the employee's death, the company receives compensation that is the greater of the amount of premiums paid for the policy and the policy's cash value. (In basic terms, a policy's "cash value" represents the amount of money that would be payable to the policyholder if he or she were to cancel or "cash in" the policy.) Any remaining death benefits from the corporate split-dollar policy go to the employee's chosen beneficiaries. In exchange for allowing the employee to designate a beneficiary, the business also reserves the right to borrow money from the policy's cash value at any time during the employee's lifetime.

Life Insurance and Taxes

As long as a policyholder does not borrow money from or cancel a policy, life insurance proceeds are generally exempt from income taxes. This tax break serves beneficiaries well, but the policy might be taxable as part of the deceased person's estate. The value of life insurance might be taxed against the deceased's estate if the deceased owned the policy within three years of death or if the estate is the beneficiary.

The federal estate tax (generally due within nine months of a death) can drastically reduce compensation for legal heirs. To combat this situation, many financial advisers champion the use of insurance trust funds. An insurance trust puts the policy irrevocably under the control of an executor. This person acts on the deceased's behalf by giving policy proceeds to beneficiaries at designated times and in designated amounts.

On occasion, policyholders look to avoid estate taxes by transferring policy ownership to heirs. In order for the proceeds to receive an exemption from estate taxes, such transfers must occur at least three years before the original policyholder's death.

Transferring ownership of a life insurance policy can still require the original policyholder to pay gift taxes. In general, in 2019, a person could pass along assets worth up to roughly $15,000 to non-spouses, without fair compensation, and avoid gift taxes.

This course's reduced emphasis on the federal estate tax stems not only from the daunting complexity of modern tax law but also from the issue's arguably minimal relevance to the majority of consumers. The federal government allows each person's estate to exempt a set dollar amount from taxation, and these exemptions tend to grow as the years go by. At the time of this writing, a person could exempt roughly $11 million from federal estate taxes, and perhaps much more depending on his or her marital status. Estates valued below this amount were exempt from federal estate taxes in 2019.

With this and the "needs analysis" concept in mind, an insurance producer could probably serve clients best by emphasizing a policy's tax advantages to people with large estates and deemphasizing them to people with few assets.

Kinds of Life Insurance

Before we begin to investigate the purpose and intention of various life insurance provisions, terms and conditions, we will first review the most common kinds of life insurance policies.

Term Life Insurance

Term life insurance is sometimes called "pure insurance" because, unlike other policies, it lacks investment options and has no cash value. Instead, term life customers pay premiums only so that beneficiaries can potentially receive the policy's "face value."

The face value is clear to the insurer and the policyholder when the policy is issued, and it generally does not change as long as premiums are paid. The face value is generally not dependent on the economy or the performance of investments. If a person who is insured through a $100,000 term life policy dies, the insurance company pays $100,000 to beneficiaries, barring any unusual circumstances.

As their name suggests, term life policies remain in effect for a contractually agreed-upon time and then expire. People who opt for a term life policy instead of a permanent life policy tend to have short-term needs and view beneficiaries' welfare as their top life insurance concern. A father, for example, might purchase a term life policy in order to ensure that his young children will have some financial support if he were to die before they reach adulthood.

When a policy's term concludes, the insured individual often can reapply for another term insurance policy. However, premiums for the new term policy are likely to be higher than premiums under the old policy. This is because the person's susceptibility to mortality risks will have increased with age.

If policyholders have no interest in renewing a term life policy they can sometimes exchange it for one of the several permanent life policies we will discuss later.

Term life insurance policies may be categorized based on the way consumers pay for them. An "annual renewable" term life policy might attract buyers who can see themselves canceling the insurance in the not-too-distant future. Premiums for these policies are at their lowest in the first year of coverage and can go up for each additional year.

Technically, people with annual renewable term policies enter into a new contract with the insurer for every year of coverage, but the insurer can change nothing but the premiums throughout the term. The insured does not need to medically qualify for the annual renewable policy every year. He or she must only continue to pay the company's asking price.

"Level term life insurance" lets policyholders maintain their term coverage at the same price for several years. Companies that

sell these policies work around age-specific mortality risks by charging customers a consistent average of the cost that would be charged for all years in an annual renewable contract.

Suppose, for example, the insured's policy costs $40,000 over a 20-year term. Instead of paying a low first-year premium of $500 and a twentieth-year premium of $5,000 under an annual renewable contract, the level term customer could pay $2,000 each year for the entire term.

A level term insurance policy will probably cost more than a standard annual renewable policy near the beginning of the term when the insured person is younger, but it will cost less than a standard annual renewable term policy near the end of the term when the insured person is older.

Permanent Life Insurance

Permanent life insurance is very different from term life insurance. Whereas term life insurance is either renewed frequently or allowed to expire after a specified number of years, permanent life insurance should cover the insured individual no matter how long a person lives. Also, whereas the cost of some term life policies can increase dramatically as the insured person ages, many permanent life policies feature locked-in premiums that remain the same for several years.

Cash Value

In addition to paying premiums for possible death benefits, people who purchase permanent life insurance are engaging in a financial investment. Permanent coverage allows buyers to turn the money they spend on their policy into accessible cash that will hopefully increase in value over time. Part of the premiums paid to the insurer is set aside and allowed to grow (or at least remain untouched) in tax-deferred accounts until the policyholder decides to use the money. In general, this money is known as the policy's "cash value."

Cash value makes permanent life insurance a very versatile asset. In many cases, it can be utilized to keep premiums at a level amount even as the insured person grows older. It also allows policyholders to either obtain a low-interest loan from their insurer or use their policy as collateral for a loan from another lender. It also gives people who no longer want their policies the chance to recover a portion of the money that was spent on the insurance. This amount of money is known as the "cash surrender value." The cash surrender value is equal to the policy's cash value minus any unpaid policy loans and unpaid premiums.

Some policies' cash surrender values and premiums are impacted by dividends. In the context of insurance, a "dividend" is a yearly partial return of premiums that insurance companies believe is in excess of their operating needs. Policyholders who receive dividends often have multiple options regarding what to do with them. For example, dividends might be paid to the policyholder in cash, held by the insurance company for the purpose or collecting interest or (in most cases) used to offset the cost of future life insurance premiums.

It is important to note that not all permanent life insurance policies pay dividends. Insurers that are configured as stock companies share profits with stockholders and usually do not incorporate dividends into their policies. Mutual life insurers, on the other hand, share their profits with their policyholders and do incorporate dividends into their cash-value contracts. This distinction helps explain why policies from mutual insurance companies are often called "participating policies" and why policies from non-mutual insurance companies are often called "nonparticipating policies."

Permanent life insurance ideally benefits the person buying coverage as well as the company selling it. The buyer not only remains covered as long as premiums are paid. He or she also has a financial incentive to maintain the coverage for various investment purposes. At the same time, the insurer benefits from offering this incentive because customers who maintain their coverage give the company a steady supply of capital to invest.

Despite this give and take, some critics say cash-value accumulation takes too long to materialize. This waiting period for growth exists, in part, because much of the premiums paid during the early years of coverage go toward sales commissions and administrative fees rather than toward the policy's cash value.

Types of Permanent Life Insurance

Unlike the different kinds of term life insurance, the various types of permanent life insurance policies differ significantly in ways beyond their premiums. The three main varieties of permanent coverage are whole life insurance, universal life insurance and variable life insurance.

Whole Life Insurance

Whole life insurance contracts can usually remain in force at least until the insured person reaches age 100, and premiums for these policies usually stay the same as long as the policyholder pays them on time. The price for whole life insurance pays for more guarantees than a person will find in a typical universal life or variable life policy, and the product remains popular among people who want permanent coverage but remain fearful of possible economic downturns.

Unless the policy's owner borrows against the policy's cash value, whole life policies will pay guaranteed minimum death benefits and feature guaranteed minimum increases in cash value. Guaranteed increases in cash value are achieved through investments in low-interest bonds and other low-risk ventures. The insurer takes responsibility for managing the investment portion of the policy, allowing customers to develop a financial asset without forcing them to wade through numerous investment options.

In some respects, the modest performances and common guarantees involved with whole life insurance can encourage saving among consumers who would not normally conserve much of their money. Many parents have utilized whole life's relative security as a foundation for college funds.

Still, among other clients who favor growth potential over security, the investment features of basic whole life insurance can seem insignificant. When interest rates on policy loans are low, some whole life customers borrow money from their policies and put that money into high-growth opportunities. Though this strategy has certainly not paid off in every instance, it has absolutely encouraged carriers to develop different life insurance products that give buyers more control over how their premiums are invested.

Universal Life Insurance

"Universal life insurance" tends to get tagged with the adjective "flexible" quite often. This product attracts people because it allows them to make changes to their insurance in a far simpler manner than under a basic whole life insurance agreement.

Rather than needing to pay an agreed-upon premium for permanent coverage, a universal life insurance policyholder has some control over the size and even the frequency of premiums. A person looking to grow a universal policy's cash value can increase premiums when interest rates are high and decrease premiums when those interest rates drop. Of course, the policyholder might also have personal reasons for raising or decreasing premiums at any given time.

Universal life insurance premiums are often disclosed in a divided manner, showing how much of each payment ultimately goes toward the death benefit and how much goes toward the policy's cash-value component. The portion of premiums that goes toward the death benefit is known as the "mortality cost." In order for the policy's death benefit to remain fully guaranteed, premiums paid by the policyholder must be at least as much as the mortality cost.

Due to their flexibility and emphasis on mortality cost, universal life insurance policies are less likely than whole life policies to fully guarantee large death benefits. Some insurers have offered policy riders that can fatten the guaranteed payouts, but these riders can make a universal insurance contract cost just as much as (or even more than) a basic whole life policy. Fully guaranteed death benefits from a universal life insurance policy tend to only apply when the policyholder has paid at least a specified minimum amount of premiums to the insurance company. The amount of premiums paid to the insurer must have been enough to fully offset the policy's mortality cost.

Variable Life Insurance

Variable life insurance is a form of permanent life insurance that exposes a policy's cash value to market risks in exchange for potentially higher returns. The owner still pays premiums for mortality costs and administrative expenses, and the beneficiary is still guaranteed to receive a death benefit when the insured dies. However, the policyholder (and not the insurance company) has control over how the premiums applied to cash value are invested. This is in contrast to the other forms of insurance we've covered in this chapter, which generally require that the insurer invest premiums in safe places and guarantee that the cash value won't drop due to economic downturns.

Variable life insurance premiums for mortality cost and administrative expenses become part of the insurance company's general account. Premiums applied to cash value, on the other hand, go into a "separate account" for the policyholder. The separation of this money is meant to ensure that bad investment choices by policyholders don't jeopardize the insurance company's solvency.

Money in the policyholder's separate account will be invested in a manner similar to mutual fund contributions. Most insurers offer a variety of investment options, including the chance to put money into bonds, government securities and domestic or foreign stocks. The owner of a variable life insurance policy can invest in several of these options at the same time and move money from one option to another within certain insurer-imposed limits. Any growth or decline in the cash value as a result of the owner's investments won't be taxable until the money is actually withdrawn and paid to the owner.

Variable life insurance can work well for people who want to pay for a death benefit and are comfortable with the uncertainty of long-term investing. People who are generally not comfortable investing in mutual funds and tend to worry about the short-term performance of their portfolios should probably avoid this product. Although variable life insurance has a guaranteed minimum death benefit that won't decline in a bad economy, the insurer will make no guarantees regarding the cash value unless the owner is willing to amend the policy with a potentially expensive rider.

Group Life Insurance

Though it can perform other functions, "group life insurance" is most commonly used to insure several people who work for the same employer. Premiums for group coverage usually depend on the collective age of the group participants and help pay for limited death benefits in the neighborhood of one or two times an insured person's annual salary.

Group life insurance involves very little underwriting and, therefore, can allow an ill or older individual to obtain some coverage at a low price. Some employers even offer limited group life insurance benefits at no cost to their workers. The typical employer-funded group plan will pay at least enough death benefits to offset funeral and burial expenses and perhaps some debts.

Unfortunately, many consumers do not realize that group life insurance is unlikely to help beneficiaries meet their long-term financial needs. Death benefits from these policies are not likely to sustain a young child for several years and might not satisfy outstanding debts on a home.

Laws and products that address insurance portability have allowed people who leave a group to convert their group life coverage into an individual policy under certain circumstances.

Accidental Death Insurance

"Accidental death insurance" is often bought by consumers who want to pay low premiums for at least some level of coverage and by travelers who are buying plane tickets. Many employers offer accidental death coverage as a free employee benefit.

This insurance can be purchased in combination with dismemberment coverage, or it can be bought as a rider to another policy. As a rider, the coverage will generally pay double the death benefit if the insured's life ends in an accident. This explains why accidental death benefits are often associated with the term "double indemnity."

In order for accidental death policies to pay benefits, there must be clear evidence that a death occurred because of an accident and not because of other factors or some combination of accidental and non-accidental factors. Most policies will only pay benefits if the undisputed accident occurred no more than three or four months before the insured person's death.

Deaths that are unlikely to be covered by this product include death by non-sudden illness, natural causes, sunstroke, drug overdoses, suicide by insane persons and deaths suffered by people aboard non-commercial aircrafts.

Credit Life Insurance

"Credit life insurance" is typically included in an umbrella-like policy that also covers unemployment and disability risks for people who are in debt. This product is similar to mortgage insurance, but beneficiaries can use its death benefits to eliminate debts that have nothing to do with real estate.

Though no specific numerical limits exist regarding the face value of a credit life insurance policy, the face value is nearly guaranteed to be low because the insurance is only designed to cover outstanding debts and any interest owed to a lender. The

policy usually does not include a death benefit that can replace income or provide for a dependent.

Premiums for credit life insurance are likely to remain the same throughout the coverage period, but the policy's face value drops as the insured person pays down debts. Insurers price the coverage as if it were an extremely inclusive group policy, with eligibility rarely jeopardized by a person's age or health status.

Funeral Insurance

Funeral insurance remains a multi-billion dollar industry despite criticism from some consumer advocacy groups and is commonly targeted at low-income families. For a few dollars each month, this insurance offers a modest death benefit (usually anywhere between $5,000 and $10,000) that families can use to pay for burial and other death expenses. The death benefit from a funeral insurance policy is rarely intended to replace the deceased's income.

Funeral insurance companies have stressed that, unlike term life insurance policies, claims on many funeral insurance policies can be paid no matter when the person dies. Other insurance workers believe a consumer should purchase a funeral policy only if he or she is ineligible for other life insurance products.

Joint and Survivor Life Insurance

Joint and survivor life insurance policies extend coverage to two or more people (usually a married couple), but they only pay one death benefit. Because only one death benefit goes to beneficiaries, a joint or survivor policy can cost significantly less than two individual permanent life products.

"Joint life insurance" is often called "first-to-die" coverage because the death benefit comes when the first person among the insureds passes away. This product became popular initially as a tool to help ensure that one spouse could pay off a mortgage loan and remain in a family home after the death of the other spouse. Some joint life insurers offer a "survivor purchase option," which might allow the survivor to trade in the death benefit for another first-to-die policy or an individual policy of equal value.

"Survivor life insurance" is often called "second-to-die" coverage because the death benefit comes when the last of the insureds passes away. This product became popular initially as a tool to help ease estate tax concerns for heirs.

Parts of a Life Insurance Policy

Now that we understand the general differences among the various life insurance products available in today's market, we can explore the intricacies involved with policy terms and conditions.

The Face Page and the Entire Contract Clause

Perhaps the most important element to understand throughout our exploration of these issues is that a life insurance policy is a legally binding contract between the policyholder and the insurance company. This point is usually stressed somewhere on the policy's "face page" or within the policy's "entire contract" clause.

The face page explains the duties that the insured and the insurer are expected to perform throughout the policy's lifespan. It declares that the policyholder will be held accountable for filling out a valid, honest application and for paying premiums. Meanwhile, the insurer will be held accountable for paying benefits on any valid claims, as long as the policyholder fulfills his or her end of the agreement.

An entire contract clause can be found within the actual policy (as opposed to within a policy summary or other document). This clause alerts all involved parties to the fact that the delivered policy contains all the terms and conditions related to coverage. It says the terms and conditions within the policy cannot be changed by the insurer to the detriment of the consumer during the policy period. It also states that the policy application, as filled out by the applicant, is considered part of the contract.

Minding the Application

The life insurance application and any personal medical records used by the insurer to underwrite a policy become part of the contract. The policyholder who makes false statements on these documents might risk either a reduction in his or her coverage or full termination of the contract.

Policyholders will typically receive copies of the completed application no later than when they receive a copy of the full policy. By retaining and reviewing copies of these documents, insurers and their clients can substantiate or dispel various alleged misstatements that could affect a person's right to death benefits.

Providing copies of the completed application to the consumer does not entirely eliminate the potential for disputes between insurers and the public. In order to reduce additional legal problems, insurance producers must make an effort to explain how customers should fill out applications and how incorrect information on the application could have a negative impact on coverage.

Ownership Clauses

A life insurance policy might mention "pre-maturity rights," also known as "ownership" rights. The policy owner (who might or might not be the person insured by the policy) is the individual who is legally held to the consumer's responsibilities that are spelled out in the life insurance contract.

Other than the insurance company, the policy owner is the only party who controls how the policy is set up. The owner is also the only person capable of choosing beneficiaries.

Once the policy is issued, the owner reserves the right to do any of the following:

- Borrow money from the policy.
- Use the policy as collateral for a loan.
- Access the policy's cash value within the limits of the contractual agreement.
- Utilize accelerated death benefit features.
- Designate and change beneficiaries.
- Make any other permissible changes to a policy, such as deciding how much to pay for a universal life insurance product or how to invest premiums for a variable life insurance product.

The owner may also transfer some or all pre-maturity rights to another entity without needing consent from beneficiaries or the insured.

The insured individual and the owner of the life insurance policy will often be the same person. Yet it is possible for a beneficiary or a third party to own an insurance policy on another person's life.

Practical reasons exist for this kind of arrangement. For example, even though some children are covered by life insurance or are listed as beneficiaries on policies, laws might prohibit anyone under the age of 18 from owning a policy. Other reasons for transferring policy ownership tend to involve probate and tax issues. Some applicants grant ownership to a trust in order to avoid estate taxes.

Insurable Interest

In general, a person can take out a life insurance policy on another person if the proposed owner can demonstrate an "insurable interest" in the other person's life. In simple terms, insurable interest within this context is a reasonable desire, on the owner's part, for the insured person to remain alive.

Ever since insurable interest became an industry issue, insurers have assumed that an individual has a reasonable desire to remain alive. Therefore, people are allowed to own life insurance policies on themselves. Insurers have also traditionally assumed that close family members (such as spouses, parents and children) and business partners have reasonable desires to see one another remain alive. So these people are usually allowed to own policies on one another.

Over time, the definition of insurable interest has become broader. Employers can now own policies on key personnel, and former spouses can often take out policies on each other, particularly when alimony and child support factored into a divorce settlement. Some insurers will even allow an unmarried person to own a policy that insures a significant other.

Despite the flexibility that is sometimes allowed by insurable interest, the insured person often must consent to another person owning a policy on his or her life. This consent might or might not be required when there is a spousal relationship between the policy owner and the insured. If people wish to void life insurance policies that have been taken out on their lives by another person or corporate entity, they should seek out local legal counsel.

Assignment Clauses

The owner's option to transfer his or her rights to another entity is spelled out in a life insurance policy's "assignment clause." In general, insurers put few restrictions on assignments, but some insist that the new owners either demonstrate an insurable interest in the insured's life or pay fair market value for the policy. Even when the insurer sets conditions for assignment, the company typically warns it will not be liable for any negative consequences that may arise as a result of the assignment.

Collateral Assignment

There are a few kinds of assignments that the owner can choose from. In a "collateral assignment," the policy owner uses the insurance strictly as a means of obtaining credit from a lender. Collateral assignments are meant to be temporary, with the end date dependent on when the policy's owner repays a loan.

Rather than granting the lender major ownership rights, a collateral assignment only allows the creditor to collect a portion of the death benefit and to access part of the cash value if the owner never repays a debt. If the owner dies, collateral assignees who are listed as beneficiaries are entitled to a death benefit equal to any remaining debt.

A collateral assignment agreement will be made in writing and will state whether or not the lender has assumed any responsibility for paying policy premiums. If creditors take on responsibility for paying premiums, they might be able to borrow money from the policy's cash value in order to keep the policy active.

Absolute Assignment

In an "absolute assignment," the original owner transfers all rights to a different person or entity, thereby losing control of the coverage and its cash value.

Absolute assignments can greatly affect insured persons and beneficiaries. The new policy owner is under no obligation to continue paying for the coverage and can exchange the policy for its cash value at any time. Depending on the insurer and the policy, an absolute assignment might either remove beneficiaries automatically from the contract or give the new owner the opportunity to revoke the existing beneficiary designations.

Other Forms of Assignment

Other transfer-related options exist somewhere between collateral and absolute assignments and allow the original policyholder to retain certain ownership rights. The original owner might, for instance, insist on preserving his or her right to receive dividends on a participating life insurance policy but be willing to forfeit all other pre-maturity rights.

Incontestability Clauses

The "incontestability clause" specifies how long an insurer may investigate possible frauds or misstatements on an application and deny coverage after the policy has been issued.

Incontestability clauses typically give the company two years to probe for untrue statements that affected the price and scope of coverage. These untrue statements are known as "material misrepresentations." When an insurance company refuses to cover a person based on alleged material misrepresentations, it must usually return all premiums to the policy owner in exchange for voiding the insurance.

Depending on state laws and judicial opinions, an insurer might be able to lean on the incontestability clause to deny a death claim based on a material misrepresentation even if the misrepresentation was not a factor in the insured person's death. This means, for example, that someone who lies about not having cancer, for example, can jeopardize death benefits for beneficiaries even if he or she ends up dying in an accident or from a disease other than cancer.

Insurers generally cannot rescind a policy after the contestability period has passed, even if they realize a policyholder has clearly engaged in material misrepresentation. Exceptions to this rule might include cases in which the policyholder bought the coverage with intent to murder the insured, lacked an insurable interest in the insured or recruited an impostor to impersonate the insured in a medical examination. In these situations, it is often assumed that no valid contract ever existed and that the insurer is therefore not liable for overstepping the incontestability clause's boundaries.

The incontestability clause protects policy owners from some potential instances of "post-claims underwriting," in which an insurer does not fully judge an insurance applicant's risk potential until after a policy has been in effect and after beneficiaries have requested compensation for a loss. With the incontestability clause in effect, the insured does not need to spend several years worrying about having made an innocent mistake when he or she applied for coverage. The incontestability clause has proven to be broad enough to even protect some applicants who intentionally defrauded insurance companies.

Some Incontestability Clause Case Studies

In order to comprehend the significance of the incontestability clause and the varying legal interpretations of other clauses, the reader is asked to examine the real-life case studies in this chapter. These examples were chosen in order to show students how different policies, laws and circumstances can lead to different legal outcomes even if two given situations seem very similar. Our first two case studies deal with alleged medical misrepresentations and an insurer's limited right to deny death benefits.

Incontestability Case #1

A man bought a $2 million life insurance policy on himself for use as collateral for his business. He listed the business as the intended owner and beneficiary.

On an application, the man was asked if he had ever had cancer, and he answered, "No." The application stated, "The statements and answers are true to the best of my knowledge," and also said, "No insurance shall take effect unless and until the policy has been physically delivered and the first full premium paid during the lifetime of the insured and then only if the person to be insured is actually in the state of health and insurability represented in … this application."

The man took a physical to obtain coverage, and the insurance company received copies of his medical records from a physician. The insurer believed the man's health was satisfactory and issued the policy on April 26. On May 1, the man filled out an identical application for a policy that listed a trust, rather than his business, as the owner and beneficiary. This new policy was delivered to him 24 days later, and the initial policy never went into effect.

