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The format includes traditional headings and subheadings, as well as highlighting and text borders to bring attention to critical concepts and facts that will help you pass the exam.

1. **Highlighting:** Pay particular attention to areas highlighted in yellow. Understanding concepts and facts contained within these areas are critical to successful completion of the final examination.

2. **Text Borders:** In order to reinforce certain material in the text it will be set apart through the use of text borders such as the one surrounding this paragraph. When you encounter text surrounded by a text border, pay particular attention to the point being made. Material within the text border will be reinforced later in the course through the use of review questions.

3. **Case Studies:** Some of the more variable concepts will be illustrated using case studies. These case studies are designed to reinforce the concept being discussed and it is recommended that you take the necessary time to digest the points made within the case studies.

4. **For Insurance Licensees in Non-Monitored States,** our exclusive web-based search feature allows quick retrieval of important data for maximizing the learning process. Simply execute Ctrl + F (the Ctrl and F keys at the same time) and enter keyword(s) or key phrase(s) to locate those items electronically in the course material.

Understanding all of the material in this text is necessary to achieve the overall learning strategies that have been incorporated to Success Continuing Education