The application from May 1 contained no mention of an April 18 physical examination that revealed blood in the man's feces. On June 20, the man was diagnosed with colon cancer and later died from the disease. The insurance company learned that the man had had a tumor at least since January, roughly three months before he ever applied for the coverage, and it decided to void his policy.

The man's wife sued for breach of contract, but the insurer claimed it was within its rights because the man had misrepresented his medical condition. The wife argued that even though her husband had misrepresented his health, he had not intended to commit fraud. Though he might have had cancer when applying for coverage, he had not been conclusively diagnosed with the disease by that time.

The United States Court of Appeals for the 8th Circuit ruled in the insurance company's favor, determining that the man's good faith was not the issue at hand. Instead, the coverage had been denied because the information given to the insurer about the man's health turned out to be factually inaccurate.

Incontestability Case #2

In another case, a Michigan woman filed a $44,000 death claim after her husband died in a swimming accident. Despite the expiration of the policy's contestable period, the insurance company denied the claim and offered to return premiums to the wife after it learned the man had not disclosed a heart condition when applying for coverage.

Both parties agreed the heart condition did not play a role in the husband's death, but the insurance company claimed it was within its rights to deny benefits because the man would not have received coverage in the first place if he had properly told the insurer about his health.

Though judges acknowledged that laws in other states might contradict their ruling and that misrepresentations need not relate to death in order to merit a denied claim, the state Supreme Court ruled in the wife's favor.

In its opinion, the judiciary said the incontestability clause "balances the concerns of insureds that years after the application date an insurance company would refuse to pay benefits and desire to avoid contracts, no matter how old, if there was material misrepresentation at the time the contract was made."

Incontestability Case #3

Our next two case studies demonstrate different interpretations of how the incontestability clause can protect either the insured or the insurer when relatively obvious instances of fraud are revealed.

A New Jersey man applied for disability insurance on January 20, 1987, and claimed, on his application, he had not been treated, observed or examined by a doctor in the preceding five years and had not been alerted to any possible eye diseases he might have developed. The insurer issued the policy less than two months later and used an incontestability clause that said, "After your policy has been in force for two years, excluding any time you are disabled, we cannot contest the statements in the application. No claim for loss incurred or disability beginning after two years from the date of the issue will be reduced or denied because a disease or physical condition existed before the date of issue, unless it is excluded by name or specific description."

When the man filed a disability claim on January 7, 1991, for loss of vision, the insurer denied benefits and said its action was based on material misrepresentation. According to an attending physician, the man exhibited symptoms related to an eye disease in late 1989 and had sought similar treatment from two other doctors in 1985.

The man admitted playing a role in insurance fraud, yet he reasoned the insurance company could not deny his claim since the contestability period had ended.

The Supreme Court ruled in the insurer's favor and said incontestability clauses were created to protect policyholders who made "technical" mistakes on their insurance applications. According to the court, "Statutory language that precludes a defense based on a pre-existing disability does not protect insureds who make fraudulent misrepresentations in their applications. Rather, the language is intended to protect those insureds who are unaware of their diseases."

Incontestability Case #4

A different outcome surfaced in a decision from the Supreme Court of California. In this instance, a man with AIDS lied about his condition in order to obtain a life insurance policy and recruited an impostor to take a medical examination in his place.

On his application, the man claimed he was 5'6", weighed 142 pounds and did not smoke. But the man who gave a physician an HIV-negative blood sample stood 5'10", weighed 172 pounds and produced urine that proved he was a smoker. The examined person had no identification to match him with the applicant, and the insurer's medical examiner documented this fact.

The insurance company opted to issue a policy for the applicant on May 1, 1991, which said, "We will not contest coverage under

the certificate after it has been in force during the life of the covered person for two years from the certificate effective date, if all premiums have been paid."

The applicant eventually sold his policy in the secondary market, and the policy's new owner received confirmation from the insurer that the contract's contestability period had expired. The applicant died on June 11, 1993, and the new policy owner filed a death claim with the insurer.

A tip eventually alerted the insurance company to possible fraud, and after conducting a handwriting analysis, the insurer denied the claim. The new policy owner sued for compensation, and the court ruled against the insurance company.

The court acknowledged that fraud is bad but also said the insurer only has a limited time to look for it. The judiciary reasoned that the insurer had all the evidence it would have needed to void the policy within a two-year period and said the company squandered that chance by just accepting premiums rather than investigating the matter promptly.

In response to the insurer's impostor defense, the court said the sick man was the one who applied for coverage and was the person who the company intended to cover. Therefore, the covered person was not an impostor.

According to the court, "When the named insured applies for the policy, and the premiums are faithfully paid for over two years, the beneficiaries should be assured they will receive the expected benefits, and not a lawsuit, upon the insured's death."

Suicide Clauses

Since self-inflicted deaths factor into the mortality tables that insurers use to underwrite coverage, it would be illogical for insurance companies to exclude all suicides in their life insurance policies. But insurance professionals still hope to discourage people from taking their own lives in order to create income for beneficiaries.

Similar to the incontestability clause, the "suicide clause" usually states that an insurer will not pay death benefits when insured people kill themselves within two years of obtaining coverage. A clear and complete suicide clause will also mention the company's claim responsibilities in cases when the insured commits suicide while sane or insane.

Contrary to tradition, some modern courts have put the burden of proof on the insurance company's' shoulders in regard to denying death claims based on suicide. This means an insurance company that wants to deny a claim on suicidal grounds might need to prove that a person's death was a suicide and had nothing to do with any accidents or medical problems.

A Suicide Clause Case Study

Firm disagreements between insurers and beneficiaries in regard to an alleged suicide are very likely to push the arguing parties into a courtroom. For a real-life example, we will turn our attention to a case heard by a U.S. district court.

A depressed man went to a physician, who prescribed anti-depressant medication for him. According to the doctor, the man did not seem suicidal during the appointment.

At some point, the doctor doubled the dosage, and the man shot himself two days later without leaving a note. His wife filed a claim with the company that insured him through an accidental death policy.

The accidental death policy did not cover "suicide or any intentionally self-inflicted injury," but the wife claimed the policy should have paid benefits because it failed to differentiate between sane and insane suicide. She said her husband did not intend to kill himself and that the anti-depressant medication was to blame for his actions.

The wife, who also sued the drug company, conceded that a statement on the policy summary said the insurer had the power to interpret the policy, but she also claimed this statement did not exist within the policy itself and that the actual policy's content ought to have overruled the content of the policy summary. She brought the insurance company to court, alleging it needed to prove the policy did not cover her husband's death.

The court disagreed, concluding that the burden of proof was on the wife. If she wanted the death to be covered by an accidental death policy, she would first need to prove that the death was, indeed, an accident.

Misstatement of Age or Sex Clause

Age and gender are important underwriting factors for life insurers. After all, on average, younger people will live longer after qualifying for coverage than older people, and women will generally live longer than men.

The "misstatement of age or sex clause" allows an insurance company to adjust coverage appropriately when an insured's supposed age or gender turns out to be inaccurate. The clause forbids cancellation of a policy based on these inaccuracies, unless the policy and local laws allow an exception when the owner or an insurance representative has clearly and intentionally tried to defraud the company.

If an insurance company can prove a misstatement of age or sex, the policyholder will typically need to pay an adjusted premium in order to avoid a change in coverage. When the insured's age is actually higher than originally thought, either premiums will rise or the death benefit will be reduced. When the insured's age is actually lower than originally thought, the insurer will either return a portion of premiums or increase the death benefit.

Sometimes uncertainty arises when an insurance company confirms a misstatement of age. The client and the salesperson might understand that the premiums and coverage will be adjusted. But how will this be done?

Suppose a person has been covered by a life insurance policy for 20 years, and the insurer finally recognizes that the person's stated age is incorrect. Will the coverage and premiums be adjusted based on the insurer's current rates, or will the adjusted premiums and coverage be based on prices from 20 years ago? A proper misstatement clause will explain how the insurer will handle this sort of situation.

Adding to possible confusion is the fact that insurance companies treat age in different ways, even before misstatements are realized. Some insurers base their rates on a person's actual age upon application for coverage, while others round the person's age to the nearest birthday.

Note that misstatements of age do not always stem from an applicant's conscious desire to receive a lowered premium. They also can grow out of confusion and mistakes. These mistakes can apply to the producer as well as to the applicant.

In one documented case, a person applied for life insurance, received an issued policy and had a birthday in between. In error,

the insurer used the age listed on the application and gave the insured a lower premium than he deserved.

When discussing age-related errors, experts have offered precautionary suggestions to their peers. The suggestions include the following:

- Making space on applications for a person's age AND birthday.
- Requiring an applicant to submit a birth certificate to the company before a policy may be issued.

Dividends, Vanishing Premiums and Policy Illustrations

As we learned earlier, certain types of insurance companies pay back a portion of premiums to policyholders in the form of dividends when profits exceed business needs. These dividends might be possible because an insurer priced a product too high or because the company made more than enough money in a year to meet requirements related to its reserve and surplus accounts.

Technically, only mutual insurance companies (which share company profits with customers rather than stockholders) give out true dividends to policyholders. When people use the term "dividends" in connection with policyholders at stock insurance companies, they are probably referring loosely to interest earned on permanent life insurance policies.

Mutual insurance companies calculate dividends by looking at mortality rates, interest rates, business expenses and other statistics. Due to the variable nature of those numbers from year to year, dividends are not guaranteed.

If a mutual company experiences an unfavorable investment outcome, the insurer may choose to lower dividends or to temporarily not offer them at all. Yet careful insurers have found ways to compensate for unknown economic results and have always been able to offer some dividends to policyholders, even if those dividends are lower than expected.

Insurance companies give customers several options when it comes to utilizing their dividends. These options are typically as follows:

- A policyholder can receive a check from the insurance company and use the money created through the dividend to pay for private expenses.
- A policyholder can keep the money with the insurer and allow it to gather interest.
- A policyholder can use the money to increase a policy's death benefit on a cash-value policy.
- A policyholder can exchange the dividend for a term life insurance policy.
- A policyholder can repay a policy loan by giving the dividend back to the insurance company.
- A policyholder can use the money to offset current or future premiums.

That last option became very popular during the 1980s and relates to a life insurance feature called a "vanishing premium." When owners pay premiums for an extended period of time, an insurer might allow premiums to "vanish" by using policy benefits to pay for coverage. Rather than billing participating policyholders directly for coverage, the carrier might take premiums out of accumulated dividends and interest.

When everything goes as planned, a policy with vanished premiums can create convenience for people who expect to hang onto their permanent life insurance for a long time. These policy owners might believe that they possess fully "paid-up" coverage.

Unfortunately, a vanished premium can sometimes reappear if dividends from a participating policy become too small to cover the cost of the insurance.

It's also important for insureds to know that dividends—no matter how steady they might seem at any given time—are not guaranteed to remain stable forever. When a policyholder depends on them to vanish premiums, dividends that go up or down even a single percentage point can mean the difference between the policy paying for itself and the buyer needing to pay more money to the insurance company.

A few major insurance companies have been accused of overstating the probable size of future dividends to older customers in order to make policies with vanishing premiums seem attractive to retirees on fixed incomes. One company was accused of making retirees think the money they were actually paying to vanish a life insurance premium was funding an annuity. In the end, the company faced fines of up to $20 million and was forced to give millions of dollars in refunds to policyholders.

In a real-life example from a district court in Mississippi, a man bought three $230,000 vanishing-premium policies. An insurance producer allegedly showed the man an illustration that suggested the policies would be paid up after two years if the prospect paid at least a $2,800 annual premium for each policy.

After two years, the man received a letter from the producer, as well as documents from the insurer's home office, which said the financial plan had worked successfully and that the premiums had vanished. Over the next three years, the man received premium notices from the insurer, and the producer told him dividends and policy loans would continue to cover the cost of coverage.

The man later learned the vanished premiums could return and that the illustrations used to demonstrate policy dividends had been based on overly optimistic investment projections. He accused the insurer and the producer of fraud, breach of contract, intentional interference with contract rights and negligent misrepresentation, and he instigated a class action lawsuit that included plaintiffs who had bought whole life or universal life policies from the company from 1982 through 1996.

Courts ruled the producer had no fiduciary duties to the policyholders in this case, cleared the producer of charges related to deceptive sales practices and dismissed the contract-related charges. They did not, however, dismiss fraud charges against the company. In response to the suit, the insurer offered a settlement to 240,000 policyholders that was worth $55 million in increased benefits and other compensation.

As lawsuits of the real and threatened varieties became more prevalent, the insurance industry responded to the vanishing-premium controversies. One insurer accused of wrongdoing stopped using the words "vanishing premium" and substituted "premium offset by policy values" in their place. The National Association of Insurance Commissioners (NAIC), which creates model industry regulations, has supported the following measures:

- Stopping the use of the term "vanishing premium."
- Forcing insurers to have dividend illustrations approved by a special actuary who has no connection to sales or marketing.

- Requiring the agent and the consumer to sign a document that says the consumer understands the illustrations and the potential benefits and consequences that could materialize based on the policy's structure.

The legal disputes over dividends and vanishing premiums have lent themselves to a broader discussion about fairness and policy illustrations. Professionally constructed illustrations can help consumers visualize how permanent life insurance policies can grow in cash value over time. But because policy illustrations should ultimately serve as a buyer's tool rather than as a salesperson's weapon, some insurance producers have called on the industry to forbid agents and brokers from emphasizing interest rates and dividends that are not guaranteed.

Some among this group would still allow salespersons to discuss an insurer's past interest rates and dividends with clients but would not allow salespersons to use these numbers on illustrations or even discuss them without emphasizing that past dividends are not guarantees of future dividends. Other people suggest that an insurer should be able to use non-guaranteed interest rates and dividends in illustrations as long as the company lowers its projections by a percentage point or two. Most state regulators have adopted the stricter of those two positions and require insurers to emphasize that dividends are not guaranteed.

Policy Loans

Several reasons exist for policyholders to take advantage of a contract's loan features. For example, prospective borrowers are unlikely to be turned down by their insurance company as long as their policies serve as adequate collateral for a loan. Along with this privilege come fewer questions on a loan application and greater overall privacy than a person would receive from a traditional lending institution, such as a bank.

Though the federal government has tightened tax laws pertaining to life insurance loans over the past several decades, borrowing from a life insurance policy is still likely to incorporate fewer tax issues than borrowing from a person's 401(k) or other retirement account. Also, unlike other credit situations, a loan from a life insurance company usually comes with a low-pressure obligation to pay off the debt. If a person dies or cancels a policy without paying off a loan, the company can simply take money out of the policy's cash value.

For a long time, policy loans were considered a great bargain for consumers because interest rates were fixed throughout the industry near 5 percent, a much lower rate than what banks were offering to borrowers at the time. By the 1970s, so many people had taken out policy loans that life insurers had become a bit nervous. As an insurer passed out loans, it had to work harder to maintain adequate reserves. The strain on reserves, in turn, limited insurers' investment options by forcing companies to keep their money in safe, low-interest bonds rather than in higher-risk and higher-growth markets like real estate. Insurers eventually gained the ability to give loans at variable interest rates.

Many companies give policyholders a few choices in regard to interest rates on loans. These choices relate to a concept called "direct recognition," in which coverage and benefits will depend on a policyholder's lending preferences and outstanding debts. Because borrowing money from an insurance company temporarily deprives the company of money it could invest, participating clients who take out policy loans might watch their dividends drop. Borrowing money could also affect the interest rates that are applied to a policy's cash value. A client can lessen these negative consequences by agreeing to a larger interest rate on a loan. Someone who chooses higher interest rates on a loan might also have the ability to obtain more overall coverage at a cheaper price.

A number of borrowers lose sight of the fact that, like most other unpaid debts, the amount of money owed to an insurer will increase if a person does not pay off a loan in a timely manner. This forgetfulness or lack of understanding can spell trouble for people who take out major loans on policies with insufficient cash values. When left unpaid, loans plus accumulated interest on those loans can impact the amount of death benefits payable to beneficiaries.

Automatic Premium Loans

A policy feature known as an "automatic premium loan" permits the insurance company to use part of a permanent life insurance contract's cash value to keep a policy in force when the owner misses a premium payment. Most insurers do not place limits on automatic premium loans in regard to either amount or frequency, as long as the policy's cash value is large enough to cover the cost of coverage. Other companies might have rules that prevent an owner from utilizing automatic premium loans too frequently. Their policies might state that owners can only take out a specific number of consecutive loans to pay premiums, or they might say owners cannot take out any more than a specific number of automatic premium loans in the same year.

Life Insurance Premiums

The cost of life insurance to the consumer will depend on several factors, including mortality rates, lapse rates, administrative expenses and an insurer's investment performance. A person can buy a policy with one lump sum, secure the coverage permanently through a set number of premium installments or pay premiums on a steady schedule until a policy reaches its maturity date.

Insurance companies reserve the right to charge policyholders interest when premiums do not arrive on time, but many carriers are lenient and do not bother to follow through. For life insurance policyholders, the chief risk involved with not paying premiums in a timely fashion is that the insurer might revoke coverage. If an insured person dies without having paid a premium, the company will recoup the cost of coverage by deducting it from the death benefit.

Free-Look Periods

A policy provision called a "free-look period" gives new policyholders a short period of time to possibly reconsider their purchase, cancel the policy and receive a refund of that first premium with no questions asked. In order to receive a full return of the first premium and not face any surrender charges, the owner must return the policy to the home office or to the agent or broker before the free-look period expires.

The free-look period begins on the day the policy's owner receives the newly issued policy from the insurer. The deadline for a complete return of premium and other related fees will depend on state laws and policy language. Some insurers limit the free-look period to 10 days. Others allow for a 20-day period. In some states, people over the age of 60 have received a 30-day free-look period for life insurance policies and annuity contracts.

Policies meant to replace previous coverage will usually feature longer free-look periods than other policies. Universal life

insurance contracts, which commonly replace other life insurance policies, tend to give consumers longer free-look periods than other life insurance products.

Variable life policies deserve special mention in any discussion of life insurance and free-look periods. People who own these policies obviously want their cash value to grow quickly, yet a fast, negative return on an investment would complicate matters if the owner were to ask for a return of premium in accordance with a free-look provision.

Perhaps this explains why initial premiums for variable life insurance are often put in money market accounts, where policyholders' invested funds are very unlikely to decrease in value. When insurance companies decide to put an initial premium into special accounts during free-look periods, they might need to disclose this fact in the policy, so that policyholders are not surprised by early investment performances and are able to allocate their investments at their own discretion immediately after the free-look period passes.

Grace Period

Even if a policyholder misses a premium payment, the insurer must keep coverage intact until the policy's "grace period" has ended. This grace period typically lasts anywhere from 30 days to 60 days.

A Grace Period Case Study

A grace period can certainly ease insurance concerns for policy owners who either forget about a payment or find themselves on too tight a budget to pay a required premium. But as a case study from the U.S. Court of Appeals for the 8th Circuit proves, this policy feature can also offer unexpected comfort to life insurance beneficiaries.

A married couple in Arkansas had bought a group-rate accidental death and dismemberment policy worth $150,000. On June 30, the husband talked to an insurance representative and intended to cancel the policy. The insurer gave the man two options: He could receive an immediate refund from the company, or he could simply not pay the next premium—due August 13—and allow the policy to quietly lapse. The man opted for the latter. He and his wife died in an automobile accident on September 11 that same year.

State law, at the time of the deaths, said, "The group policy, excluding an annuity policy, shall contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force unless the policyholder shall have given the insurer written notice of discontinuance and in accordance with the terms of the policy."

The couple's children argued, based on the law, that their parents' policy should have remained in force until September 13. Meanwhile, the insurer argued that the husband's phone call served as adequate notice of his intent to cancel, based on company practice, and refused to pay any death benefits to beneficiaries.

Furthermore, the insurer said the state law did not apply to the couple's policy because the law concerned group life insurance coverage and not group accidental death and dismemberment coverage.

The insurer's argument did not satisfy the court. State law defined "life insurance" as "insurance on human lives," and the judiciary said it had "no reason to exclude from that definition a human life lost to an accident or by accidental means."

Cancellations and Nonforfeiture Benefits

Sometimes, rather than worrying about the continuance of coverage, consumers might decide that they no longer want their life insurance policy. As anti-insurer as this might sound, these people might have good reasons for getting rid of their coverage. A person might have little concern for estate planning and believe enough assets exist to leave dependents and loved ones a substantial financial cushion. People with average or modest savings might have managed to pay off debts and raise a family to a point where they no longer need to worry about dependents' financial futures. When people grow older, they might not have potentially needy beneficiaries, and they might feel like cashing in their permanent life insurance policy in order to fund their retirement.

Permanent life insurance policies feature "nonforfeiture benefits," which give longtime policy owners some level of compensation when they either cancel or reduce their coverage. In a bit of a give-and-take situation, these benefits tend to increase as an in-force policy ages and as the policy's cash value grows. This gives owners an incentive to not terminate their coverage after only a few years.

Different insurers will have their own variations of nonforfeiture options, but we are at a point in history when those options, across the industry, can be narrowed down to three choices.

One option involves a clean break between the insurer and the consumer and sees the policyholder surrendering coverage in exchange for its cash value. When a person asks for the cash value, the insurer will deduct unpaid premiums and outstanding loans from the total surrender value. As good as this option might sound, it can entail a few drawbacks. Surrendering a life insurance policy could involve surrender fees, and people who cash in their policies might have to count a portion of the cash as taxable income if investment gains have pushed a policy's cash value above the amount of money a client actually spent on premiums.

Other options merely modify the relationship between the insured and the insurance company and continue coverage in some form. A popular nonforfeiture benefit allows the policyholder to exchange permanent life insurance for paid-up term life insurance. In a third arrangement, a person who still prefers to own at least some life insurance but worries about outliving term coverage can trade in a policy's cash value for a lesser amount of paid-up permanent insurance.

A policyholder often has the right to choose among these three basic nonforfeiture options upon cancellation or reduction of coverage. However, a life insurance contract may list a default nonforfeiture benefit that will go into effect if coverage is canceled and the buyer takes no further action.

Term life insurance boasts a comparatively clean-cut cancellation process. Because term life insurance has no cash value, a policyholder who no longer desires coverage can simply ignore premium notices, take advantage of a grace period and allow a term life insurance policy to lapse. Income tax issues should be non-existent in this case, and any cancellation fees will generally be smaller than surrender charges for permanent life insurance. A person who actively cancels an annually renewable term policy might even be entitled to a partial refund of premiums.

Each policy might feature important details regarding cancellations. Consumers would benefit from consultations with unbiased financial experts before deciding whether or not to cancel their life insurance.

Reinstatement Clauses

When an insurance company rescinds coverage because of unpaid premiums, the policyholder often has the right to regain coverage within a certain period of time. Conditions for this option are found in a policy's "reinstatement clause."

Through reinstatement, the policyholder might be able to regain the previously cancelled policy's cash value. Plus, when the policy is reinstated, the owner will often be charged the same premiums that were in place at the time of cancellation instead of a higher premium based on the person's age.

However, the owner will need to pay all premiums that would've been due between the point of cancellation and the point of reinstatement. Also, the insured might need to medically qualify for coverage again and, therefore, might run into problems if he or she has experienced serious medical issues in the interim.

Replacement Policies

Buyers might replace life insurance policies because their needs change, because they recognize a better policy from a different insurance company or because they feel most comfortable working with their longtime agent who has moved to another carrier. At other times, salespersons have been known to instigate policy replacements in the hope of receiving fresh and large commissions. No matter the motive behind the replacement, insurance customers and producers must understand the risks involved with swapping policies.

It is almost always unwise for customers to cancel one insurance policy before they have been approved for a replacement policy. An older, sicker person who forfeits an old policy might never again be able to find equally affordable or sufficient coverage. Even a brief gap in coverage for a younger, healthier person can put dependents at risk, given the unpredictability of death.

A Replacement Policy Case Study

From the insurance company's perspective, replacement policies can also create unexpected problems when someone files a claim. A case study courtesy of the District of Columbia Court of Appeals showcases how claims and replacement policies can cause confusion.

In 1979, a man purchased a $35,000 life insurance policy, which said, "In the event of suicide of the insured while sane or insane within two years from the issue date, the amount payable under this policy shall be limited to the amount of premiums paid."

By 1985, the man was considering getting rid of the policy, but the agent who handled the initial sale convinced him that the policy's cash value and the family's decreased insurability were decent-enough reasons to maintain the coverage.

Three years later, the agent suggested that the family increase its coverage to $50,000. The man agreed to the increase without viewing the policy or discussing anything other than premiums with the agent. The insurance company signed and issued a new policy for the man on November 8, 1988, but the man did not sign the contract.

The new policy said, "For the first two full years from the date of the issue, the company will not pay if the insured commits suicide, while sane or insane. The company will terminate the policy and give back the premiums paid less any loan and any partial surrender amount [previously paid]. A like limitation applies to any increase in benefits and the effective date of such increase."

When the man killed himself 20 months later, his wife filed a claim for $35,000; the amount that would have been owed to her under the 1979 contract. The insurer denied the claim, saying the husband had died during the 1988 policy's contestability period, but it paid back premiums that turned out to be in excess of the premiums paid for the 1988 policy.

The wife sued, claiming the 1988 replacement policy should have been treated as an extension of the older policy and that only the original suicide clause applied in this case. The court ordered the insurer to honor the claim and commented on the wife's reasoning.

"By not claiming the $15,000 increase agreed to within two years of (her husband's) suicide, (she) implicitly recognizes the reasonableness of the term of the 1988 policy…that expressly excludes payment of the amount of any increase in benefits if the insured commits suicide within two years of the effective date of the increase."

Beneficiary Designations

Correctly designating a beneficiary on a life insurance policy might seem like a simple act. But because an invalid or incorrect beneficiary designation could defeat the purpose of buying the insurance in the first place, buyers and carriers must have a mutual understanding of how a policy bestows death benefits upon selected individuals. When a person's life insurance policy does not clearly list a valid, identifiable beneficiary, death benefits will become part of the deceased's estate, and, contrary to popular belief, a dead person's last will and testament will often not suffice when survivors try to overrule designations made on insurance beneficiary forms.

There are two general ways in which beneficiaries can be categorized. The first way categorizes beneficiaries by their permanence. Some beneficiaries are "irrevocable beneficiaries." These designated individuals will remain beneficiaries even if the policy owner changes his or her mind and wants someone else to serve in that role. Other beneficiaries are "revocable beneficiaries." No matter their own desires, these individuals can be removed from a policy at the owner's command.

Beneficiaries are further categorized as either "primary beneficiaries" or "contingent beneficiaries." Primary beneficiaries are first in line to receive any death benefits. If a policy lists more than one primary beneficiary, the listed individuals will share death benefits based on the percentage that the owner has designated for each party. Multiple contingent beneficiaries may also share benefits, but they can only receive compensation if no primary beneficiaries are alive at claim time.

In rare cases, a policy might contain a "survivorship clause" that could cause a change in beneficiaries even after the insured person dies. This clause might state that a beneficiary must outlive the insured by a specific number of days before the person can receive any money from the insurance company.

When adding or removing beneficiaries from a life insurance policy, the owner must provide written notice to the insurer and complete any additional company-mandated paperwork. Some insurers will wait for owners to request these forms, but others send out change of beneficiary forms every few years in order to give their clients regular opportunities to update their policies.

A Beneficiary Case Study

A case from the U.S. Court of Appeals for the 5th Circuit shows how an understanding of beneficiary forms might help prevent legal trouble. A man purchased a $20,000 accidental death and dismemberment policy through his employer, along with $126,000 in supplemental life insurance.

On the beneficiary form, the man listed his former wife in a section for primary beneficiaries and wrote “100%” by her name. Below his ex-wife’s name, but still in the space for primary beneficiaries, he listed his sister and wrote “100%” by her name, too. In a section for contingent beneficiaries, he listed his son and indicated the son should receive 100 percent of the death benefits if none of the other beneficiaries were alive at claim time.

The policy said, “If more than one beneficiary is named and you do not designate their order or share of benefits, the beneficiaries will share equally.” It also stated, “When making a benefit determination under the summary of benefits, (the insurer) has discretionary authority to determine your eligibility of benefits and to interpret the terms and provisions of the summary of benefits.”

When the man died from a heart ailment, his ex-wife filed a death claim and received roughly $95,000 from the insurance company. The insurer decided to hold onto the remaining death benefits and review the claim. The man’s sister insisted that her brother intended for her and his ex-wife to split 100% of the death benefits as primary beneficiaries. She claimed she was not specifically listed as a contingent beneficiary and that she was entitled to half of the policy’s face value. She said the insurance company should have been held responsible for making sure her brother understood how the death benefits would be disbursed.

In response, the insurer said it could not have determined the man’s intentions ahead of time because his employer had held onto the beneficiary forms until the death claim arrived. The court ruled against the sister, concluding that the man had, indeed, put the beneficiaries in order and had listed percentages for each person. In the court’s opinion, the insurance money would have only belonged to the sister if the ex-wife had passed away before the man’s death. This case highlights the importance of clearly stated desires when listing beneficiaries.

Beneficiaries and Divorce

Of all the factors that contribute to beneficiary disputes, divorce seems to receive the most attention from the judiciary. Laws and insurance practices among all the states are far from uniform in regard to this topic, making it even tougher for insurance professionals and their customers to understand how a failed marriage might affect a former spouse’s right to death benefits and policy ownership. On one hand, many divorce courts force people to maintain life insurance on themselves if a former spouse or a former spouse’s child is listed as a policy’s beneficiary. Other state laws effectively remove former spouses as beneficiaries on life insurance policies.

Divorce Case Study #1

In a case heard by the Missouri Court of Appeals, a husband and wife divorced after having four children. The divorce settlement called for the husband to take out a $100,000 life insurance policy on himself and to list his former wife as the beneficiary until all their children came of age.

Three years later, the man finally bought a policy and listed his ex-wife as a revocable primary beneficiary and his new wife as a contingent beneficiary. According to court documents, the new wife paid premiums for the policy.

Later, the man changed beneficiaries on the policy without alerting his ex-wife to the situation. In its revised form, the policy listed his new wife as the primary beneficiary and his stepdaughter as the contingent beneficiary.

The man and his new wife eventually got divorced, but they continued to live together, and she continued to pay for the life insurance. Their divorce settlement gave the second wife control over some of their assets but did not specifically mention the policy.

The man later died when the youngest child from his first marriage was 9 years old. This set up a court battle between his estate and his second wife. According to the estate, the change in beneficiaries should not have been allowed, the second wife should have lost her beneficiary status in the divorce, and the death benefits should have gone to the estate.

The court ruled initially in the second wife’s favor, saying the first wife had no power in regard to the policy because she was not married to the man when the contract was issued. The court also said evidence—such as the fact that the man and his second wife continued to live together even after their divorce—suggested the man had no intention of revoking his second wife’s beneficiary status.

But, just two months later, the same court withdrew its opinion and ruled in the estate’s favor. This time, the ruling centered on a state law, which said, “If after an owner makes a beneficiary designation, the owner’s marriage is dissolved or annulled, any provision of the beneficiary designation in favor of the owner’s former spouse or a relative of the owner’s former spouse is revoked on the date the marriage is dissolved or annulled, whether or not the beneficiary designation refers to marital status. The beneficiary designation shall be given effect as if the former spouse or relative of the former spouse had disclaimed the revoked provision.”

This eliminated the second wife as a beneficiary and left the proceeds of the policy to the deceased man’s estate.

Divorce Case Study #2

In a case that made it all the way to the U.S. Supreme Court, a man listed his second wife as the beneficiary on a $46,000 life insurance policy bought through his employer.

The couple divorced, and according to the man’s first wife, the second wife knew he intended to remove her as a beneficiary. The man’s children from his first marriage—who would have received the death benefits under the intended change—sued the second wife when she filed a death claim.

The children argued the second wife’s beneficiary status was invalid due to state law, which said, “If a marriage is dissolved or invalidated, a provision made prior to that event that relates to the payment or transfer at death of the decedent’s interest in a nonprobate asset in favor of granting an interest or power to the decedent’s former spouse is revoked. A provision affected by this section must be interpreted, and the nonprobate asset passes, as if the former spouse failed to survive the decedent, having died at the time of entry of the decree of dissolution or declaration of invalidity.”

Although a court ruled against the children on legal technicality, this case again highlights the need for clarity when listing beneficiaries and keeping these provisions current.

Divorce Case Study #3

In yet another example, a man bought a joint life insurance policy and listed himself as the primary insured and his wife as the primary beneficiary. The couple later divorced, and the former spouses were allowed to keep their personal property, with no mention of the insurance policy in their divorce settlement.

The husband eventually remarried, but he neither cancelled the policy nor removed his ex-wife as the primary beneficiary. When the man died, his ex-wife and his estate fought over the death benefit, with the estate claiming the former spouse nullified her beneficiary status at the time of the divorce and that the divorce settlement gave her no clear right to policy benefits.

When the man bought the policy, state law called for the removal of former spouses as beneficiaries, but the law had changed by the time of the man's death. Although a trial court granted the insurance money to the ex-wife, an appeals court ruled in favor of the estate. According to the appeals court, a legal agreement should be based on the laws that were in force when the agreement went into effect.

Divorce Case Study #4

Shared finances between spouses can also create uncertainty when divorce and beneficiary issues arise. A husband and wife in Illinois paid $50,000 each for two universal life insurance policies. One policy insured the husband for $81,000, while the other contract insured the wife for $100,000. They listed each other as revocable beneficiaries on their respective policies and paid for both contracts with a single check.

The couple divorced, and both the man and the woman altered their policies so that their respective children (all from other relationships) became beneficiaries. The man eventually died of cancer, and his ex-wife tried to collect the death benefit made available through his policy. She argued that her ex-husband's illness might have prevented him from realizing what he was doing when he changed beneficiaries and that she was entitled to the insurance money because marital funds had paid for the two policies.

An appellate court disagreed and pointed out that both parties had the legal right to change beneficiaries on their policies and that even the ex-wife had exercised this right.

Life Insurance Claims

Different insurance companies have different ways of dealing with death claims. Some home offices will handle the sending and receiving of claim forms on their own. Other companies ask a life insurance agent to put claim forms in the mail to beneficiaries, and many insurance professionals visit beneficiaries personally in order to deliver paperwork and answer any questions that beneficiaries or families might have.

Agents who handle death claims have yet to arrive at a consensus regarding how this part of their job should be done. While some producers prefer to give survivors considerable breathing room by not emphasizing sales and by sticking primarily to the claims process, others view these situations as opportunities to stress the importance of financial planning and the benefits of annuities and other products offered by insurance companies.

Beneficiaries who can locate a policy should be prepared to give the insurance company the policy's identification number and the insured person's date of death. Policy language might require that an insurer receive a copy of the death certificate, but special circumstances can cause insurers to waive this requirement. After the September 11, 2001, terrorist attacks on U.S. soil, for instance, most insurers allowed victims' beneficiaries to collect death benefits without a certificate.

If the insurance company sold multiple policies to the insured and concludes that the person has actually died, it might have an obligation to contact beneficiaries who are named in those additional contracts.

Settlement Options

The manner in which a beneficiary receives policy benefits is called a "settlement option." Many companies have a default way of paying benefits, but this does not mean beneficiaries must always accept the insurer's preferred method.

Historically, most life insurance beneficiaries have received their money in a lump sum. This settlement option is perhaps the least complex one and can be attractive to beneficiaries who have a pressing need for money. It also tends to suit people whose shares of death benefits are relatively small.

People who receive large death benefits might opt to have their money rationed and given out periodically so that they can count on a steady income that continues for several years. This option basically transforms the life insurance policy into an annuity.

Several insurance companies allow beneficiaries to invest death benefits in money market accounts. This option gives people more time to consider what they should do with large sums of money and gives the death benefit a chance to grow in an interest-bearing environment. When a beneficiary decides that the death benefit can be put to good use, he or she can withdraw some or all of the invested funds via check-writing privileges. Be aware, however, that interest earned by the beneficiary on death benefits might be taxed as income.

Life Insurance Riders

Life insurance riders are policy features that may be added to a contract (often at an additional cost), either at the application stage or after the policy has been issued. In this portion of the course, we will examine a few of the many riders offered by life insurers. But please be aware that not all insurance companies offer these mentioned additions, and many insurance companies might include the benefits described here within their basic policies. Also, as is the case with policy terms and conditions, a rider available from one company might go by a different name at other companies.

Waiver of Premium

A waiver of premium rider protects disabled or terminally ill individuals by not charging the policy owner for coverage after he or she has lived with life-altering medical conditions for an extended period of time. If a policy owner were to suffer a debilitating stroke, for example, and could not physically pay or afford premiums because of the medical condition, the waiver of premium would likely prevent the insurance contract from lapsing. Meanwhile, the policy's cash value would remain untouched.

When consumers replace one life insurance policy with another, the new policy might automatically include a waiver of premium if the original policy had the feature. At other times, policyholders can request in writing that a waiver of premium rider be added to a replacement policy.

Living Benefits

When a Canadian wing of Prudential Financial introduced a "living benefit" several years ago, this feature catered almost exclusively to terminally ill people with only a few months left to live.

Today, many insurers allow policyholders to access anywhere from 25 percent to 100 percent of a life insurance policy's face value if they are struggling with terminal or non-terminal medical problems, such as surgery, serious illnesses, doctor bills or assorted long-term care expenses. As more insurers have offered them and expanded their scope, living benefits have taken different names, including "accelerated death benefits."

The insured will need to prove medical hardship in order to qualify for these benefits, but the money given out by the insurance company does not necessarily need to go toward medical expenses. These benefits are different than policy loans because they do not create an interest-enhanced debt that is owed to the insurance company. Instead, living benefits are usually subtracted directly from a policy's death benefit.

Other Riders

Other popular riders over the years have included the following:

- **Cost of living rider or guaranteed insurability rider:** These riders allow policyholders to increase their life insurance's face value on a periodic basis without needing to medically qualify for the additional coverage.
- **Paid-up additions rider:** This rider attempts to create a vanishing premium by using some of today's premiums to pay for tomorrow's coverage.
- **Accidental death rider:** This rider, mentioned earlier in the text, generally pays double the death benefit if the insured dies in an accident (a concept commonly known as "double indemnity").

Conclusion

By now, you should be able to comprehend the versatility of life insurance products. From term life all the way to the latest hybrid contracts with variable life insurance features, the insurance industry has done its best to develop fresh provisions that cater to a broad base of consumers. But a wide variety of products and consumer options might do little to promote lasting business relationships between insurers and the public if insurance workers forget to explain some of the complexities of these products.

CHAPTER 3: PROPERTY AND CASUALTY INSURANCE PRINCIPLES

Introduction

Loss is a factor of everyday life, and most people handle small everyday losses on their own. But when there is a potential of an unmanageable loss, individuals and businesses look for other sources to be protected from financial ruin.

One such source is insurance. Insurance transfers the risk of an uncertainty of a loss from an individual to an insurer. Property and casualty insurers accept risks related to loss or damage to buildings and possessions, as well as risks related to liability.

The insurance company accepts risk from its customers and charges a fee or "premium" based on the likelihood and severity of a loss. More specifically, the insurance company will consider at least the following factors:

- **The certainty of the loss:** For example, is a home sitting on a mountainside where landslides are an everyday occurrence, or is the home sitting in a subdivision of leveled land where there is no potential of landslide? Is a home situated in a flood plain, or is it far away from this potentially hazardous type of area?
- **The management and reduction of the risk of loss:** For example, proper training of an employee who uses a blowtorch or other high-risk machinery would curtail loss frequency and will generally be viewed favorably by an insurance company. The same could be said about installing a sprinkler system in a home, office or factory since it would curtail the severity of possible fire damage.

Premium Basics

An insurance contract transfers the risk from an individual, a business, or a group of individuals to an insurance company in exchange for a premium. The premiums of many individuals are 'pooled" by the insurance company to create the funds necessary to pay for losses.

In pricing their premiums and determining how much risk they will absorb, insurance companies use statistics showing how many potential losses can occur within a numerical quantity of people. The higher the quantity of people used in establishing the statistics, the more accurate the prediction will be.

Is It Insurable?

Before an individual, entity or piece of property can be insured, several factors must be considered. One major consideration is the presence of insurable interest.

In property and casualty insurance, "insurable interest" is defined as any actual, lawful and substantial economic interest in the safety or preservation of the subject of the insurance from loss or destruction or financial damage or impairment. Someone who lacks insurable interest in something cannot insure it.

Other considerations related to insurability include:

- The potential for loss, or at least the timing of loss, must be unpredictable.
- The potential loss must be able to be assigned a financial value.
- The presence of the "spread of risk" must be available. (Spread of risk is defined as the insurer's ability to spread insured risks over a large geographical area. Without spread of risk, a single disaster could put an insurance company out of business.)
- The risk must be pure and not speculative. ("Pure risk" is defined as a risk in which there is no chance of gain, whereas a "speculative risk" is defined as a risk that can result in either a loss or gain. Since investing in the stock market could result in a loss or gain, it is considered a speculative risk and is generally not insurable.)

Perils and Hazards

In discussing property and casualty insurance, the terms "peril" and "hazard" need to be defined. A peril is the cause of the loss. A hazard is anything that increases the potential of the loss.

There are three different types of hazards:

- A "physical hazard" arises from the condition, occupancy or use of the property itself, such as a slippery or broken-down staircase.

- A "morale hazard" arises through unintentional carelessness or irresponsible actions, such as a belief that front doors don't need to be locked because a neighborhood is considered "safe."
- A "moral hazard" arises when an individual is tempted to create a loss for the purpose of collecting the insurance money and commits fraud.

The Insurance Contract

The insurance company and the owner of an insurance policy have a contractual relationship.

A contract is a legal agreement between two competent parties that promises certain performances in exchange for a certain consideration. When an insurance company agrees to compensate the insured for certain losses in exchange for a premium, both parties have entered into a contract.

In order for a contract to be valid, it must have certain elements, and an insurance contract is no exception. The elements of a contract include the following:

- **Competent parties:** In order for an individual to be judged competent, that individual must be of legal age, not considered mentally incapacitated and not under the influence of alcohol or other drugs.
- **Legal purpose:** Any contract entered into for an illegal purpose (such as a contract to steal property) is not valid.
- **Agreement by the parties:** The parties must come to a mutual agreement that is beneficial to both parties.
- **Offer and acceptance:** When an individual or entity submits an application for insurance, this is considered an offer. Acceptance occurs when the insurer accepts a premium.
- **Consideration:** Consideration is provided to the insurance company by the insured when the insured pays the premium. Consideration on the part of the insurer occurs when the insurer promises to pay certain losses under certain conditions.

Concept of Indemnification

A special characteristic of an insurance contract is a feature called "indemnification."

Indemnification is a guarantee by the insurer that when a loss occurs, the insured will be restored to the approximate financial condition he or she was in before the loss, not better and not worse. With this in mind, it is often said that insurance is meant to make the policyholder "whole" after a loss.

Contracts Within a Contract

Insurance policies are complex documents that are actually several different types of contracts built into one. For example, most insurance contracts can be correctly described in all of the following ways:

- **Aleatory contract:** An insurance contract is aleatory because it depends on a loss occurring before the insured receives monetary compensation. If no loss occurs, the insurer generally provides no benefits.
- **Adhesion contract:** Insurance contracts are contracts of adhesion because one party draws up the contract (the insurer) and the other party (the insured) agrees to the terms and conditions. It is very rare for the insured to have much say in the specific wording of the contract. Because of this, if a dispute arises due to ambiguous language in the policy, the courts often apply a doctrine of reasonable expectations and generally rule on behalf of the insured.
- **Unilateral contract:** An insurance contract is unilateral because one side (the insurer) must perform or potentially be subject to court action, whereas the other side (the insured) can opt not to perform and generally won't be subject to court action. If the insured opts not to perform the obligation to pay premiums, the insurer's main option—rather than taking the insured to court—is to cancel the contract.
- **Good faith contract:** An insurance contract is a contract of good faith because both parties rely on the truthfulness and integrity of each other. An insurance company must act in good faith and pay a claim as long as the premium is paid, subject to the terms and conditions of the insurance policy. Making the insured complete unreasonable tasks in order to get a legitimate claim paid can result in regulatory fines or a lawsuit.
- **Conditional contract:** An insurance contract is conditional because it relies on certain stipulations outlined in the contract that each party must perform. Many insurance policies outline the duties, obligations, and definition of terms and roles in five separate sections. Those segments are:
    - **Declarations:** In property insurance, the declarations page typically includes the name of the insured, the address, the amount of coverage, a description of the property, and the cost of the policy.
    - **Insuring agreement:** The insuring agreement outlines what is covered by the policy.
    - **Conditions:** The conditions section outlines the responsibilities and obligations of both parties.
    - **Exclusions:** The exclusions section describes which losses are not covered by the policy.
    - **Definitions:** The definitions section spells out what different words mean in relation to the policy.

Property and Casualty Endorsements

In property and casualty insurance, endorsements change and modify the original policy in some way. In life and health insurance, the term "rider" is typically used instead of "endorsement."

Types of Insurance Companies

Depending on the prospective purchaser and the type of desired coverage, insurance might be obtained from any of the following entities:

- Stock companies.
- Mutual companies.
- Reciprocals.
- Lloyd's associations.
- Fraternal benefit societies.
- Risk-retention groups.
- Government.

Stock companies are structured by the sale of stock to individuals who become stockholders in the company. The goal of the company is to make a profit and return dividends to its stockholders. Stockholders can be either insured parties or simply investors in the venture.

Mutual insurance companies are owned by all the insureds, and profits are returned either in the form of dividends or a reduction in future premiums.

A reciprocal is made up of members who agree to share the insurance responsibilities with all the other members of the unincorporated group. All members insure each other and share in the losses. A reciprocal is often managed by an attorney who handles all the business of the reciprocal.

A Lloyd's association is structured as a voluntary association of individuals, or groups of individuals, who agree to share in insurance contracts. Each "syndicate" or individual is individually responsible for the amounts of insurance it writes.

Fraternal benefit societies are structured as incorporated societies or orders without capital stock. Business is conducted solely for the benefit of its members and their beneficiaries. They operate on a not-for-profit basis. Fraternal organizations offer insurance that is available only to their members.

A risk-retention group is an insurance company formed by several organizations to cover those organizations' loss exposures. It is often exempt from most state laws that apply to insurance companies.

Government insurance programs are often available to provide coverage that is not normally available through private insurance companies. Examples of this are flood insurance and high-risk auto insurance programs.

Types of Property and Casualty Coverages

Property insurance generally insures personal property, homes and buildings. Common examples of property insurance are listed below:

- **Dwelling insurance:** This insurance might be purchased by the owner of a non-owner-occupied rental property.
- **Homeowners insurance:** This insurance might be purchased by the owner of a home.
- **Commercial property insurance:** This insurance might be purchased by a business to protect its own property and that of its customers.
- **Inland marine insurance:** This insurance might be purchased to insure property that is commonly in transit, either by road or waterway.
- **Ocean marine insurance:** This insurance might be purchased to insure vessels and cargo that travel on the oceans.

Casualty insurance normally covers the liability risk that we face as a result of our actions toward others. Included in this category are the following types of insurance, among others:

- Aviation insurance.
- Auto insurance.
- Crime insurance.
- Workers compensation insurance.
- Surety bonds.

Regulating the Property/Casualty Field

The insurance industry as a whole is regulated by various entities. In addition, some entities don't directly regulate insurance but have significant influence on those that do. Some of the agencies or organizations that have the most influence on the property and casualty industry include:

- State departments of insurance.
- Federal regulatory bodies.
- National Association of Insurance Commissioners (NAIC).
- A.M. Best Company.
- Standard and Poor's.

Each state has an insurance department that is charged with regulating the insurance industry within that particular state. The administrators of their departments are called "directors," "superintendents" or "commissioners" of insurance.

These administrators, on a voluntary basis, become members of a national organization called the National Association of Insurance Commissioners (NAIC). This organization meets at established intervals to exchange information. Through their recommendations and decisions, the nation's insurance laws reach a certain level of uniformity. Although not binding on any state, their recommendations often become law and are employed in individual states.

A.M. Best Company and Standard and Poor's each publish ratings of insurance companies, evaluating the financial position of these companies. Consumers looking to choose an insurance carrier are often encouraged to check with these ratings services because a low-rated company might not have as much financial health to pay claims as a high-rated company.

When a state gives an insurance company the ability to do business in its area, the company is authorized either as an "admitted" insurer or a "non-admitted" insurer. An admitted insurer is fully authorized to conduct business in that state, whereas a non-admitted or non-authorized insurer is only permitted to do business under certain special circumstances, such as when coverage is not available from an admitted carrier.

Each state's insurance department plays a vital role in the areas of:

- Regulation of agents.
- Ratification of forms.
- Ratification of rates.

Regulating the Agent

With minor exceptions, insurance agents must be licensed and regulated by the state. It is generally illegal for an individual to sell insurance without being licensed.

Agents must complete an established amount of pre-licensing education before they can be administered an exam for their initial licensing. The successful completion of this exam and proper processing of their application will permit agents to become licensed to sell insurance.

In addition to initial licensing, all states have enacted laws that require an agent to complete a prescribed amount of continuing education hours of study in order to renew their licenses at each renewal interval.

Ratification of Forms

Policy forms (such as a company's standard insurance policy) and endorsement forms used by insurers in most states must be approved by the states. Several methods are used to achieve this goal, with the appropriate method often depending on the type of insurance being sold and the state where insurance transactions are occurring. These methods include:

- **Prior approval:** In this method, all forms must be submitted to the state for approval prior to the use of the forms.

- **File and use:** In this method, a company can start using the forms as soon as they have been filed with the state but might need to stop using them if the state later decides not to approve them.
- **Use and file:** In this method, an insurance company can use the forms in advance as long as the forms are eventually filed with the state within a specified period of initial usage.
- **Mandatory forms:** In this method, all insurers in a particular market must use a special state-approved policy form.
- **Open competition:** In this method, companies can use forms that are competitive to the marketplace, as long as they are non-discriminatory.

Ratification of Rates

Much like the use of forms, rates for insurance have certain controls imposed upon them before they can become official and charged to customers. Again, the manner in which rates are regulated and approved will likely depend on the type of insurance and the state where it's being sold. Approaches to rate approvals are listed below:

- **Prior approval:** In prior approval states, all rates must be approved by the state before an insurance company can begin using them.
- **File and use:** In file and use states, insurance companies may begin using rates as soon as they are filed with the state. Eventually, the state can either approve or disapprove the rates.
- **Use and file:** In use and file states, insurers may begin to use rates but must eventually file those rates with the state within a specified period of time.
- **Open competition:** In open competition states, insurance companies are free to set rates in accordance with the marketplace as long as they meet the requirements of adequacy and nondiscrimination. In establishing rates by this method, an insurance company must calculate rates that will be adequate to cover:
    - The cost of losses that will have to be paid.
    - The cost of conducting business.
    - A margin of profit.
- **Mandatory rates:** In these states, the rates are set by the state, and the insurance company must adhere to them.

Enforcement of Insurance Regulations

Failure to comply with state regulations can result in any of the following consequences:

- Fines.
- License suspension for the agent.
- License revocation for the agent.
- Suspension of a company's authority to do business.
- Revocation of a company's authority to do business.

The Application For Insurance

The insured's offer of insurance is made through the application form. The accuracy of the information on the application form is critical to the acceptance of the insured. Both the agent and applicant must be totally truthful and thorough in providing the requested information. The information provided in the application will help the underwriter determine whether to accept the risk as well as what rate to charge for the requested insurance.

The Binder

Once the application form has been completed, the property and casualty agent may have the authority to issue a "binder." A binder is a statement, usually in writing, that the insured has immediate protection for a specified period of time. A binder is not a guarantee that a policy will be issued but is merely a temporary coverage until the application has been investigated and reviewed.

Binders tend to be fairly unique to the property and casualty field of insurance and are not commonly used in the life insurance or health insurance fields. In those areas of the insurance business, a more restrictive document, known as a "conditional receipt," will often be provided in place of a binder.

Since binders can force an insurer to pay for losses that occur even while an applicant is still being evaluated, agents should understand their level of binding authority and should only issue these documents with care.

Evaluating and Investigating the Application

The evaluating and investigating of the facts of an application are done by an underwriter. In addition to the application, underwriters turn to other sources for information. Included in these sources are:

- The company's own claim files.
- Previous insurers of the applicant.
- Inspection services.
- Insurance industry bureaus.

If an applicant is denied as a result of information provided by an outside credit reporting firm, the applicant, by requirement of the federal Fair Credit Reporting Act, must be notified in writing and must be given the opportunity to receive a copy of the derogatory information from the reporting agency.

An underwriter also has an obligation to protect the insurer against "adverse selection." Adverse selection is defined as the tendency of insureds with a greater-than-average risk of loss to purchase insurance.

Rating the Policy

There are at least three basic ways of rating a policy:

- Judgment rating.
- Manual rating.
- Merit rating.

The judgment method of rating establishes premiums based on a careful evaluation of each individual risk without the use of manuals or tables.

The manual rating method uses rates based on collected statistics. The rates, which apply per unit of insurance, are published in manuals.

The merit rating method determines premiums by starting with a manual rate and then modifying it to reflect the risk's unique characteristics.

Proof Of Insurance

Once a policy has been accepted, a consumer might ask for and receive a certificate of insurance. The certificate carries a general summary of the coverage of the policy and is often provided by the consumer to third parties who want confirmation of the consumer's insured status. For example, a building contractor might ask a subcontractor to provide a certificate of insurance

before allowing the subcontractor to complete any work on a construction project. Similarly, a home improvement business might provide certificates of insurance to its customers as reassurance that the company is properly covered for property damage, workers compensation and other liability risks.

Cancellation of the Policy

Once a policy has been issued, a company can cancel it only under the specified conditions of the policy. Three of these conditions are:

- Misrepresentation.
- Concealment.
- Fraud.

"Misrepresentation" is a written or verbal misstatement of facts involved in the contract on which the insurer has relied in order to issue the specified coverage. Misrepresentation can be either intentional or unintentional. If misrepresentation involves a material fact, the insurer might have solid legal standing to cancel the policy.

"Concealment" is the withholding of facts involved in the contract on which the insurer relies. In this case, the person engaging in concealment doesn't outwardly lie but fails to disclose important information.

In general, "fraud" is a deliberate misrepresentation that causes harm.

Other important terms in property and casualty insurance are listed below:

- Waiver.
- Estoppel.
- Policy period.
- Unearned premium.
- Short-rate basis.
- Pro-rata basis.
- Flat-cancellation basis.

A "waiver" is the intentional relinquishment of a known right.

"Estoppel" is the principle that states that if one party intentionally or unintentionally creates the impression that a certain fact exists, and an innocent party relies on that impression and is injured as a result, the guilty party may be legally prohibited from asserting that the fact does not exist.

The "policy period" is the date and time specified in the declarations page, showing when coverage begins and ends.

"Unearned premium" is any premium not yet "used up" and that will be returned if the policy is canceled.

"Short-rate basis" is a method of calculating a premium refund for unused premium wherein the company not only keeps the premium for insurance already used, but also keeps an allowance for expenses, such as issuing the policy.

"Pro-rated basis" is a way of computing a premium refund when the insurance company cancels the policy and returns all unused premiums without deduction for any costs.

"Flat cancellation" refers to a policy being canceled by either party on its effective date.

The History of Fire Insurance

Fires are an alarming cause of financial insecurity. The destruction of property values and the loss of human life can be a traumatic experience to families and businesses alike.

The first fire insurance company in the United States was established in 1734 and was called the Friendly Society for the Mutual Insurance of Houses Against Fire. By 1740, this firm was out of business as a result of a fire in Charleston, South Carolina, that wiped out most of the area.

After the disastrous fire of 1740, several other fire companies were formed. These insurers used a risk classification method basing rates on the construction materials used in the building of the dwelling. Thus, a building constructed of brick had a more favorable risk rating than one made of wood.

Fire insurance companies in early America sometimes operated on a subscription basis. Subscribers would pay fire-fighting companies in advance and receive a metallic logo in return that would be installed outside their building. If a protected property had a fire, the appropriate fire-fighting company was notified. And once the fire mark was identified, the fire was fought.

During the early years of fire insurance, insurers drafted their own policies, and the contracts lacked uniformity. The contracts were lengthy and restrictive, and numerous moral hazard clauses and other restrictive provisions were inserted in the contracts, which permitted insurers to deny claims.

Furthermore, insurance policies were written to cover a single peril. If an insured needed additional coverage, such as for wind damage or some other peril, it was written as a separate policy. Often, these additional perils were not even covered by the same company.

In 1873, Massachusetts became the first state to adopt a standard policy for the writing of fire insurance. New York passed a similar law in 1886. The standard fire policy was later revised in 1918 and later in 1943 and became the basis for fire insurance policy language in many other parts of the country.

Two major advantages result from a standard policy, such as the one crafted in New York all those years ago. First, loss-adjustment problems are lessened, since the possibility of two contracts with different policy provisions is reduced. Second, there are fewer legal difficulties, since the courts have interpreted the words, phrases and provisions of the standard contract repeatedly, and their meaning is known more precisely.

Despite being replaced by other standard policy forms in subsequent decades, the standard fire policy from New York remains an important historical document. Many basic property insurance concepts were first legally defined in it. For example, the principles of indemnity, insurable interest, actual cash value and pro-rated sharing of losses can all be traced back to the New York document.

Although the standard fire policy offered basic protection, many insurers argued that a policy offering broader coverage would benefit the industry as well as the public. In particular, a product that covered both property and liability in one policy would be much more desirable.

Insurance companies felt that they would benefit from a combined fire and liability policy in the following ways:

- Decreased adverse selection against the company.
- Reduction in overall administrative and underwriting costs.
- Increased policy retention.

In the late 1940s, insurers were permitted by insurance regulators to combine property and casualty perils into one policy. Many formats and combinations of coverage sprung out

from this deregulation. Eventually, most property and casualty insurers settled on offering a standard package policy that is known generally today as "homeowners insurance."

Although insurance companies selling homeowners insurance are not necessarily required to sell the exact same policy with the exact same wording as their competitors, most at least base their homeowners policy forms on language crafted by a private company called the "Insurance Services Office" (ISO). Language from the ISO is then commonly amended, often by adding an endorsement to the standard policy, to suit a carrier's or customer's specific goals or needs.

Homeowners insurance is a package policy that combines two or more separate contracts into one policy. The current homeowners insurance format typically incorporates the standard fire policy with other coverages, including comprehensive personal liability insurance, additional living expense coverage, replacement-cost coverage on the dwelling and medical expense coverage for people other than the homeowner and family.

As mentioned previously, most but not all homeowners insurance policies follow a framework created by the ISO, with occasional endorsements or amendments added at the company's discretion. There are several ISO homeowners forms, each designed for a different audience and intended to cover slightly different losses. The ISO's standard policies have names that feature the letters "HO" followed by a number. In theory, a person could purchase an HO-1, HO-2, HO-3, HO-4, HO-5, HO-6, HO-7 or HO-8 policy.

Let's briefly review those common forms now.

HO-1

An HO-1 policy insures the dwelling and other structures and also covers the insured's personal property. An HO-1 policy is a named-perils policy, meaning it only insures against perils that are specifically mentioned in the coverage form. This is in contrast to other types of homeowners insurance, which might cover the dwelling against all perils except those that are specifically excluded in the policy. The HO-1 is not widely used at the present time and has even been withdrawn from use entirely in many states.

An insurance policy modeled after the ISO's HO-1 form insures the homeowner against property losses caused by the following perils:

- Fire.
- Lightning.
- Wind.
- Hail.
- Explosion.
- Riot and civil commotion.
- Aircraft.
- Vehicles.
- Smoke.
- Vandalism and malicious mischief.
- Theft.
- Volcanic eruptions.

HO-2

The HO-2 policy form is sometimes referred to as the "broad form." This policy insures the homeowner against property losses caused by many common perils. In addition to covering losses brought on by all the perils mentioned in the HO-1 form, the HO-2 form reimburses the insured for losses related to the following:

- Falling objects.
- Weight of ice, snow or sleet.
- Accidental discharge of water or steam.
- Accidental overflow of water or steam.
- Freezing.
- Sudden and accidental tearing, cracking, burning or bulging of heating, air conditioning, water or steam systems.
- Sudden and accidental discharge from artificially generated electrical current.

HO-3

The HO-3 policy form is sometimes referred to as the "special form." It is generally considered the standard version of modern homeowners insurance.

Unlike previously mentioned homeowners forms, the HO-3 form covers the insured dwelling and detached structures (detached garages, sheds, etc.) on an "all-risk" basis. This means a loss will be covered by the policy unless the insurance contract specifically excludes it.

When explaining the positive features within HO-3 policies, insurance producers sometimes forget to mention that the all-risk coverage applies only to the dwelling and detached structures. By contrast and by default, HO-3 policies cover personal property on a "named-peril" basis, just like HO-1 policies and HO-2 policies. This means a loss pertaining to personal property will only be covered if it has been caused by a peril specifically mentioned as a covered peril in the insurance contract. With respect to personal property, the covered perils in an HO-3 policy are basically the same as those in an HO-2 policy.

HO-4

The HO-4 policy form is used to insure renters and their belongings. The HO-4 policy form insures personal property against the same perils named in the HO-2 form. But the typical renters insurance policy is different from other homeowners policies in several respects.

The most significant difference between HO-4 policies and the other forms we've previously discussed is that the HO-4 policy's main emphasis is on contents coverage rather than on dwelling coverage. This makes sense because the responsibility of maintaining the building and fixing structural problems usually belongs to the landlord rather than the tenant. Like all other standard homeowners forms, it also often provides personal liability protection if the policyholder is accused of causing property damage or bodily injury.

HO-5

The HO-5 policy form gives the insured all-risk coverage for both the dwelling and personal property. As good as that may sound, HO-5 policies can be very expensive.

If a person prefers all-risk coverage for both the dwelling and its contents, the insurer will probably not even bother selling the person an HO-5 policy. Instead, the all-risk coverage for personal property will simply be added onto an HO-3 policy for an additional cost.

HO-6

Condominiums and townhouses are covered by a "master policy," which is purchased by an elected association on behalf

of all residents at the complex. The master policy will cover damages to a building's exterior, as well as common areas such as basements and hallways. The extent to which the master policy insures each individual unit is left up to the association.

The portions of each unit that are not insured by the master policy will be disclosed in the association's bylaws or in similar documents. At the very least, the policy ought to cover the unit's walls, ceiling and floors.

Those parts of the unit that aren't covered by the master policy are the individual owner's responsibility. Of course, each individual owner is also responsible for obtaining his or her own insurance for personal property and personal liability.

To address the concerns of condo dwellers and townhouse owners, insurance companies sell policies based on the HO-6 form, also known as the "unit-owners" form. The unit-owners form features named-peril coverage for the insured's personal property and a little bit of named-peril coverage for the unit itself. The named perils in an HO-6 policy are the same as those in an HO-2 policy.

HO-7

HO-7 policies are meant to insure mobile homes, which can also be covered by adding endorsements to other homeowners insurance forms.

HO-8

The HO-8 policy form is sometimes known as the "modified" form. It is not used in all states and is typically intended to cover older homes in urban areas when the dwelling's market value is considerably lower than its replacement cost.

In many ways, the coverage available through an HO-8 policy is identical to the coverage in an HO-1 policy. However, in a very important difference, HO-8 policies cover the dwelling only up to its actual cash value. Unlike the HO-2, HO-3 and HO-5 forms, they do not insure the dwelling up to its replacement cost.

In general, actual cash value is the property's replacement cost minus depreciation. A few states have multiple definitions of "actual cash value" with regard to dwellings. In California, for example, actual cash value generally means replacement cost minus depreciation. But if a dwelling in that state is covered for actual cash value and is completely destroyed, the owner might receive the dwelling's fair market value or the policy's dollar limit, whichever is less.

Liability Insurance Fundamentals

Liability losses are losses incurred by individuals as a result of their actions toward other people or their property. When an individual is required to make financial restitution to other people for causing or contributing to those people's losses, a liability loss has occurred.

In the civil legal system, when an individual violates the rights of another, that individual has committed what is known as a "tort." A tort can either be intentional or unintentional. Liability insurance provides coverage for unintentional torts. In general, insurance cannot be used to protect someone when he or she commits intentionally harmful acts.

Negligence is a key factor in determining liability. In order for a person to be liable to another, that individual must have been negligent. "Negligence" is defined as the lack of reasonable care that is required to protect others from the unreasonable chance of harm.

In order to establish negligence, several factors must often be present:

- **There must be a legal duty owed to someone:** Legal duty owed is that obligation that we all have toward one another to reasonably protect one another's rights and property. Within that duty, there are several levels of accountability depending on the relationship and conditions. For example, a person invited to our home is owed the highest degree of care. An individual performing a service in our home is owed a lower degree of care. And a trespasser is owed the lowest degree of care.
- **A breach of a legal duty owed to someone must occur:** Breach of legal duty occurs when it is established that standard care was not taken and that lack of precaution caused harm to another individual or the person's property.
- **The allegedly negligent person must be involved in the proximate cause for the loss:** The proximate cause is the action that occurred that resulted in the harm or damage. The action must be continuous and unbroken. If the action is broken by an intervening action, this new action becomes the proximate cause.
- **There must be damages:** If no harm came to an individual or the person's property, there was no negligence and therefore there can be no claim.

Contributory Negligence

When both parties contribute to negligence, "contributory negligence" exists. The degree to which each party contributed is taken into account in arriving at a payment, or perhaps a non-payment, of damages.

Liability and Statutes of Limitations

A statute of limitations requires that a suit must be filed within a specified period of time in order to be valid under the law. If this period of time has passed, the harmed party might not be able to make a successful claim against the negligent party.

Conclusion

Property and casualty insurance is a broad field that offers a wide variety of risk-related products and services to the public. With the right insurance solutions in place, consumers can successfully transfer risks related to damage to their property as well as various risks associated with liability.

CHAPTER 4: HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE HEALTH PLANS

Introduction

In addition to creating the federal program known as "Medicare Part D," the Medicare Prescription Drug Improvement and Modernization Act of 2003 gave consumers the option to fund their health care through "health savings accounts" (HSAs). When used correctly, these accounts can reduce the size of insurance premiums, increase patients' knowledge of the health care system and provide some unique tax benefits. But if pushed onto an audience that doesn't understand them, health savings accounts might result in higher-than-expected medical bills and won't live up to their full potential. Therefore, improving one's knowledge of these accounts should be an important goal for health insurance professionals as well as health insurance buyers.

According to the Employee Benefit Research Institute (EBRI), approximately 20 million HSAs existed in 2016, valued at a combined $37 billion in assets. The increasing acceptance of these accounts has been influenced, to a large degree, by their ability to bring down insurance costs for businesses and their resulting prominence in employer-sponsored health plans. Among companies ranging in size from 10 to 500 workers, 25 percent of businesses offered an HSA-related option as part of their employee benefit packages in 2016. For companies with more than 500 workers, according to the EBRI, that figure jumped up to 61 percent.

Meanwhile, HSAs have been part of several proposals aimed at making high-quality health care more affordable for all Americans. Although this certainly isn't the appropriate forum for evaluating those assorted proposals, both the heated debate surrounding them and the aforementioned numbers from the EBRI should lead us to essentially the same two conclusions: HSAs have become a common option for individuals and families, and they're not likely to go away anytime soon.

If you are new to HSAs, this chapter will introduce you to the important basics. If you are already familiar with these accounts, we hope this will serve as a helpful reminder of the HSA-related choices that many insurance buyers are facing.

However, it's important to remember that an HSA—though linked to particular types of health insurance plans—is a tax-favored savings account and is not, in fact, insurance. Health insurance professionals certainly need to be capable of conversing with a prospect or client about HSAs, but they also must avoid overstepping the boundaries of their license and acting as unqualified attorneys or tax advisers.

Similarly, this chapter should be viewed as general information within an insurance-focused education course and not as an authority on federal or state tax issues. For up-to-date answers to specific tax-related questions, please consult an appropriate expert in your community.

Tax-Favored Health Insurance Accounts

Many types of tax-favored accounts have been introduced in the United States to encourage more "consumer-driven health care." This type of health care typically involves providing tax breaks and savings opportunities as incentives for patients to be more careful about how they spend their health-care dollars. For example, some proponents of consumer-driven health care believe that if patients receive a set amount of tax-favored dollars each year for medical care, those patients will make more cost-effective medical decisions, such as using generic medications instead of name-brand drugs and, when possible, opting for treatment at stand-alone immediate-care facilities rather than using hospital emergency rooms. Consumer-driven health care still utilizes various types of insurance as a backstop against costly, catastrophic ailments, but it is designed to shift more of the initial care decisions (and often the initial costs) to the patient.

The most common consumer-driven health care plans in today's market combine a high-deductible health plan with a health savings account. However, these plans are often misunderstood by consumers due to the number of other tax-favored, health-related accounts in existence, the names of which can create a confusing bowl of alphabet soup. For example, in addition to HSAs, some consumers might be eligible for HRAs and FSAs.

Before turning our attention back specifically to health savings accounts, let's look at what some of those other types of accounts have to offer.

Health Reimbursement Arrangements

A "health reimbursement arrangement," also known as a "health reimbursement account," (HRA) is a method of paying for health care in which an employer reimburses its employees for qualified medical expenses after treatment has been rendered. Reimbursements from the employer are tax-free to the employee up to a certain amount. Although money reserved by the employer for reimbursements can be carried over from one year to another, HRA funds are not portable and therefore do not follow employees when they leave the business.

Flexible Spending Accounts

A "flexible spending account" (FSA) lets employees use pre-tax dollars to pay for various medical expenses through a combination of salary deductions and employer contributions. Withdrawals for qualified medical expenses are not taxed, but FSAs are subject to an important "use-it-or-lose-it rule," which prohibits most money within an FSA from being carried over from one year to the next. An FSA's "use-it-or-lose-it" feature is one of the most important distinctions between this type of account and a health savings account.

Health Savings Accounts

A health savings account lets individuals and employers make tax-free contributions to an investment account that can be used to pay for qualified medical expenses. Unlike an FSA, an HSA belongs fully to the individual and is not subject to a "use-it-or-lose-it" rule. Money left over at the end of a year can remain in the person's account, where it can earn tax-free interest until the person withdraws it. According to a survey reported by the insurance trade journal Rough Notes in 2013, nearly 70 percent of respondents believed, incorrectly, that money deposited in an HSA would be lost if not spent within a given year.

HSA contributions can usually only be made by enrollees in a special high-deductible health plan, but the insured retains ownership of any HSA funds upon leaving the plan, including upon leaving an employer.

Now that you're familiar with the simplest traits of HSAs, let's look at their crucial connection to high-deductible health plans.

High-Deductible Health Plans

In order to understand HSAs, a health insurance professional must first know the purpose and features of a "high-deductible health plan" (HDHP). As its name suggests, a high-deductible health plan is a health insurance plan that has a larger-than-usual deductible and a certain, specific cap on a person's out-of-pocket medical expenses for the plan year. As a reminder, a "deductible" is the amount of money, stated in dollars, that an insured must pay after a loss for otherwise covered care before the insurer will start providing any financial benefits.

The minimum deductible and out-of-pocket limits for an HSA-eligible high-deductible health plan tend to change from year to year, based on inflation, and will differ depending on whether the insurance covers an individual or a family.

According to a survey from human resources consulting firm Mercer (and as reported by the publication Crain's Chicago Business), roughly 30 percent of workers were enrolled in a high-deductible health plan in 2016, a huge increase from 3 percent just 10 years earlier. Some enrollees in these plans like them because the higher deductibles and out-of-pocket expenses allow insurance companies to charge significantly lower premiums. The low premiums tend to attract younger people with

few or no immediate medical problems and are also purchased by relatively unhealthy consumers who can't afford the higher premiums for traditional health insurance. Businesses tend to like these plans, too, due to their comparatively lower costs and are likely to include an HDHP as either the only or one of several health plans available to employees.

No matter the potential benefits of a health savings account, anyone who is thinking about opening one should first carefully consider the potential positives and negatives of enrolling in a high-deductible health plan. Proponents of HDHPs tend to emphasize the lower premiums and the ways in which the plans might turn patients into discerning buyers of health care. For example, if the insured will be responsible for a larger deductible and higher out-of-pocket expenses, that patient might be more inclined to research the cost of prescribed care (such as the cost differentials between a name-brand drug vs. a generic drug, an MRI performed at a hospital vs. at a stand-alone clinic, or non-emergency treatment at an immediate-care facility vs. at an emergency room) and choose a cheaper option. Detractors sometimes worry that, because of the high deductible and because comparing the price of treatment options isn't always easy, these plans might ultimately discourage cost-conscious patients from seeking important care and thereby contribute to negative health outcomes.

High-deductible health plans are essential to determining the suitability of health savings accounts because a person generally cannot open or contribute to an HSA unless he or she has insurance through an HDHP. Note, however, that not all high-deductible health plans are compatible with HSAs and that, in fact, millions of enrollees in high-deductible health plans do not own a health savings account.

In 2019, an HSA-eligible high-deductible health plan required a deductible of at least $1,350 for individual-only coverage and at least a $2,700 deductible for family coverage. A person whose heath plan had a deductible below those figures in 2019 was generally not allowed to open or contribute to a health savings account. You'll learn more about deductibles and other out-of-pocket expenses related to HSA-eligible HDHPs later in this chapter.

Basic HSA Tax Advantages

Assuming their owners follow all applicable rules from the Internal Revenue Service, health savings accounts can result in what are often called "triple-tax advantages." These advantages are available to HSA owners regardless of whether they itemize on their federal income taxes or claim a standard deduction.

The basic three-pronged tax benefits of HSAs are as follows:

- Typical contributions to HSAs are treated as pre-tax dollars, generally exempting them from federal payroll taxes and federal income taxes.
- Contributions kept in an HSA can be invested into subaccounts, similar to mutual funds, where any interest or other investment gains are allowed to grow on a tax-free basis.
- Withdrawals from an HSA, including interest or other investment gains, are generally tax-free if they are used to pay for qualified medical expenses.

The tax incentives available within HSAs are intended to encourage owner contributions and help consumers plan a careful budget for upcoming health care. In addition, they've prompted people in higher tax brackets to pay for health care with non-HSA dollars but still contribute maximum amounts to their HSAs in order to reduce current taxable income and to grow an IRA-like account specifically intended for health care in later years.

Although health insurance professionals should understand the basic tax benefits of HSAs, it's worth noting again that a license to sell health insurance is not a license to provide tax advice. Also, be aware that the general tax information found in this course is based on federal rules. Tax implications for HSA owners might also exist at the state or local level.

HSA Eligibility

Despite the growing number of health savings accounts in the United States, the ability to open an HSA isn't available to everyone. For example, a person generally cannot open or contribute to an HSA if any of the following statements are true:

- The person is claimed as a dependent on someone else's federal income taxes.
- The person is covered by a health plan other than an HSA-eligible high-deductible health plan. (This prohibition includes other coverage through an employer, a spouse and even the federal Medicare program, regardless of whether the other coverage is the person's primary insurance or secondary insurance. However, it generally doesn't include coverage through disability, long-term care, dental or vision insurance.)

Although IRS rules put restrictions on who can open and contribute to HSAs, the rules mentioned above do not force owners to forfeit money in existing HSAs when changes in their insurance or employment status occur. For example, someone who opens an HSA in connection with a high-deductible health plan and later enrolls in a different health plan will continue to own and have access to the HSA, even though he or she might not be allowed to make any additional contributions to it.

Deductible Requirements and Out-of-Pocket Limits

In order to open and continue contributions to a health savings account, the insured must be enrolled in an HSA-eligible high-deductible health plan. To qualify for HSA-eligibility, the plan must have a deductible that is at least as high as a dollar amount set by the federal government and must feature an out-of-pocket limit that is at least as low as a dollar amount set by the federal government. Both numbers tend to change from year to year based on inflation-related adjustments and will depend on whether the insurance is for an individual or a family.

As mentioned previously, the minimum allowable deductible for an HSA-eligible plan in 2019 was $1,350 for single coverage and $2,700 for family coverage. Some preventive care, such as annual physicals, immunizations, routine prenatal care and disease screenings, might be completely exempt from the deductible requirement or be subject to a lower one. Although patients are ultimately responsible for paying their deductible, they can use money from a health savings account to fund this part of their care.

Along with the necessarily large deductible, an HSA-eligible plan must have a specific yearly cap on an insured's out-of-pocket expenses. This cap generally applies cumulatively to deductibles, copayments and coinsurance fees. It generally doesn't apply to insurance premiums, costs associated with using out-of-network health care providers and care that is otherwise not covered by the high-deductible health plan. The ability to use HSA funds to pay for these various out-of-pocket expenses will depend on the specific type of expense.

In 2019, an HSA-eligible plan could not have an out-of-pocket limit higher than $6,750 for an individual or $13,500 for family coverage.

HSAs and the Employer's Role

High-deductible health plans that allow employees to open health savings accounts have become a very common part of employers' benefit offerings. Even if traditional PPO and HMO health plans remain available to its workers, a company might include an HSA-related option during annual open enrollment periods. At other businesses, if traditional group health insurance is unaffordable, a high-deductible health plan that is compatible with health savings accounts might be the only employer-sponsored plan available for workers.

When sponsoring an eligible high-deductible health plan, an employer has the option—but not the obligation—to contribute to each enrolled employee's health savings account. Contributions ranging from $500 to $1,000 are commonly offered to entice higher enrollment in the plan and ease the transition for people who aren't accustomed to such a high deductible.

No matter the exact contribution chosen by the employer, the amount of the contribution generally must be the same for all similarly situated employees. This typically means that the employer will contribute either the exact same dollar amount or the exact same percentage of the plan's deductible to each employee's account.

Most new owners of health savings accounts will open them with help from an IRS-approved "custodian" or "trustee" affiliated with the employer-sponsored group health plan. (This custodian or trustee might be an insurance company or some other financial institution.) In these cases, contributions made by employees to their own accounts will usually be deducted directly from their paychecks and deposited into the accounts. However, employees also have the right to open an HSA with an IRS-approved custodian or trustee that has no relationship with their employer or their insurance company.

Unlike some other types of tax-favored accounts intended for health care, HSAs are portable from job to job, and none of the money contributed to them belongs to the employer. Yet in order to continue making contributions to an existing HSA, an employee who changes jobs must continue to be covered by an HSA-eligible high-deductible health plan.

Setting Up an HSA

A person interested in opening an HSA can do it via an IRS-approved trustee or custodian. Common financial institutions that can serve in a trustee or custodial role include banks, insurance companies and credit unions.

In exchange for holding and managing money held within an HSA, the owner's chosen trustee or custodian may charge various fees similar to those imposed against IRAs and other investment accounts. Fees, including their size and frequency, may differ from one financial institution to the next.

As part of opening a health savings account, the owner will likely be asked to name a beneficiary, who will receive any remaining HSA funds when the owner dies. If the chosen beneficiary is a spouse, the HSA ownership will generally be transferred to the spouse upon the original owner's death and can continue to be used by the surviving spouse as an HSA. If a beneficiary receives HSA funds and is not the owner's surviving spouse, the money will no longer be considered part of an HSA and will be taxed accordingly.

Keep in mind, too, that some HSA-eligible individuals choose to never open a health savings account. Although a person must be enrolled in high-deductible health plan in order to open an HSA, a person does not need to open an HSA in order to enroll in a high-deductible health plan.

Making HSA Contributions

HSA contributions can be made by the owner or by another party on the owner's behalf, such as an employer making contributions to an employee's account. In most cases, contributions will be deducted directly from the owner's paycheck, but the owner can also bypass his or her employer (or be self-employed) and make contributions directly to the trustee or custodian.

Federal rules put a cap on the amount of contributions that an owner can make to an HSA each year. Like the numbers for deductibles and out-of-pocket limits for an owner's high-deductible health plan, contribution limits tend to change each year and are impacted by whether the owner's insurance is just for one person or for a family.

For example, most owners with self-only coverage in a high-deductible health plan could contribute up to $3,500 to their HSA in 2019. For owners with family coverage, contributions could rise up to $7,000.

As a method of preparing for looming retirement, HSA owners who are 55 or older can contribute a special "catch-up" amount each year. In 2019, these older HSA owners could contribute an additional $1,000.

Note that these contribution limits—regardless of the owner's age—include contributions made directly by the owner as well as contributions from another party, such as an employer.

Contribution limits can become confusing if both members of a married couple choose to open HSAs, particularly when one or both of those spouses opts for family coverage rather than individual coverage. Specifics of these scenarios are beyond the scope of this course and should be understood with the help of careful research and tax experts.

Despite the limits on annual contributions, there is no overall limit on the value of an HSA. Similarly, money left over from one year can roll over in the account to the next year and generally isn't subject to a dollar limit. However, as mentioned previously in this chapter, contributions to an HSA generally must stop when the owner no longer receives health insurance from an HSA-eligible high-deductible health plan.

Investing Within HSAs

Rather than parking their contributions safely in a health savings account and treating them like cash, some HSA owners take advantage of potential investment opportunities made available by HSA trustees and custodians. In these cases, the process, benefits and drawbacks are similar to investing in mutual funds within a traditional retirement account. By choosing to invest their HSA contributions in something other than cash, owners might receive compounded interest or other increases in their account's value. On the other hand, choosing this option might expose the account to economic volatility and could require payment of additional administrative fees.

Each HSA trustee or custodian will likely have its own rules regarding the minimum amount needed to invest in options besides cash. In fact, some of these HSA administrators don't offer non-cash options to account owners at all.

Even with some investment choices at their disposal, the overwhelming majority of HSA owners opt to ignore them. According to the Employee Benefit Research Institute, only approximately 4 percent of HSA owners kept their contributions outside of cash accounts in 2017. This suggests that most owners are using their HSAs in a more traditional way by saving for short-term medical costs (such as yearly deductibles) rather than viewing their accounts as long-term tax shelters. This conclusion seems even firmer when paired with multiple press reports from 2014 through 2017, which estimated that the average value of an HSA was somewhere between $1,000 and $1,500.

Making HSA Withdrawals

Upon opening a health savings account, the owner will typically receive a debit card or checkbook in order to use the assets from the account to fund various medical expenses. This is a convenient change from several years ago, when owners often needed to send receipts to their HSA custodian or trustee and await reimbursement. Money withdrawn from an HSA will be tax-free to the owner if applicable IRS rules are obeyed.

To avoid significant penalties, withdrawals from HSAs usually must be used to pay for "qualified medical expenses," as defined by law and the current tax code. In 2017, for example, qualified medical expenses included (but weren't limited to) the following items:

- Health insurance deductibles.
- Health insurance copayments.
- Health insurance coinsurance fees.
- Premiums for Medicare, COBRA insurance, disability insurance and—based on age—long-term care insurance (but generally NOT premiums for other health insurance).
- Vision and dental costs.
- Prescription drug costs (but NOT over-the-counter medications that haven't been prescribed by a physician, other than insulin).

Be aware that the items included within the definition of "qualified medical expenses" are a source of seemingly constant debate among legislators and that the definition can change due to new laws and new IRS rules.

There's also plenty of confusion among the public regarding these expenses. For example, a survey reported by the trade publication Benefits Selling in 2014 found that over half of respondents wrongly believed HSAs could be used to pay for insurance premiums and over-the-counter drugs. Anyone who is providing answers to consumers about what counts as a qualified medical expense should ensure that their information is coming from an up-to-date and expert source.

Withdrawals used for purposes other than qualified medical expenses will be typically treated as taxable income to the owner and will also result in a 20 percent tax penalty. (The penalty rose from 10 percent in 2011 as part of the Patient Protection and Affordable Care Act.) However, the 20 percent penalty can be waived when the owner dies, becomes disabled or turns 65. In most cases, owners who escape the 20 percent penalty will still need to pay income taxes on their withdrawals if the money goes toward items besides qualified medical expenses.

To comply with HSA rules and provide defense against an IRS audit, owners are required to keep records of their spending. It is generally the responsibility of the HSA owner—not the HSA custodian or trustee—to ensure that withdrawals are used for qualified medical expenses.

HSA Portability

As mentioned earlier in this chapter, the dollars invested in health savings accounts are portable from job to job and from health plan to health plan. An employee who leaves an employer or moves from an HSA-eligible health plan to a non-eligible health plan still keeps ownership of any funds inside an existing HSA. Those funds can be accessed at any time to pay for qualified medical expenses. Even though they might contribute to workers' HSAs, employers don't own any of the money within their employees' health savings accounts.

Conclusion

More than a decade after their introduction as an option for funding consumers' health care, health savings accounts continue to be a topic of great interest among policymakers, health care advocates and other interested parties. Arguments in favor and against HSAs seem to be made just as passionately as in years past and can often be based on how the exact same studies are interpreted.

For example, an extensive study conducted by the Employee Benefit Research Institute using data from 2009 through 2014 attempted to determine the impact for consumers who moved from a traditional health plan to a high-deductible plan with an HSA. Persons in favor of HSAs could point to the fact that patients with HSAs ended up spending roughly $300 less on health care per year and did not spend more days in hospitals than patients with traditional insurance. Meanwhile, those more opposed to health savings accounts could reference the study's finding that lower-income patients with HSAs were at least temporarily more likely to utilize emergency rooms than lower-income patients with traditional insurance and that—regardless of income level—patients with HSAs tended to receive less preventive care, even when such potentially important care was exempt from plan deductibles.

Despite the debates, it might be fair to argue that, just like any other type of insurance-related product, a high-deductible health plan paired with an HSA should be judged within the context of each individual person's unique situation and goals. In order to better understand the suitability of these common health care accounts, health insurance professionals—as well as health insurance buyers—must maintain a commitment to product-related education.

CHAPTER 5: EMPLOYMENT PRACTICES LIABILITY INSURANCE

Introduction

Changes in local, state and federal laws over the past 50-plus years have made it easier for employees and job applicants to fight back against discrimination and harassment in the workplace. Yet the presumed positive goals of those laws—to ensure that individuals be evaluated fairly and treated with respect by employers—have also increased the risks of "employment practices liability" (EPL) for many businesses.

This liability, which exists when a business is accused of violating someone's employment rights, is rarely top of mind for an organization. Small businesses, in particular, tend to lack the resources to keep up with consequential changes in employment law and might not fully understand their legal responsibilities pertaining to hiring, firing and supervising a workforce. Small

organizations might also fall into the trap of viewing their employees as a second family, the members of which would never engage in seriously inappropriate behavior or take their bosses to court.

Through education and legal counsel, entities such as the federal Equal Employment Opportunity Commission (EEOC) have helped make it easier and cheaper for workers to protect themselves from unacceptable conduct in the workplace. But whereas employees can file complaints with the federal government at no cost, businesses accused of discrimination or other illegal employment practices can spend thousands of dollars defending themselves against even meritless claims. Although insurance is certainly no substitute for running a law-abiding operation, it can help reduce the financial burden when employment-related misunderstandings or mistakes get out of hand.

This course module will offer detailed information about common coverage, exclusions and other important provisions within EPL insurance policies. If you hope to expand your knowledge of commercial lines insurance to better serve consumers, the material should provide an excellent starting point for your EPL education. If you're also an employer, perhaps the next several pages will cause you to reexamine your own insurance portfolio and any gaps that might personally expose you to employment practices liability.

Common Employment Liability Issues

No matter if you're considering buying or selling EPL insurance, your knowledge of the product will be inadequate if you don't understand the liability risks associated with the employer/employee relationship. Allegations linked to the following acts can be particularly damaging to employers:

- Sexual harassment.
- Discrimination.
- Retaliation.
- Privacy violations.
- Libel/slander.

As we review each of these acts and go into further detail about employment liability, please be aware that the provided information is intended to be general in nature and not a substitute for legal counsel. For specific concerns about employment liability and employment laws, readers should consult material written by legal professionals or speak to a licensed, experienced attorney. This chapter exists purely as a source of background information for interested insurance professionals and is not a guide to avoiding employment liability.

Sexual Harassment

Sexual harassment may be occurring when workers or job applicants are either physically or verbally subjected to unwanted sexual advances. Whether unwelcome advances rise to the level of illegality will depend on a number of factors, including their severity and frequency. But even a merely inappropriate incident should be addressed quickly and carefully by management. A manager who ignores inappropriate conduct puts company morale at risk and increases the business's chances of being sued for future incidents.

Quid Pro Quo vs. Hostile Environment

Illegal sexual harassment occurs in employment when unwanted sexual advances are made "quid pro quo" or when they create a "hostile work environment." Let's learn more about the differences between these two types.

Quid Pro Quo

Quid pro quo sexual harassment exists when employees are expected to accept sexual advances in exchange for a tangible employment decision in their favor. For example, there might be an explicit or implicit understanding that an employee must have a sexual relationship with someone in order to be hired, promoted or given certain benefits. Unlike other kinds of sexual harassment, which can be caused by nearly anyone in a work environment, quid pro quo sexual harassment is committed almost exclusively by supervisors.

Hostile Work Environment

A hostile work environment is either a work situation that is highly offensive and intimidating or one in which sexual advances unreasonably interfere with an employee's job performance.

Existence of a hostile work environment usually requires more effort to prove than quid pro quo harassment, but the potential for it exists in a wider variety of situations. Whereas quid pro quo harassment almost always involves supervisors taking physical advantage of subordinates, a hostile environment can be created by victims' colleagues as well as their supervisors. Although physical contact can certainly be part of a hostile environment, an illegal amount of hostility can also result from sexually charged gestures, comments and jokes.

In judging whether a hostile environment exists, courts often try to determine how a reasonable person would feel under the specific circumstances. If a reasonable person would feel intimidated in the workplace because of a sexual advance, harassment is more likely to have been committed. If a reasonable person would merely feel awkward or momentarily uncomfortable after an advance, a judgment of harassment is less likely.

Preventing and Responding to Harassment Complaints

Businesses cannot protect their employees from harassment in every case, but they can significantly reduce the risk by taking a few important steps. The EEOC has made the following recommendations:

- Be clear about what kind of conduct is not acceptable in the workplace.
- Assure employees that they will not be penalized for reporting inappropriate behavior.
- Make employees aware of how to make a complaint (including what to do if the person who normally handles complaints is also the alleged harasser).
- Emphasize that the details of complaints will remain as confidential as possible.
- Develop a procedure for conducting quick and fair investigations.
- Take action if an investigation reveals that something inappropriate has occurred.
- Ensure that any corrective actions in response to a complaint don't penalize the alleged victim.

Discrimination

For several decades, most businesses have been prohibited from discriminating against workers or job candidates on the basis of race, religion age and gender. Over time, additional protections have helped disabled persons and pregnant woman

achieve fairer treatment from current or prospective employers. More recently, we've seen antidiscrimination laws and rules protecting gay and lesbian Americans, and several states have either already approved or begun debating similar protections for transgender people.

Several federal laws aim to stop discrimination in the workplace. Due to their importance, many of those laws (including the Civil Rights Act of 1964 and the Americans With Disabilities Act) will be summarized later in this course. Be aware that additional protections often exist at the state or local level.

Retaliation

Within the context of employment practices liability, "retaliation" occurs when a worker receives punishment for exercising (or attempting to enforce) his or her employment rights. Examples of retaliation appear below:

- An employee is fired for complaining about unfair treatment or taking legal action against an employer.
- An employee is passed over for a promotion for testifying in support of a coworker who has accused their employer of wrongdoing.
- An employee is denied a raise because he or she refused to follow an illegal employment practice.

As explained well by insurance veteran Catherine M. Padalino in the trade publication National Underwriter, an employee's retaliation case can succeed even if the initial complaint that triggered it is groundless. For example, consider a scenario in which an employee files a discrimination complaint with the EEOC and that, upon an investigation, the government finds no evidence of discrimination. If the employer responds by firing the employee for making the original complaint, the employee might be able to win in a separate case by alleging retaliation.

Privacy Violations

Employers face potential liability if personal information they receive from an employee becomes unsecure and accessible by third parties. In their hiring process and roles as benefit administrators, employers often must take special care to safeguard employees' Social Security numbers, health information and other sensitive facts.

Relatively new privacy risks can also arise when an employer conducts online background checks on prospective or existing employees. Public profiles on social media platforms might contain information about a person's religion, sexual orientation or other traits that typically won't appear in an applicant's resume or be discussed with a new boss. Viewing this information might expose the employer to allegations of discrimination if the employee/applicant believes it influenced an employment decision.

Libel/Slander

Unfortunately, some employment relationships will end on bad terms. A business with anger toward a former worker should control that emotion in order to avoid accusations of defamation. Written defamation is known as "libel," whereas spoken defamation is known as "slander."

The potential for libel or slander might exist when supervisors cast a former employee in a negative light when explaining the person's departure to other workers. Similar risks exist if a former employer is asked by a potential new employer to verify a job applicant's work history and provides too many sensitive or untrue details.

Employment Rights and the Federal Government

We've already mentioned some of the federal entities and laws that aim to promote and mandate a fair, professional and nondiscriminatory workplace. Those entities and laws deserve further explanation and will receive it in the next few sections.

Although risks related to many federal employment-related laws can be managed via EPL insurance, others will be excluded from EPL policies. (Common coverages and exclusions will be explained later in this course.)

Once again, it's important to note that the laws mentioned here aren't the only employment-related statutes for businesses and that additional worker protections usually exist at the state and local level. In addition, understand that these sections are meant to summarize federal workplace protections but aren't a comprehensive or authoritative source for interested employers. For the most up-to-date and relevant information impacting a particular business, businesses should seek out appropriate legal counsel. Similarly, insurance professionals should be careful not to promote themselves inappropriately as legal experts and should instead encourage their EPL prospects to learn more about employment laws from qualified attorneys or other trusted sources. We will state what should be obvious here and say that a license to sell insurance is not a license to offer legal advice.

The Equal Employment Opportunity Commission (EEOC)

The Equal Employment Opportunity Commission (EEOC) is a federal agency charged with investigating allegations of workplace discrimination and enforcing several workplace antidiscrimination laws. The agency also serves as a resource for businesses that want to know more about how to comply with those federal laws.

According to figures found at its website from 1997 through 2017, the EEOC has typically received anywhere from 75,000 to nearly 100,000 charges of workplace discrimination from employees and job applicants each year. When a charge is made, the agency has the authority to investigate it, file a lawsuit on the alleged victim's behalf or attempt to engage the accuser and the employer in mediation to settle the dispute. These actions are often taken at no cost to the person making the charge.

The Age Discrimination in Employment Act

The Age Discrimination in Employment Act prohibits workplace discrimination on the basis of age. Here are a few additional details about the law from the EEOC and AARP:

- The law makes it illegal to discriminate in hiring, firing or other employment matters on the basis of age if the impacted person is 40 or older.
- The law applies to businesses with 20 or more employees, although state laws might require compliance from smaller entities.
- The law generally does not apply to independent contractors or members of the armed services.
- The law does not prohibit age discrimination against people under 40, although state laws might offer this protection.
- Employers might be able to set age limits on some jobs but must take several factors into consideration and follow very specific rules to avoid liability.

The Civil Rights Act of 1964

The Civil Rights Act broadly prohibited various forms of discrimination in voting, education, employment and access to public accommodations. (This law should not be confused with the Civil Rights Act of 1968, which prohibited discrimination in housing.)

Antidiscrimination provisions in the Civil Rights Act of 1964 appear primarily in Title VII of the law. Here are some particulars, according to the EEOC:

- The law prohibits employment discrimination on the basis of race, color, religion, gender or national origin, although state laws might include additional protected classes.
- In time, the antidiscrimination protections based on gender were clarified to prohibit discrimination specifically against pregnant women.
- The law generally applies to businesses with 15 or more employees, although state laws might extend protections to workers at smaller entities.

The Americans With Disabilities Act

In addition to making public accommodations more accessible for people who lack traditional mobility, the Americans With Disabilities Act (ADA) prevents employers from taking negative actions against workers or job applicants because of a perceived or actual physical or mental disability. Here are some more basic facts from the EEOC and the online resource FindLaw.com:

- People with disabilities cannot be discriminated against in employment if they are otherwise capable of performing a job's essential tasks.
- People with disabilities cannot be discriminated against in employment if they merely require a "reasonable accommodation" to complete a job's essential tasks.
- People with disabilities cannot be discriminated against in employment if they cannot perform a job's unessential tasks.
- The law does not prohibit discrimination if a person cannot reasonably perform a job's essential tasks.
- The law does not exempt a disabled person from needing to satisfy other pre-requisites for a job, such as relevant experience, education, etc.
- A disabled job applicant cannot be denied an interview because he or she requires a reasonable accommodation in order to participate in the discussion.
- Disabled applicants or workers are generally expected to alert an employer when they require a reasonable accommodation.
- Although the law generally applies to businesses with 15 or more employees, state laws might extend protections to disabled persons at smaller entities.
- Although issues related to an applicant's or worker's drug use might create separate privacy issues between employers and their workers, drug use is not a protected disability under the ADA.

The Family and Medical Leave Act

The Family and Medical Leave Act preserves employees' jobs and their health insurance when they take a leave of absence to care for themselves or a family member. Employees covered by the law are entitled to 12 weeks of unpaid leave (and continued health insurance) per year under any of the following circumstances:

- They need time off to become acquainted with a newborn, a newly adopted child or a newly placed foster child. (Men who take leave for this reason are entitled to the same rights as women.)
- They need time off to care for a seriously ill child. (The child doesn't need to legally or biologically be their son or daughter. However, an employee must have assumed some kind of parental role.)
- They need time off to care for a seriously ill spouse.
- They need time off to care for a seriously ill parent or guardian. (The parent or guardian doesn't need to legally or biologically be their mother or father. However, the ill person must have assumed some kind of parental role when the employee was a minor.)
- They need time off to manage their own serious illness.
- They need time off for reasons related to a family member's involvement in the National Guard or Reserves. (In addition, family members may take 26 weeks of unpaid leave to care for a seriously ill service member.)

Not all businesses are impacted by the Family and Medical Leave Act. For the law to apply, all the following statements must be true:

- The employee has worked for the employer for at least a year.
- The employee has worked at least 1,250 hours for the employer over the past 12 months.
- The employer employs at least 50 people within 75 miles of the employee's workplace. (Individual states might provide similar protections to employees at smaller businesses.)

The Equal Pay Act

The Equal Pay Act provides additional antidiscrimination protections on the basis of gender and requires that men and women be paid an equal amount for equal work. Details from the EEOC are summarized below:

- Men and women must be paid equally (regardless of job title) if they are performing essentially the same tasks, possess essentially the same skills, have essentially the same experience, are given essentially the same responsibilities and work for the same employer.
- Unequal compensation can still be provided on the basis of experience, seniority, merit, quality of work or quantity of work.
- If an employer attempts to correct an unequal pay issue, the situation must result in increased pay for the discriminated worker rather than decreased pay for the non-discriminated worker.
- Although some businesses, jobs and scenarios are exempt from the Equal Pay Act, there is no exemption based on the number of employees.

The Pregnancy Discrimination Act

The Pregnancy Discrimination Act amended the aforementioned Civil Rights Act of 1964 to clarify that employment discrimination on the basis of pregnancy is a form of illegal gender discrimination. Here's some more information from the EEOC:

- Employers must allow pregnant employees to work as long as they are reasonably capable of performing their job duties.

- In general, employees cannot put restrictions on pregnancy-related leave that are different from other types of permitted leave.
- When providing health benefit opportunities to employee spouses, health plans cannot discriminate on the basis of a spouse's gender (such as by only allowing husbands, but not wives, to enroll in a plan).
- The law applies to businesses with 15 or more employees.

The Fair Labor Standards Act

The Fair Labor Standards Act, which is enforced by the federal Department of Labor, puts restrictions on mandatory work hours, sets standards for payment of the federal minimum wage and sets rules for overtime work.

The Employee Retirement Income Security Act

The Employee Retirement Income Security Act (ERISA) contains several requirements related to managing employer-sponsored retirement plans. The law's specifics are beyond the scope of this material.

The Occupational Safety and Health Act

The Occupational Safety and Health Act (OSHA) requires employers of all sizes to provide a safe work environment for their onsite employees. Specific compliance requirements may differ across various industries and can depend on number of employees. For example, some employers with 10 or more employees must maintain records of workplace injuries and illnesses. The law also created the federal Occupational Safety Health Administration, which enforces the law's requirements and provides educational tools for workers and businesses.

The National Labor Relations Act

The National Labor Relations Act generally protects employees' rights to join and form unions and to informally bring coworkers' concerns to an employer's attention. Its specific impact is beyond the scope of this course.

The Genetic Information Nondiscrimination Act

In addition to providing some health insurance nondiscrimination protections to consumers, the Genetic Information Nondiscrimination Act (GINA) generally prohibits employers from requesting genetic information or family medical history from employees and job applicants. In rare cases where this information becomes known to an employer (according to the EEOC), the information must remain confidential and cannot be used as a basis for discrimination. The federal law applies to businesses with 15 or more employees, but several states have passed similar laws with broader applicability.

EPL Risk Management

Although the rest of this chapter will focus largely on EPL insurance and the way it can reduce employment liability risks, this important coverage shouldn't be the only tool for a concerned business. In fact, some risk managers believe other basic forms of risk management should be pursued before spending any money on EPL insurance. In addition to purchasing appropriate insurance, businesses might reduce—if not eliminate—some employment risks via the following steps:

- Review compliance with federal and state laws with a qualified attorney.
- Check for periodic legal updates and guidance from government agencies and other reputable sources.
- Create and distribute policy manuals regarding workplace professionalism to all employees, and obtain written confirmation that each employee has read the document.
- Provide initial and refresher training on issues like workplace discrimination and harassment.
- Promote a welcoming environment in which employees are encouraged to share concerns and complaints with supervisors without fearing retaliation.
- Document adverse actions taken against employees and job applicants, as well as the valid reasons for those actions.
- Use careful and clear job descriptions when advertising employment.
- If terminating someone's employment, treat the terminated employee with as much dignity as the situation allows, without creating unnecessary public embarrassment.

Insurance companies tend to agree with many of these recommendations and have proven it by offering free resources, such as legal assistance and policy manuals, to some of their EPL policyholders. These resources are more commonly available when a business purchases stand-alone EPL insurance rather than coverage that has been included as a rider to a different policy. More information about the differences between stand-alone coverage and "add-on" coverage will appear later in this course.

EPL Insurance Defined

Employment practices liability insurance aims to protect businesses when they are accused of violating someone's employment rights. The person whose rights might or might not have been violated could be a current or former employee or anyone who unsuccessfully sought work at the business.

Common EPL claims involve allegations of discrimination, retaliation or sexual harassment. Such allegations are often linked to the hiring, firing, layoff, promotion or demotion processes but can occur at seemingly any time.

With the online insurance trade journal Property Casualty 360 reporting in 2015 that only 30 percent of businesses had EPL insurance, it's obvious that this coverage isn't a top concern for most organizations. The apparent apathy means the product requires more effort to sell than other forms of commercial coverage, such as general liability or workers compensation insurance. But with enough patience and knowledge, it can become an important moneymaker for producers and an important safeguard for buyers.

Coverage Under Other Insurance

One of many reasons why most business don't pursue EPL insurance comes from the misconception that employment risks are covered by their existing insurance. Some carriers might've paid some EPL-related claims decades ago thanks to loopholes and borderline-ambiguous language in commercial general liability (CGL) and business owner's policy (BOP) forms, but those insurers largely stopped being so lenient as allegations of discrimination and harassment gained wider attention. Even among insurers that had never planned on covering EPL risks under CGL or BOP products, the industry opted to protect itself further by adding exclusionary endorsements, which closed most

of the potential loopholes and corrected the arguably ambiguous terminology.

In today's insurance market, CGL and BOP policies will typically only cover EPL risks if a business specifically requests that coverage be added to those products at an additional cost. Similar "add-on" options might exist in a few personal lines liability scenarios in which a homeowner employs domestic workers.

If adding onto an existing insurance product does not provide adequate protection for an employer, a stand-alone EPL policy might be advisable.

EPL Insurance Underwriting

As in any other line of insurance, carriers offering EPL products will evaluate each applicant carefully by asking questions about the buyer's past, present and future susceptibility to risk. Here are some questions that might be particularly important to an underwriter when evaluating EPL risks:

- Have you ever been accused of an illegal employment practice, and if so, what was the outcome?
- How many people do you employ?
- How often do you experience employee turnover?
- What level of hiring, firing or layoffs have occurred recently or are likely to occur in the near future?
- Do you have a company policy manual that promotes consistent professional conduct at the workplace?
- Do you have a team of employees working exclusively in human resources? If so, how much influence does the team have in company decisions?
- In which states does your business operate? (This can be a factor because employment laws differ by state.)
- What types of information do you request on employment applications?
- What type of (and how much) training do you provide to employees on an initial and ongoing basis?

Common EPL Insurance Coverage

We'll now turn our attention to common features and exclusions in EPL insurance products.

As you finish the rest of this chapter, please be mindful of the relative lack of uniformity in the EPL market. Whereas most commercial lines insurers offer similar coverage for CGL risks by basing policy language on standard forms from a third party called the "Insurance Services Office" (ISO), standardization across EPL product lines remains a work in progress. Despite the introduction of a standard ISO form for EPL stand-alone coverage and add-ons, many carriers still utilize their own coverage forms or at least offer products that differ from what's written in the ISO language. Never assume that any two carriers' EPL products will feature the exact same benefits and exclusions.

Stand-Alone Policies vs. Endorsements

For those businesses that really want it, EPL insurance can be obtained in several ways. In general, those options can be broken down into two broad categories: stand-alone policies and endorsements (or add-ons) to other policies.

Stand-alone EPL insurance products tend to offer the broadest protection on the market and have higher dollar limits that won't be reduced by other types of claims, such as a slip-and-fall claim under a CGL policy or a class-action claim brought by shareholders under a directors and officers (D & O) claim. The obvious tradeoff, though, is cost. Since stand-alone EPL insurance tends to have higher premiums than an EPL endorsement to another insurance product, stand-alone coverage is typically geared toward larger businesses with larger insurance budgets.

Smaller companies that have EPL concerns but want to pay less for insurance can compromise by adding an EPL endorsement to one of their existing insurance policies, such as a CGL policy, a BOP or a D & O policy. However, this typically results in the coverage limits being shared across a variety of different risks and might result in underinsurance.

For example, assume an EPL endorsement has been added to a CGL policy. Now imagine the policy has a $1 million coverage limit for each annual policy period. If the business is held responsible for a serious injury to a customer and is also sued for employment practices in the same year, the $1 million limit will need to be divided in some way between the injury claim and the EPL claim. If the combined losses from both claims exceed $1 million, the business might need to pay the excess amount out of pocket.

An experienced insurance broker who understands the intricacies of a business's risks should be able to help the business avoid inadequate coverage limits. You'll learn more about coverage limits later in this chapter.

Who Is "the Insured"?

A worker or job applicant who feels violated by an employer might take action against a broad range of individuals affiliated with the organization. In addition to filing a complaint or lawsuit against the company, the alleged victim might name high-ranking directors, middle-managers, low-level employees, former employees, shareholders, independent contractors or temporary workers and accuse any of those parties of inappropriate behavior. Businesses and their insurance advisers should pay close attention to the definition of "the insured" in an EPL policy so that liability protection exists for the appropriate people and not just for the business entity.

At minimum, EPL insurance will usually include coverage for the business entity and high-ranking employees who might be held liable for the illegal conduct committed by lower-ranking personnel. A mid-level approach to EPL insurance also provides liability protection for shareholders, current non-manager employees and people who formerly worked as employees and have since left the business. Even broader (but increasingly rarer) EPL insurance can define "the insured" to also include temporary workers, independent contractors and interns accused of discriminatory or harassment-level acts. Not coincidentally, products with broader definitions of "the insured" (and that thereby expose the insurer to a broader set of losses) tend to require higher premiums.

When evaluating the definition of "the insured" for the purpose of EPL products, the insurance professional should pay close attention to any specially defined terms within that definition. For example, even if a policy defines "the insured" to include "employees," a separate portion of the policy might further limit this definition by saying an employee is someone who works on a particular schedule, such as at least 30, 35 or 40 hours per week. In the event of a claim, the insurer's definitions of these terms—not the ones used casually by the business in workplaces or even within employment contracts—can make the difference between a covered loss and an uncovered loss.

Coverage Limits

EPL insurance tends to insure businesses for millions of dollars per policy period, with most policy periods lasting one year with the option of renewal.

Although this might seem like a lot of coverage, be aware that coverage limits are often divided into a per-claim limit and an aggregate limit. For example, assume a company has a $1 million per-claim limit and a $5 million aggregate limit. Next, assume the company is accused of discriminating against an employee and loses a resulting lawsuit for $5 million. Although the $5 million is within the policy's aggregate limit, the insurer will only agree to absorb $1 million of the cost, based on the per-claim limit.

Policy wording should be carefully reviewed when several claims are made by the same employee or when multiple claims from multiple employees all stem from the same incident (such as several employees being inappropriately fired at the same time). Depending on the scenario, a carrier might treat all interrelated claims as a single claim for purposes of coverage limits or treat each one as its own claim.

When choosing coverage limits, a business and its financial advisers should also pay attention to how the cost of defending a claim (no matter the claim's legitimacy) will factor into those limits. If defense costs will reduce the policy's coverage limits, there will be less money available for settlements, fines or any judgments imposed by a court. You'll read more about defense costs and their impact on coverage limits in a later section.

What Are Covered Acts?

Though still relatively limited in scope, EPL insurance has gradually evolved to respond to an increasingly broader range of "covered acts."

At first, covered acts that could trigger coverage were largely limited to discrimination or sexual harassment alleged by either regular full-time employees or applicants for regular full-time employment. These days covered acts typically also include alleged retaliation and even accusations made by part-time employees, contractors and other types of workers.

Yet because we still lack a standard coverage form for EPL insurance, it's important to carefully review the definition of "covered acts" and who can make a related allegation. (Note that the parties who can allege a covered act might not be the same as those who can be insured for a covered act. For example, although a business might be covered if a part-time employee alleges sexual harassment, a part-time employee might not be insured under an EPL policy if he or she is accused of such harassment.)

The following list of potentially covered acts is intended as a general summary and should be cross-checked against any EPL product under consideration:

- Alleged discrimination under the Civil Rights Act, Americans With Disabilities Act, Equal Pay Act, Age Discrimination in Employment Act, or Pregnancy Discrimination Act.
- Alleged sexual harassment.
- Alleged retaliation for reporting discrimination or harassment.
- Violations related to the Family and Medical Leave Act.
- Alleged libel or slander committed by a supervisor about a current or former employee.
- Alleged privacy violations committed by employers against employees or job applicants.
- Alleged discrimination under applicable state law. (Note however, that some policies will name protected classes—race, religion, ethnicity, etc.—for the purpose of discrimination claims rather than referencing specific state laws. As a result, producers should be mindful of narrowly defined protected classes that are not as broad as those found in applicable state law or local ordinances. For example, know to ask questions when a policy does not include "sexual orientation" or "gender identity" as a protected class but is sold in a state where employment discrimination on those specific factors is prohibited).

Remember that a business is insured for defense costs related to covered acts even if an investigation or court determines that an employer committed no illegal activity. This protection against meritless or false claims is often one of the most attractive and certainly most important features of EPL insurance.

Third-Party Discrimination/Harassment Claims

Some EPL carriers will offer to cover claims of alleged discrimination or harassment that are made by third parties who don't work for the business. For example, imagine a scenario in which a business's employee refuses to serve a member of the public and is accused of discrimination. Or consider a case in which a business hires a repairperson for a single day's work, and the repairperson harasses one of the business's customers. Although neither case involves violating someone's employment rights, EPL insurers might agree to add coverage for these risks at an additional cost. The cost and, of course, the need for this extra insurance will be higher the more a business engages directly with its customers.

Defense Costs

Like most types of liability insurance, EPL insurance provides coverage for defense costs, including the cost of hiring a qualified legal team. Basic EPL insurance will include defense costs within the policy's overall coverage limits. In other words, the more money spent to defend the insured, the less money there'll be to pay for settlements or court-awarded damages. If businesses have concerns about how this might create pressure to settle rather than defend a meritless claim, they can often pay extra to have separate limits for defense costs.

Many EPL policies give the insurance company a fairly broad "duty to defend" the insured. In essence, this means the insurance company must pay for and help organize the competent defense of a claim against the insured, as long as the claim is not obviously excluded by the policy language. However, if further developments (such as a judge's or jury's verdict) later make it clear that the claim is excluded by the policy language, the insurer can stop defending the claim and refuse to pay for any settlements or damages.

Due to its broad duty to defend the insured, the insurance company typically has the authority to choose the defense team or at least require that the insured choose a team from a carrier-approved list. Some EPL products will give the insured greater power over the choice of a defense team, but this might be done only in exchange for either a higher premium from the business or a narrower duty to defend from the carrier.

Deductibles

Compared to other types of liability insurance, such as CGL insurance, EPL insurance is more likely to require payment of a "deductible." The deductible is the amount of otherwise covered losses, in dollars, that the insured must pay out of pocket before the insurer will provide benefits.

EPL insurance deductibles will commonly amount to thousands of dollars, with higher deductibles typically resulting in slightly lower premiums. In choosing the deductible, the business should first understand how this number might apply to various claims. Here are a few questions worth considering:

- Will the deductible be enforced on an annual basis or a per-claim basis? (In the event of a per-claim deductible, the insurance company might treat interrelated claims—such as a class-action suit involving several former employees—as a single claim.)
- Will the deductible apply to defense costs or just judgments and settlements?

Coinsurance Fees

Along with paying a per-claim deductible, an EPL-insured business will likely be responsible for a per-claim "coinsurance fee." Within the context of EPL insurance, a coinsurance fee is the amount, as a percentage of each covered loss, that the insured must pay out of pocket. Research conducted during development of this course unearthed coinsurance fees as low as 5 percent per claim and as high as 35 percent per claim. As with the deductible, the higher the coinsurance fee, the lower the business will usually pay in premiums.

Claims-Made Policies vs. Occurrence Policies

Liability insurance policies can be either "occurrence policies" or "claims-made policies." The important distinction between the two types relates to the time period in which a claim and the action that prompted it must occur.

Occurrence Policies

Some older liability insurance policies were structured as occurrence policies. These products provided insurance protection to policyholders as long as the incident that led to a claim occurred during the policy period, regardless of when a claim (such as a demand for money) actually arose.

For example, assume a business had EPL insurance in the form of an occurrence policy during the entire time of its operations. Next, assume the business shut down two years ago and cancelled its insurance but has just been told that a former employee has decided to sue for harassment that occurred a decade ago. Since the EPL insurance was in the form of an occurrence policy and because the harassment is alleged to have occurred while the insurance was in force, the insurance company would still be required to defend the former business and perhaps cover any settlement or judgments.

Claims-Made Policies

By contrast, a claims-made policy will generally only respond if both the claim itself and the incident that led to it occurred while the insurance was in force. In the case of the business that shut down years ago and is just now receiving notice of alleged harassment, a claims-made policy would probably provide little or no protection.

Due to the shorter duration of potential liability for insurance companies, most EPL products in today's market are claims-made policies.

Retroactive Dates and Prior Acts

For coverage to exist under a claims-made policy, the claim must occur prior to the policy's expiration date, and the incident that led to the claim must occur on or after the policy's "retroactive date." When EPL insurance is purchased, the retroactive date will almost always be the policy's issue date and will not change unless the business ever cancels or lets its coverage lapse.

A business that wants a retroactive date prior to the policy's issue date might be able to purchase a limited amount of "prior acts coverage." However, even if this type of insurance might respond to claims in an alleged employment violation occurred deeper in a business's past, it will still not respond to cases in which the business already knew about the alleged violation. If prior acts coverage is available at all, it will only protect businesses against past events that had not yet been brought to their attention at the time of purchase.

Reporting a Claim

Failure to report existing or potential claims in a timely manner is one of the most common and harmful mistakes made by EPL policyholders. Too many businesses opt not to involve their insurance company until they have received a formal written notice of a lawsuit, thereby making it harder for insurers to provide an adequate defense and even making it possible for the carrier to deny the claim on account of late notice.

EPL policy language should clearly explain a business's claims-reporting responsibilities, as well as the specific definition of "claim." For example, some policies might define claim to include certain instances that can happen prior to the filing of a lawsuit or a demand for money, such as notice of an investigation by the EEOC.

Also, some carriers might require reporting even the potential for a claim by a specific date, assuming the potential reasonably exists. For instance, a policy might call on the insured to report the possibility of a claim within 30 or 60 days of being aware of the possibility.

Regardless of specific deadlines, the insured will likely need to provide any documentation related to an actual claim (such as a written demand for money) or related to a potential claim (such as the date and details of an informal complaint made by an employee to a supervisor regarding alleged violations of employment rights).

Extended Reporting Periods

Let's assume an entity has decided to stop insuring itself against future EPL risks, either to reduce insurance costs or because it is either closing its business or will at least no longer employ anyone other than its owners. How can the business continue to protect itself against EPL claims that might arise soon after the traditional coverage is no longer in place?

The answer for many businesses involves an "extended reporting period." This common feature in casualty insurance gives the business a limited amount of time in which claims that arise after the end of the policy period can be covered as long as the incidents leading up to them occurred while the policy was in force. Or to put it another way, an extended reporting period can turn a claims-made policy into an occurrence policy for a very limited time.

As an example, let's pretend a restaurant shut down yesterday without any knowledge of potential EPL violations against its workers and has immediately opted to get rid of its EPL insurance. Despite no longer having traditional EPL insurance, the old policy's extended reporting period might help protect the business if alleged discrimination or harassment occurred while the restaurant was still open but was not known to the business owners until 30 or 60 days after they'd ended their insurance.

Often, this type of extended reporting period—lasting one to three months—is included at no additional cost. Businesses that want a longer extended reporting period (such as one allowing potential claims to be reported several months or even years after traditional coverage ends) might want to pay extra for what's known as "tail coverage."

Note, however, that even though extended reporting periods and tail coverage allow for more time to report claims, the alleged incidents leading up to the claims must still have occurred while the policy was in force, and timely notice of potential claims must still be provided to the insurer.

Settling a Claim

Being accused of illegal activity, particularly by a trusted current or former employee, can elicit extreme emotions for business owners and supervisors. EPL insurers understand this reaction but also want to manage claims so that the insured's anger, pride and concerns about reputation don't cloud the accused's judgment. Since even meritless allegations can cost businesses thousands of dollars in legal expenses and lost time, sometimes the most practical solution to an EPL claim is to pursue a settlement.

Settlements and Hammer Clauses

Usually, an insurer cannot settle an EPL claim without the insured's written consent. Instead, if the carrier wants to settle and the insured disagrees, the claim can continue to be fought in court or via other legal channels but might then be subject to a policy's "hammer clause." The hammer clause essentially allows the insurer to document the amount for which it wanted to settle the claim and makes the insured responsible for the portion of any eventual settlements or judgments in excess of that amount.

In a simple example, imagine the insurance company proposes a $500,000 settlement for a discrimination claim, but the insured refuses consent. Under a basic hammer clause, If the claim later results in a judgment against the insured for $700,000, the insured will need to pay the excess of $200,000.

Wage-and-Hour Violations

Before summarizing several common exclusions found in EPL insurance policies, we should focus on one particular issue that—while still commonly excluded—has become more prominent in EPL products due to consumer demand.

Most EPL insurance policies won't cover the insured against alleged "wage-and-hour violations." Essentially, these alleged violations involve failing to pay non-salaried employees for the amount they've actually worked or failing to pay them in accordance with applicable overtime rules. (One exception in which EPL coverage might be more responsive would be a scenario in which a wage-and-hour violation is tied to discrimination, such as paying men for overtime but not providing the same overtime opportunities to women.)

Despite the general hesitancy to involve themselves in wage-and-hour disputes, some carriers have begun offering limited coverage to certain applicants. For example, limited coverage for wage-and-hour disputes might be offered in the following manner:

- Offered with its own sublimit far below the EPL policy's overall coverage limits.
- Offered within coverage of defense costs but not as coverage for any settlements or judgments.
- Offered to smaller businesses but not to larger ones (unless a larger business engages the help of a special insurance broker with connections to offshore carriers).

Since this is an evolving coverage issue, insurance professionals might want to pay attention to the latest product options and pass along any relevant news to their customers.

Other EPL Exclusions

Other common exclusions in EPL insurance policies are listed in this section. However, be aware that each EPL insurance product will likely be a bit different from the next. So careful attention should be paid to the exact policy language when explaining gaps in coverage to prospects.

On a similar note, although the following types of claims are often excluded in today's market, some carriers will provide narrow coverage that requires attention to each exclusion's wording and its surrounding clauses. For example, some of the claims listed here might still be covered, to a certain extent, if they are tied to discrimination or retaliation or might be eligible for help with defense costs but not with settlements or judgments:

- Assault and battery against workers.
- Disputes regarding unlawful strikes, walkouts or lockouts.
- Employee benefit liability under Employee Retirement Income Security Act.
- Blatant disregard for federal or state employment laws.
- Fines imposed by regulators (with coverage perhaps depending on the specific type of violation).
- Certain class action suits (with coverage perhaps obtainable as an endorsement to a carrier's standard policy).
- Punitive damages (unless allowed to be covered by law).
- Damage to employee property.
- Workplace injuries and workers compensation issues.
- Employment violations related to the OSHA, COBRA, the National Labor Relations Act or the Fair Labor Standards Act.

For the sake of a review, many of the laws mentioned in this list are summarized earlier in this chapter.

Conclusion

So, what's next for EPL insurance? As a guess, many observers point to the influence of social media and wonder if future issues related to alleged discrimination, harassment and other illegal employment activities will be tied to what employers find or prohibit on workers' personal online profiles. More generally, the assumption is that EPL issues will always gain in prominence and concern during difficult economic times, when the job market becomes extremely competitive and when businesses are faced with the tough decision to downsize their workforce. Society's increased attention to sexual harassment in the workplace is also certainly a growing concern.

While no one can predict exactly what's to come, it's clear that avoiding accusations of employment violations should always be an important part of a business's risk management plans. Along with promoting respectful workplace culture and paying attention to the latest legal developments, exploring the need for EPL insurance can improve those plans' effectiveness.

CHAPTER 6: INSURANCE REGULATION EXPLAINED

Introduction

The history of insurance regulation has its roots in 17th century England. The controversial and highly contested route of its development has resulted in a regulatory structure that is uniquely different than that found in other industries. There is no question, however, that the activities of American insurance companies are highly regulated, and few other businesses are guided by the strict controls and guidelines found in this industry.

To illustrate, an insurance company cannot establish operations without specific and regulated levels of operating funds. Other businesses do not have these start-of-business requirements. Similarly, insurance products generally must be sold by licensed agents or brokers only, while other businesses may market their goods and services through whatever means they elect to use. The insurance industry must have its rates approved by the state in which it is operating, while other businesses are free to set their own prices and rates. Finally, regulations require insurance companies to maintain certain levels of funding (reserves) for the protection of their consumers.

Generally, in most other industries, the state regulatory focus becomes secondary to federal regulation as an industry matures, but the insurance industry in the United States has moved away from a centralized federal regulatory structure, and the concentration of regulation has been passed to state governments.

Although the states exerted little control over insurance businesses prior to the Civil War, several states established statutes requiring charters for the insurers selling products within their boundaries. These charters and their provisions restricted insurance company activities and offerings, specified reserves and established parameters regarding investments.

In some states, chartering bodies directed insurance companies to make their financial standings public, while others required insurers to publish annual reports. Companies in Massachusetts were mandated to make these reports public as early as 1818. Other states soon followed this lead, asking for annual reports from state-based insurance companies and requiring insurers outside the state to make statements of their financial condition available. Other than these parameters, the insurance businesses of the time were allowed to operate as they chose.

While these chartering mechanisms provided regulatory guidelines for the industry, little was available in the way of enforcing them. The states were adept at issuing charters and often appointed various departments to tax their earnings from premiums, but the administrators assigned to regulate insurance businesses in certain states were not always effective in policing the industry in regard to legislation.

As a result, some companies made poor investment decisions and squandered their funds. Others simply went bankrupt. Still others used deceptive and unfair policy provisions. This rollercoaster track record made it obvious that some type of regulation was necessary for the protection of the public. It also indicated a need for regulation to balance business activities and sustain the industry.

In an effort to more efficiently empower state regulatory offices, New Hampshire was the first state to establish a three-seat insurance commission in 1851. The board was later reorganized to include a single commissioner in 1869. Other states followed, and today, the state insurance commission continues to exercise substantial influence within the insurance industry.

In 1855, the state of Massachusetts established the first department of insurance and, in 1858, appointed mathematics professor Elizur Wright as insurance commissioner. Wright would later be credited as the person who contributed most to the future of insurance supervision, due to his concept of regulation for the purpose of insurer solvency.

Shortly after New Hampshire created the first insurance commission, the U.S. House of Representatives proposed a bill to establish a national bureau of insurance as an adjunct of the Treasury Department. Two years later, the Senate passed a similar bill. Both were defeated, however. The reason for the failure of the two bills, it was speculated, was because the country was not yet ready to embrace the idea of federal control of the insurance industry.

In the early 1900s, the effectiveness of the regulation of the insurance industry was studied by two separate committees. The New York legislature appointed a committee—The Armstrong Commission—for the purpose of studying the life insurance industry in 1905. The committee reported finding several areas of abuse regarding financial reporting and other wrongdoings resulting from the lack of effective regulation.

In 1910, the New York legislature appointed the Merritt Committee to investigate non-life insurance lines. This committee reported that price competition would result in rate wars that would be devastating to the industry. It noted that insurers that had only marginal operations would be forced to offer coverage at a slightly lower rate and that those insurers with stronger operations would respond to these decreases by lowering their rates. Eventually, this would create a problem for the marginal insurers, which would result in bankruptcies. This study reported that cartel insurance pricing was acceptable for the public good as well as for the good of the industry.

Congress passed the McCarran-Ferguson Act in 1945 to declare that states should regulate the business of insurance and to affirm that the continued regulation of the insurance industry by the states was in the public's best interest.

The Financial Services Modernization Act of 1999, also called Gramm-Leach-Bliley. established a comprehensive framework to permit affiliations among banks, securities firms and insurance companies. Gramm-Leach-Bliley once again acknowledged that states should regulate the business of insurance. However, Congress also called for state reform to allow insurance companies to compete more effectively in the newly integrated financial services marketplace.

In most states, the insurance department is part of the executive branch of state government, and it is under the direction of the insurance commissioner. In a few instances, this is an elective position. However, in other states, the governor appoints the commissioner. The commissioner's main duty is to administer the insurance laws of the state along with the assistance of staff members.

The Role of the State Legislatures

State legislatures set broad policy for the regulation of insurance. They establish and oversee state insurance departments, regularly review and revise state insurance laws and approve regulatory budgets. State insurance departments employ tens of thousands of regulatory personnel. Increases in staff and enhanced automation allow regulators to substantially boost the quality and intensity of their financial oversight of insurers and expand consumer protection activities.

National Association of Insurance Commissioners (NAIC)

The National Association of Insurance Commissioners (NAIC) serves as a vehicle for individual state regulators to coordinate their activities and share resources. The NAIC functions as an advisory body and service provider for state insurance departments. State insurance regulators use the NAIC to pool scarce resources, discuss issues of common concern and align their oversight of the industry. Each state, however, ultimately determines which actions it will take.

The NAIC was developed to coordinate the activities of the individual state insurance departments. Founded by George W. Miller, the second superintendent of insurance for the state of New York, the early goals of the NAIC were of uniformity across examination practices, annual reporting statements and laws.

The first meeting of the body was in 1871 and included all of the insurance commissioners of the various states. It became a voluntary organization, and through the guidance of the NAIC, the state departments began to avoid the confusion of uncoordinated operations.

Today, the NAIC meets regularly, with regional meetings scheduled between meetings of the entire NAIC body. Various committees from the organization work throughout the year on specific topics. Much of the committee work is focused on standardization procedures and formats, but others have developed information included on policies and policy statements.

As a body, the group is committed to the development of legislative recommendations. Once the need for a new law is identified, a specific committee studies the situation and makes a recommendation to the larger group. If the group can pass the measure, it is submitted to the legislatures of the states involved in the form of a model bill for discussion. Although some states eventually reject some of these legislative proposals, the process has resulted in a growing uniformity of the industry's regulation throughout the country.

The NAIC continues to study the problems and changes within the industry. Task forces use advisory committees made up of insurers and the public-at-large to investigate issues and ideas to improve the industry as a whole. In the 1980s, for example, an NAIC task force gave primary attention to the use of gender and marital status as classification factors used in automobile insurance ratings and comprehensive health insurance coverage. They also looked at the question of state vs. federal insurance regulation and ways to detect insurer insolvency before it actually occurred.

The Purpose and Structure of Insurance Regulation

The fundamental reason for government regulation of insurance is to protect consumers. State systems are accessible and accountable to the public and sensitive to local social and economic conditions. Insurance regulation is structured around several key functions, including company licensing, producer licensing, product regulation, market conduct, financial regulation and consumer services.

Why Regulate?

The insurance industry is "affected with a public interest." This concept was initially developed by the British jurist Lord Matthew Hale in 1676. The U.S. Supreme Court used Hale's concept as a basis for writing its own decisions and determined that the insurance industry was deemed "affected with a public interest" because of its role in many other business and industry activities.

Two hundred years later, in the case of Munn v. Illinois, the Supreme Court further determined that insurance companies were businesses affected by the public interest. In its ruling, the court recognized the states' right to regulate "properties" affected with the public interest, but protected these "properties" or businesses by further stating that the courts, not the legislature, would be responsible for determining "reasonableness."

Munn v. Illinois became a landmark ruling because it specified that property was "clothed with a public interest when used in a manner to make it of public consequence and affects the community at large." However, no specific consequences were delineated in the ruling, and in its final form, the public interest concept became a dynamic one that would vary with court opinions down through the years.

The case of Paul v. Virginia in 1869 determined the legal basis for state regulation of the insurance industry. Samuel Paul was a Virginia insurance agent for several New York fire insurance companies. In Virginia at that time, insurance agents representing out-of-state companies were required to provide certain information to the state controller's office. Paul had not met these requirements. The result of his noncompliance was a $50 fine. When Paul appealed the fine, he argued that the insurance business was commerce, and in his case, interstate commerce. The U.S. Constitution, by his interpretation, controlled interstate commerce, and according to Paul, Virginia had no right to enforce its insurance-related requirements on agents.

The Supreme Court rejected Paul's argument, ruling that selling insurance policies was not commerce, but personal contracts—not merchandise that was being shipped from one state to another. In their ruling on Paul v. Virginia, the Supreme Court upheld the Virginia laws and ruled that insurance companies were not to be regulated by the federal government but by the states. Paul ultimately lost his fight and had to pay the $50 fine, but the case determined the right of the state governments to regulate insurance companies, a ruling that was held intact for the next 75 years.

In part, the ruling stated:

- *... issuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the insured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. They are not subjects of trade or barter offered in the market as something having an existence and value independent of the parties to them. They are not commodities to be shipped or forwarded from one state to another and then put up for sale. They are like other personal contracts between parties that are completed by their signature*

and the transfer of consideration. Such contracts are not interstate transactions, though the parties may be domiciled in different states. The policies do not take effect—are not executed contracts—until delivered by the agent in Virginia. They are, then, local transactions, and are governed by the local law. They do not constitute a part of the commerce between the states any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York whilst in Virginia would constitute a portion of such commerce.

In the early 1900s, it was proposed that certain aspects of the insurance industry be placed under federal regulation. However, the U.S. Congress was advised to refrain from passing such legislation on the basis that Paul v. Virginia and other cases had determined that the federal government had no documented authority over the industry. It was not until 1944 that the Supreme Court reversed its Paul v. Virginia decision and ruled in the South-Eastern Underwriters Association case that the insurance industry was indeed commerce.

In 1945, however, Congress passed the McCarran-Ferguson Act. This act stated that the states should continue to regulate the insurance industry because it was in the public interest, and it further specified that federal antitrust laws only apply to the insurance industry in instances where state regulation is not effective.

State vs. Federal Regulations

Arguments surrounding the debate of state vs. federal regulations have continued for the better part of two centuries, with flames intensifying around controversies regarding state control and the regulation of issuance rates. During former President Jimmy Carter's term in office, a national regulatory commission was named for the purpose of reviewing the implications of antitrust laws, particularly the McCarran Act, which provides certain antitrust immunity for the insurance industry.

Which type of regulation is preferable: state or federal? This question, too, remains at the forefront of the ongoing debate. However, many experts believe that such a question does not embrace the complexity of the regulatory bodies. To them, the question is not which is better for regulation—state or federal—but what combination of these two entities would be most effective?

Potential Advantages of Federal Control

Between the rulings of Paul v. Virginia and the South-Eastern Underwriters Association case, hundreds of briefs have been filed against state regulation and in favor of the insurance industry being considered commerce. However, those who were in favor of federal control of the insurance industry took this stand because they believed a federal regulatory system would be less complex.

Even today, because of issues surrounding rate regulation, those favoring federal control continue to make their voices heard. Their reasons for favoring a move from state to federal regulatory control often are prompted by their frustration with state regulatory boards, but they also contend that federal regulation would be to the advantage of the entire industry. Some of their arguments include:

- Insurance is a product sold and used throughout the nation. Because of this national scope, it logically follows that the industry should be regulated by a federal body.
- Each state has its own laws and regulations regarding the insurance industry. By placing the insurance industry under federal regulation, insurers would be able to comply with a uniform system of regulation.
- Total federal control over the industry would avoid the "overlapping" regulations that often occur in the state/federal regulatory environment.
- Because the industry is currently regulated by 52 separate departments (50 states plus the District of Columbia and Puerto Rico), it seems logical to assume that these 52 departments are more costly to operate than one centralized federal department.

Potential Advantages of State Regulation

As with the backers of federal regulation, those favoring state regulation of the insurance industry have also advanced some specific arguments over the years. Here is a sampling of these theories:

- State regulation is a familiar experience. There are less unknowns involved within the process. Many in the industry believe that it would be far more advantageous to examine current practices and build on the experience of existing regulatory measures than to begin with a totally unknown system.
- Because state offices would be more familiar with the local environment, many people believe it would be more effective to have the individual states rule on issues, as opposed to a centralized federal department of regulation.
- Currently, if a state missteps in its handling of certain problems, the surrounding states are not enveloped in the ripple effect that would occur if federal regulatory errors were made.

It is important to remember that the public interest must be of primary concern when evaluating the advantages and disadvantages of one regulatory system as opposed to another. The argument as to whether state or federal regulation is best continues to move from one side of the debate to the other. The debate will likely continue for several more decades.

Company Licensing

State laws require insurers and insurance-related businesses to be licensed before selling their products or services. All U.S. insurers are subject to regulation in their state of domicile and in the other states where they are licensed to sell insurance. Insurers that fail to comply with regulatory requirements are subject to license suspension or revocation, and states may exact fines for regulatory violations.

Producer Licensing

Insurance agents and brokers, also known as “producers,” must be licensed to sell insurance and must comply with various state laws and regulations governing their activities. More than 2 million individuals are licensed to provide insurance services in the United States. State insurance departments oversee producer activities in order to protect insurance consumer interests in insurance transactions.

The states set continuing education standards to ensure that agents meet high professional standards. Producers who fail to comply with regulatory requirements are subject to fines and license suspension or revocation.

When producers operate in multiple jurisdictions, states must coordinate their efforts to track producers and prevent violations. Special databases are maintained by the NAIC to assist the states in this effort. The National Insurance Producer Registry (NIPR)—a non-profit affiliate of the NAIC—was established to develop and operate a national repository for producer licensing information.

Product Regulation

State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected.

For property and casualty insurance sold to individuals and families, about half of the states require insurers to file rates and receive prior approval before they go into effect. With the common exception of workers compensation and medical malpractice insurance, property and casualty insurance sold to businesses is often subject to a competitive rating approach. Under such a system, regulators typically retain authority to disapprove rates if they find that competition is not working.

Premiums for life insurance and annuity products generally are subjected to less stringent regulatory approval, although regulators may seek to ensure that policy benefits are commensurate with the premiums charged. Many states subject health insurance rates to prior approval.

Simplifying Policy Language

Over the years, the insurance industry has become so complex that policies are often the subject of court interpretation. Because of these complexities, it is difficult for the average policyholder to understand even a basic policy, which allows for unscrupulous agents to write policies that may not be in the best interest of the insured. In some cases, even honest insurers may inadvertently include exclusions and special provisions that may be misleading or unfavorable to the policyholder.

Because of this situation, and because it is generally felt that most insurance policies are difficult to understand, there has been a movement in place for several years to simplify policy formats. In filing a homeowners policy, one rate advisory bureau reduced the narrative by about 40 percent and increased the size of the type used in the policy by 25 percent. More white space was also allowed between the lines. More readable policy guidelines have also been instituted for automobile, business, personal, life and health insurance policies.

To maintain a certain amount of control over the policies offered by various insurers, the state commissioner might need to approve policy forms. This makes it difficult for companies to either mislead or deceive the consumer with statements that contain highly technical terminology or ambiguous descriptions of coverage. For certain types of insurance coverage, including fire and workers compensation, a standard form is often required. Other coverages forbid the use of gimmickry in their forms and verbiage.

The commissioner, upon reviewing a new policy format, may overrule any type of wording in provisions that may be deceptive or misrepresent the "real" coverage. The unfortunate aspect of this particular type of regulation is that most state insurance departments have neither the funds nor the trained personnel to review every form that is used for insuring individuals in that state.

Financial Regulation

One of the primary goals of insurance regulation is that of preventing insurance companies from going into bankruptcy. To this end, controls have been established through government regulations unique to the insurance industry. These controls require insurance companies to maintain certain levels of operating capital, as well as specified reserves and surplus levels to underwrite "the future services" agreed upon in the policies issued by that company. The government requires insurance companies to meet these levels because of the far-reaching effects of an insurance company going bankrupt.

When any other business fails, the competition absorbs its customers and may adjust goods and prices to remain within the good graces of the public. In this scenario, both the competitor and the consumer benefit. When an insurance company fails, there are no similar beneficiaries.

Insurance premiums are based on what the insurer estimates the cost of future services will be. If the estimated costs of these services or losses are lower than the actual costs, the result is that rates are set too low and policies are underpriced. Several decades ago, the industry underestimated the impetus of rising rates in liability claims for property-casualty policies. A few years later, this area of the industry experienced significant losses because of the underpricing.

Because the industry must estimate future trends and activities, there is always the possibility that rates may be inadequate to cover losses. This fact, when coupled with the far-reaching impact of insurance company failure, forms the logic of regulation to protect the industry from insolvency.

Financial regulation provides crucial safeguards for insurance consumers. Periodic financial examinations of insurance companies occur on a scheduled basis. State financial examiners investigate a company’s accounting methods, procedures and financial statement presentation. These exams verify and validate what is presented in the company’s annual statement to ascertain whether the company is in good financial standing.

When an examination of financial records shows an insurer to be financially impaired, the state insurance department can take control of the company. Aggressively working with financially troubled companies is a critical part of the regulator’s role. In the event that the company must be liquidated or becomes insolvent, the states maintain a system of financial guaranty funds that cover a portion of consumers’ personal losses.

Regulation of Admitted Assets

The solvency of an insurance company is measured by how much admitted assets surpass the company's liabilities. This measurement is taken by state regulators. Valuations for the company are highly regulated, which makes the insurance industry—once again—unique from most corporations.

In most situations, "admitted assets" are those assets held by the company that include legal portfolio investments. Admitted assets always include office buildings and real estate (some states also allow computer equipment), but do not include operational assets for the firm (such as automobiles, supplies, furniture and other capital expenditures, or secured or unsecured loans and advances to agents).

Market Regulation

Market regulation attempts to ensure fair and reasonable insurance prices, products and trade practices in order to protect consumers. With improved cooperation among states and uniform market conduct examinations, regulators hope to ensure continued consumer protections at the state level.

Market conduct examinations occur on a routine basis but also can be triggered by complaints against an insurer. These exams review agent licensing issues, complaints, types of products sold by the company, agent sales practices, proper rating, claims handling and other market-related aspects of an insurer's operation.

When violations are found, the insurance department makes recommendations to improve the company's operations and to bring the company into compliance with state law. In addition, a company may be subject to civil penalties or license suspension or revocation.

Regulation of Sales and Sales Activities

The purpose of regulating sales activities is, at first glance, to protect the consumer from unreliable services and disreputable agents. However, this type of regulation also serves to provide a balance of fair competition within the market environment. In this area of regulation, the states regulate how insurers obtain new policyholders, the ethical standards within the industry and the standards required of insurance sales agents.

Once a prospective agent or broker has passed a licensing examination and the license is issued, the agent or broker must continue learning about the field through continuing education requirements each year or every few years. This continuing education or training may often be taken individually or through the attendance at seminars.

Once a salesperson has been licensed, that individual's activities may also fall under regulation, particularly if those sales activities drift into the realm of misrepresentation. Most of the states have statutes that prohibit misrepresentation of the facts about a policy and its coverage. Some statutes also cover the parameters of the relationship between the insured and the insurer.

In the insurance industry, the term "twisting" refers to the misrepresentation of the facts by an agent in order to manipulate the policyholder into substituting one contract for another. Twisting also includes failure to include all the facts when policies are represented. Because of regulation against twisting, agents are discouraged from making recommendations that may include dropping one policy in favor of another.

Another sales activity that is regulated against is that of rebating—where an agent would refund part of the premium to the policyholder. In most states, anti-rebating regulations have been established for the purpose of protecting the public interest. However, a few states allow rebating and believe it can help rather than hinder competition in the marketplace.

Types of Insurance Companies

Before an insurance company can sell insurance in any state, it generally must be licensed to sell insurance or, as it is called, "admitted" to that state. An insurer that is admitted to a state is authorized to do business in that state. If an insurer is not admitted to a state, it is generally unauthorized to do business in that state.

Insurance companies can be organized in several ways; however, most are organized either as stock companies or as mutual companies.

Stock Companies

A stock company gets its name from its basic ownership characteristic. Its stockholders, people who have bought stock in the company, own a stock company. The stockholders may or may not also be policyowners. The sole function of the stockholders is to elect a board of directors who, in turn, will guide the operation of the company. If the company is successful financially, the stockholders will receive dividends, which are paid for each share of stock owned. A stock insurance company, like all other corporations, is in business to make a profit for the stockholders.

Mutual Companies

Unlike a stock company, which is owned by its stockholders, a mutual company doesn't have traditional stockholders. Control in a mutual company rests with the policyowners who 'mutually" own the company. The policyowners elect a board of directors, and any "profits" are returned as dividends to the policyowners in the form of reduced costs for insurance.

It should be mentioned here that dividends from a mutual company are not profits in the mercantile or commercial sense but rather the return of an "overcharge" of premium. For example, a mutual life insurance company might sell life insurance at one specific age for $20 per $1,000 of face amount. Once a dividend has been declared, each policyowner might then receive credit on the premium statement in the amount of $2 per $1,000. Thus, the resultant cost for the insurance is $18 per $1,000 of face amount.

While not true in every case, mutual insurance companies usually issue "participating" insurance policies. The term participating means that if the company realizes a savings, these savings or "profits" are passed along to the policyowner in the form of policy dividends. Thus, the policyowner in a mutual insurance participates in any savings or "profits" enjoyed by the company.

Fraternal Benefit Societies

Another type of insurer with which you should be familiar is the fraternal benefit society, also known as a "fraternal." A fraternal insurer is a social and benevolent organization, which provides, among other services, insurance benefits for members. Membership in such an organization is often based on factors such as a person's nationality, religion or occupation. But whatever the criteria for membership, keep in mind that fraternals have functions other than providing insurance.

Each state defines and provides for the regulation of fraternal benefit societies in its insurance laws. But although the exact definition of a fraternal may differ from state to state, an organization usually must have certain characteristics to qualify as a fraternal benefit society. First, the organization generally must exist only for the benefit of its members and of their beneficiaries and be non-profit. Second, it must be organized without capital stock.

A third characteristic is that the society usually must be organized on a lodge system. This means that the organization must have local lodges or chapters that hold regular meetings to carry on the activities of the society.

Finally, the organization must have a representative form of government. There must be a governing body chosen by the

members directly or by delegates in accordance with the organization's bylaws or constitution.

Government Insurance Programs

Government insurance programs have been created when private insurers would have been subjected to adverse selection or were incapable of meeting society's needs.

By its administration of various federal insurance programs, the U.S. government has become the largest insurer in the world. These various programs include Social Security, Medicare and the Railroad Retirement, Disability and Unemployment programs.

Reciprocals

Reciprocals are groups of individuals (called "subscribers") who are insured under an arrangement where each subscriber is both an insured and an insurer. In other words, the other members of the group insure one another. However, the liability of each subscriber is limited.

The administrator of the reciprocal is an "attorney-in-fact." He or she is granted this power by the subscribers through a broad power of attorney and receives a percentage of the gross premiums paid by the subscribers. Other than this payment to the attorney-in-fact and administrative expenses, the cost to the reciprocal is limited to the amount of the losses that occur. Any unused premiums are returned to the subscribers.

Lloyd's of London

Lloyd's of London is a name familiar to many in the insurance industry. Perhaps the most interesting fact about Lloyd's of London is that it neither is an insurer nor does it issue policies. Rather, Lloyd's of London is an association of members that write insurance for their own accounts. The New York Stock Exchange bears the same relationship to stock purchases as Lloyd's bears to the purchase of insurance. Though neither organization engages in trade, both provide facilities and rules that govern how its members will pursue trade. In addition, Lloyd's maintains worldwide underwriting information and a complete record of losses. It also aids in loss settlements and supervises salvage and repairs throughout the world

At Lloyd's, an insurance transaction begins when a proposal is placed before the underwriting members or their agents by a licensed broker. The broker prepares the policy and submits it to the Policy Signing Office, where the policy is examined. if the policy conforms to agreed-upon rules, it is submitted to the underwriters. Those underwriters who wish to participate in the policy affix their signatures, or "underwrite," the risk.

Regulation by Government Branches

The insurance industry is subject to three distinct types of regulation executed by the three branches of the democratic form of government—legislative, judicial and executive. These three methods of regulation, plus the self-regulatory structures, oversee specific areas of operations within the industry and distribute regulatory powers between state and federal regulatory agencies. The following paragraphs will examine and explain the distinctions of each of the four categories.

Legislative Regulation

All insurers and their operations in the 50 states, the District of Columbia and Puerto Rico are governed by insurance laws and regulations. The states legislate these guidelines for matters such as agent licensure, methods of doing business, the availability of coverage and other aspects, and they have police power to enforce the rules protecting the health and welfare of the citizens of that state once those rules are approved.

Regarding insurance, the states do not leave the development of legislation totally to legislatures. In fact, associations of insurers and other individuals and groups are encouraged to develop model bills and submit them for legislative sponsorship.

Judicial Regulation

Through their interpretation of legislation and other questions, the judicial branch of each state plays a major role in the regulation of insurance. Although their involvement is often indirect in its nature, the courts are also employed to settle disputes between parties involved in insurance contracts. The written ruling of the court for each case, therefore, becomes a part of the body of legislation regulating insurance.

Executive Regulation

As the insurance industry became more diversified and complex, it became obvious that the industry's regulation should be supervised by knowledgeable and experienced individuals. Each state has established an insurance department headed by a commissioner or an individual with a similar insurance-specific title. Commissioners make rules, called administrative law, to assure the successful operation of the industry within their state. However, these rules and these individuals are, in turn, accountable to review by the courts.

The duties of state insurance commissioners are broad and varied, but each state insurance department has certain basic duties. These include licensing of insurance companies and agents working within the state, monitoring the activities of licensed agents and screening these activities regarding good business practices. In some cases, the commissioner is required to impose certain penalties for unscrupulous behavior, such as the revocation of licensure or the closing of businesses that fail to meet regulatory requirements regarding reserves, capital and surplus.

Since 1818, when the Massachusetts insurance department required filing of the first annual financial reports, state commissioners have required the filing of annual statements; furthermore, they act as a depository for securities in states with laws governing securities and require an evaluation of corporate assets on a regular basis.

Commissioners also regulate trade practices and oversee and approve policy contracts. In their role as a regulators, the commissioners may also monitor rates to ensure that discrimination doesn't occur. The state investigates complaints on all levels and maintains strict controls on any mail-order insurance activity in the state.

Self-Regulation

Despite the existence and power of government-level regulators, the insurance industry has continued to be a self-regulated industry to a certain degree. Through associations of insurers and agents, these self-regulatory groups have exerted some level of control through strict codes of ethical conduct and other cooperative agreements. These groups continue to function, generally out of the fear that more public regulation would impair the industry and its purposes.

Pricing of Insurance Rates

Although most insurance rates are the result of extremely complicated formulas, a simplified explanation is this: Insurance rates are a determination of a policyholder's percentage of responsibility for loss expenses. The premium to insure the property or person is the rate per unit of coverage multiplied by the number of units purchased.

Here are some examples: Say you want to purchase a homeowners policy. A unit would be 100 square feet within the building. If you want to purchase life insurance, the unit may be $100 or $1,000 of coverage purchased.

Once the cost per unit is established, the insurer must look into the future to determine the percentage chance that the homeowner will suffer a loss, based on past experience and the rate of probability that a homeowner will file a claim. This historical experience and the influence of new trends and developments (such as improved building materials) are also taken into consideration to determine the final rate to be paid.

Historically, insurers calculated each policy on a separate basis. But as business increased, this system proved to be too cumbersome, and insurance companies also found some glaring deficiencies in their existing methods. Rate setting (or “rate making”) soon became a group effort in order to make rates both profitable for the companies and fair to the policy buyers. These rates were published, and if variances were appropriate, the established rates became the basis point for these variations. The various lines of insurance began setting their own rates, and today, industry trends suggest that independent rate making is the rule for all types of insurance coverage.

Rate Regulation Objectives

When a rate filing is submitted to the state insurance department by an insurance company, the data submitted is evaluated by the department with three objectives in mind:

- To prohibit excessive rates for coverages.
- To maintain the financial solvency of the company.
- To avoid unfairly discriminatory rates.

The strictness and meticulousness with which new rates are evaluated depends upon the state. In some states, for example, property and casualty rates require explicit approval by the insurance commissioner prior to the use of new rates. In other states, the "open competition" condition exists, and it is assumed that the competition will regulate costs much more effectively than the insurance commissioner. In the "open competition" states, the commissioner of insurance may curtail the use of certain rates, particularly those violating rating standards, but rates do not have to be filed and approved, as is the practice in the more rigidly controlled states.

It is worth noting here that anyone having a grievance against an insurance agent or insurance company is invited to file a complaint with state regulators. However, the burden of proof that rate filings do, indeed, comply with the law is on the shoulders of the insurance company or the rating bureau.

Life insurance rates are not regulated in the same manner that other coverages are regulated. The control of these rates is indirect, or, in other words, based on a combination of mortality tables, dividends and interest rates used to compute the reserves of life insurers. When these controls are combined, the result is an indirect regulation of life insurance rates that are inadequate, excessive or discriminatory.

While the level for rates on many individual life policies and ocean marine insurance are not tightly regulated, there is a minimum set for group life by several state insurance departments. Property and liability rates are controlled by model rating laws. These regulations are based on historical records of prospective loss and expense, as well as the occurrence of catastrophic events and hazards within a certain area. When there is regulation of this sort, the insurance company must file premium rates, rating plans, coverage and rules for approval by the commissioner or a special committee. In this filing, the company must also provide support of any calculations with documentation.

Some insurers will go through a licensed rating organization rather than filing directly with the state commissioner; however, the commissioner can also disapprove any filing, as long as he or she specifies reasons why the filing was disapproved.

Each state commissioner must also approve a rating organization, and each rating organization must allow any qualified insurance company to take advantage of its services without any discrimination toward the company. There are technical requirements built into methods of recording and reporting loss and expense experience, exchange of rating plan data, and consultation with other states. The state commissioner usually taps a rating organization to collect this data.

Unless a company files an application for deviation, each subscriber must follow the rating organization's rates and policies; but the commissioner may also disapprove these applications if there is a hint of inadequate, excessive or discriminatory rates.

Regulating Reserves

Those companies writing property and casualty insurance should maintain loss reserves as well as unearned premium reserves. The loss reserve is the liability for claims and settlement costs that the insurer estimates. The unearned premium reserves are those at the time of valuation that represent all policies outstanding and their gross premiums.

The tricky area concerning regulators most about loss reserves is that most insurance companies estimate loss reserves lower than practicable, and, in turn, this situation leads to insolvency when the insurer is pressed for payment. Conversely, when insurers set reserves too high, they also increase their rates to excessive proportions. And because most state insurance departments do not have the trained personnel to police these areas of a firm's operations, some insolvencies have occurred.

Life insurers have one principal reserve—the policy reserve. This reserve is calculated to meet all policy obligations, as well as premiums and assumed interest. The valuation on this reserve may be different from premiums charged by an insurer because it does not include an allowance or expenses and, in fact, may be calculated based on a different set of interest and mortality assumptions.

The Modified Reserve Standard is used by some life insurers because the bulk of the expense a company incurs is during the first year that the policy is in effect. These expenses include premium taxes, general expenses on the part of the insurer and mortality costs. This leaves little of the premium left for the insurer and is definitely not enough to cover the reserve for the end of the first year.

Reserve options allow the insurer to postpone paying the full policy reserve. One such option is the "full preliminary term

reserve plan." This option allows the insurer to pay no policy reserve at the end of the policy year. Each following year, the reserve amount is set for the full reserve amount on a policy written one year later for a period one year less.

Regulation of Dividends

The payment of dividends to policyholders is usually a matter of judgment on the part of the insurer. Some state insurance departments say they control this decision by limiting the surplus amount accumulated by the insurer, not to exceed 10 percent of the policy reserve. By this type of limitation, the insurance departments effectively prevent the accumulation of a large surplus, while dividends are lower or not paid at all. This type of regulation, according to insurance commissioners, also curbs the temptation of inefficiently utilizing a large store of assets.

Regulation of Business Capacity

If an insurance company writes new business at a fast pace, there is the possibility that this increase in business could exhaust the insurer's surplus and lead to insolvency. At the end of World War II, for example, several insurance companies actually "sold out" their products because they wrote as much business as they could without bringing their surplus accounts down to low levels. Because they could not raise enough capital in a short period of time, the companies had to quit issuing new policies. Some commercial insurers decided to become selective in who they insured, favoring the more profitable companies. The less profitable businesses were left without insurance. This "capacity problem" is particularly important in discussions of property and casualty insurance.

The branch of the insurance industry that does not seem destined for "capacity problems" is life insurance. The need for a large surplus is not as immediate in life insurance, and many states limit the accumulation of surplus by those companies that sell participating policies.

Regulation of Investments

With the exception of property and casualty insurers, which experience a majority of problems in the area of underwriting, most other branches experience the majority of their financial problems as the result of problems with their investments. Because of this fact, most states regulate investment of the assets of insurance companies. These restrictions may be either quantitative or qualitative—dealing with the types of investment media, the amount of security required, the percentage of admitted assets to be invested, and the percentage of admitted assets dedicated to a single area of investment, among others.

Liquidation of Insurers

When an insurance company becomes technically insolvent, the state takes over the company for either liquidation, rehabilitation or conservation. The commissioner may take over operations at any time if the company is not being operated in the best interests of those holding policies with that company. An insurance company suspected of nearing insolvency has a right to a hearing by the commissioner. At that point, if the need for a takeover is not sufficiently supported, the assets are returned to the company's management.

Taxes

Like any other industry, insurance companies in America pay local, state and federal taxes and fees. The bulk of these taxes are levied by the state; however, some communities and municipalities collect taxes as well. These mandatory payments include income taxes, property taxes, license and filing fees for annual financial statements, and fees for taking the insurance licensing exam. Companies also pay taxes on franchises (if they apply), premium taxes (although some states tax insurance companies as an alternative to premium taxes) and special taxes on workers compensation and various other types of insurance.

Applicable Tax Rates and Rules

While state taxation varies according to state requirements, income taxes are levied according to formulas found in the IRS Code, and taxation on real estate and property are the same as for any other taxpayer. In some states, taxes levied on fire insurance premiums go to support local fire departments. Likewise, the taxes on workers compensation insurance are used to establish the system, security funds and funds to underwrite programs for employing disabled individuals.

Conclusion

Insurance regulation has not only a long history but also a continued commitment to several important goals. Whether those goals relate to insurer solvency, nondiscriminatory rating practices, fair market conduct or any other number of issues, the primary goal of insurance regulation remains the protection of insurance consumers.

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

FINAL EXAM

1. In general, the _____ process involves identifying risks, measuring those risks and figuring out what to do about them.
   A. rate making
   B. risk management
   C. risk transfer
   D. risk avoidance

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

3. A “physical hazard” is an environmental factor that increases the ___.
   A. credits applied to an insurance premium
   B. number of required underwriters on a case
   C. likelihood or severity of a potential loss
   D. size of an insurance payout to the policyholder

4. “Moral hazards” are character issues that make people more likely to ____.
   A. purchase an insurance product
   B. maintain property in good condition
   C. engage in honest mistakes
   D. cause a loss on purpose

5. "_____" are cases of indifference that make a consumer not care about preventing or reducing losses.
   A. Pure risks
   B. Speculative risks
   C. Morale hazards
   D. Liability hazards

6. A(n) _____ is a risk in which none of the potential outcomes are beneficial.
   A. pure risk
   B. speculative risk
   C. uninsurable peril
   D. total loss

7. _____ involve uncertainty surrounding whether a person or entity will be held legally responsible for someone else’s losses or for unlawful activity.
   A. Personal risks
   B. Liability risks
   C. Claims-made policies
   D. All-risk policies

EXAM CONTINUES ON NEXT PAGE

8. At its simplest level, _____ is an attempt to identify potential losses, determine the likely cost of those losses and create a path toward recovering from them.
   A. insurance underwriting
   B. risk management
   C. rate making
   D. solvency auditing

9. Losses considered high in both frequency and severity are_____.
   A. typically shifted to another party
   B. less likely to be insurable
   C. subjected to post-claims underwriting
   D. not analyzed by the typical risk manager

10. “Risk avoidance” is a risk management strategy in which a person entirely eliminates a risk by _____.
   A. giving the risk to an insurer
   B. creating a disaster plan
   C. choosing not to engage in an activity
   D. hiring a risk manager

11. Risk avoidance is often employed as a risk management strategy when losses related to a risk are likely to have _____.
   A. low frequency and low severity
   B. low frequency and high severity
   C. high frequency and low severity
   D. both a high frequency and a high severity

12. “Risk retention” (sometimes called “risk assumption”) occurs when someone decides to _____.
   A. buy an insurance policy
   B. initiate major safety measures
   C. consult a risk manager
   D. accept a risk

13. _____ occurs when steps are taken to reduce either the likely frequency or severity of a potential loss with the understanding that the risk can’t be entirely eliminated.
   A. Risk reduction
   B. Risk transfer
   C. Risk shifting
   D. Risk speculation

14. In essence, _____entails having a backup procedure in place so that important work toward goals can resume soon after a loss.
   A. claims adjusting
   B. contingency planning
   C. risk mitigation
   D. risk analytics

15. “Risk transfer” (sometimes called “risk shifting”) occurs when the consequences stemming from a risk are _____.
   A. likely to be uninsurable
   B. generally unknown to the risk taker
   C. taken from one party and moved to another
   D. handled internally rather than with help from a specialist

EXAM CONTINUES ON NEXT PAGE

16. _____ is a method by which insurance companies (as well as any other entity running an insurance program) attempt to spread either the same or similar risks across a larger group.
    A. The law of large numbers
    B. The pooling of risks
    C. Claims handling
    D. Loss indemnification

17. On occasion, policyholders look to avoid estate taxes by _____.
    A. naming their estate as a beneficiary
    B. purchasing credit life insurance
    C. transferring policy ownership to heirs
    D. increasing their life insurance premium

18. Term life insurance is sometimes called “pure insurance” because, unlike other policies, it lacks investment options and has no _____.
    A. cash value
    B. death benefit
    C. ending date
    D. settlement options

19. Permanent life insurance is very different from _____.
    A. term life insurance
    B. whole life insurance
    C. universal life insurance
    D. variable life insurance

20. _____premiums are often disclosed in a divided manner, showing how much of each payment ultimately goes toward the death benefit and how much goes toward the policy’s cash-value component.
    A. Solvency bond
    B. Viatical settlement
    C. Universal life insurance
    D. Accidental death insurance

21. Variable life insurance is a form of permanent life insurance that exposes a policy’s cash value to market risks in exchange for _____.
    A. lower premiums
    B. more guarantees
    C. potentially higher returns
    D. larger death benefits

22. Though it can perform other functions, group life insurance is most commonly used to insure several people who _____.
    A. work for the same employer
    B. have low incomes
    C. are members of the same family
    D. have similar health risks

23. _____ involves very little underwriting and, therefore, can allow an ill or older individual to obtain some coverage at a low price.
    A. Force-placed insurance
    B. Fair Plan insurance
    C. Group life insurance
    D. Variable annuitization

EXAM CONTINUES ON NEXT PAGE

24. Other than the insurance company, the _____ is the only party who controls how the policy is set up.
    A. policy owner
    B. primary beneficiary
    C. insurance producer
    D. contingent beneficiary

25. In general, a person can take out a life insurance policy on another person if the proposed owner can demonstrate a(n) _____ in the other person's life.
    A. special need
    B. insurable interest
    C. needs analysis
    D. right of ownership

26. _____ specifies how long an insurer may investigate possible frauds or misstatements on an application and deny coverage after the policy has been issued.
    A. The suicide clause
    B. The assignment clause
    C. The ownership clause
    D. The incontestability clause

27. Age and gender are important underwriting factors for _____.
    A. life insurers
    B. property insurers
    C. liability insurers
    D. private mortgage insurers

28. A policy provision called a(n) _____ gives new policyholders a short period of time to possibly reconsider their purchase, cancel the policy and receive a refund of the first premium with no questions asked.
    A. loss settlement clause
    B. free-look period
    C. elimination period
    D. premium rider

29. The manner in which a beneficiary receives policy benefits is called a(n) _____.
    A. accelerated death benefit
    B. needs analysis
    C. dividend
    D. settlement option

30. _____ is a guarantee by the insurer that when a loss occurs, the insured will be restored to the approximate financial condition he or she was in before the loss.
    A. Post-claims underwriting
    B. Risk transfer
    C. Indemnification
    D. Contractual adhesion

31. _____ insurance companies are owned by all the insureds.
    A. Stock
    B. Mutual
    C. Government
    D. Admitted

EXAM CONTINUES ON NEXT PAGE

32. _____ normally covers the liability risk that we face as a result of our actions toward others.
    A. Property insurance
    B. Casualty insurance
    C. Personal lines insurance
    D. Accident insurance

33. Once the application form has been completed, the property and casualty agent may have the authority to _____.
    A. provide legal advice
    B. rescind the policy
    C. issue a binder
    D. spend the first premium

34. The evaluating and investigating of the facts of an application are done by a(n) _____.
    A. claims representative
    B. customer service professional
    C. underwriter
    D. loss actuary

35. _____ is the withholding of facts.
    A. Testimony
    B. Conversion
    C. Concealment
    D. Churning

36. The _____ is the date and time specified in the declarations page, showing when coverage begins and ends.
    A. rescission period
    B. policy period
    C. elimination period
    D. free-look period

37. The HO-4 policy form is used to insure _____.
    A. historic homes
    B. inexpensive collectibles
    C. pets of all kinds
    D. renters and their belongings

38. A _____ requires that a suit must be filed within a specified period of time in order to be valid under the law.
    A. free-look period
    B. statute of frauds
    C. statute of limitations
    D. certificate of insurance

39. A _____ lets individuals and employers make tax-free contributions to an investment account that can be used to pay for qualified medical expenses.
    A. cafeteria plan
    B. long-term care policy
    C. health savings account
    D. managed care organization

EXAM CONTINUES ON NEXT PAGE

40. HSA contributions can usually only be made by enrollees in a special _____.
    A. managed care plan
    B. high-deductible health plan
    C. self-insured plan
    D. public-private partnership

41. Illegal sexual harassment occurs in employment when unwanted sexual advances are made "quid pro quo" or when they create a(n) _____.
    A. uncomfortable situation
    B. hostile work environment
    C. morale hazard
    D. physical hazard

42. Within the context of employment practices liability, _____ occurs when a worker receives punishment for exercising (or attempting to enforce) his or her employment rights.
    A. discrimination
    B. libel or slander
    C. retaliation
    D. wage-and-hour liability

43. The Family and Medical Leave Act preserves employees' jobs and their health insurance when they take a leave of absence to _____.
    A. increase their business skills
    B. participate in a wellness program
    C. provide in-home schooling to a child
    D. care for themselves or a family member

44. The _____ contains several requirements related to managing employer-sponsored retirement plans.
    A. Employee Retirement Income Security Act (ERISA)
    B. Affordable Care Act (ACA)
    C. National Fiduciary Standards Act (NFSA)
    D. Family and Medical Leave Act (FMLA)

45. Employment practices liability insurance aims to protect businesses when they are accused of _____.
    A. causing a workplace accident
    B. damaging customer property
    C. violating someone's employment rights
    D. breaking business antitrust laws

46. Liability insurance policies can be either "occurrence policies" or "_____."
    A. claims-made policies
    B. first-party policies
    C. all-risk policies
    D. single-peril policies

47. Congress passed the McCarran-Ferguson Act in 1945 to declare that _____.
    A. insurance agents should be licensed
    B. insurance rates should be based on claims history
    C. states should regulate the business of insurance
    D. everyone should be entitled to health insurance

EXAM CONTINUES ON NEXT PAGE

48. In most states, the insurance department is part of the executive branch of state government, and it is under the direction of the _____.
    A. state treasurer
    B. secretary of state
    C. insurance commissioner
    D. legislature

49. The fundamental reason for government regulation of insurance is to _____.
    A. protect consumers
    B. raise tax dollars
    C. encourage uniformity
    D. enforce licensing requirements

50. In the insurance industry, the term "_____" refers to the misrepresentation of the facts by an agent in order to manipulate the policyholder into substituting one contract for another.
    A. lowballing
    B. twisting
    C. rebating
    D. baiting and switching

END OF EXAM

Turn to page 117 to enroll and submit your exam(s)

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COURSE ONE: Promoting Insurance Protection (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: Risk and Insurance Fundamentals (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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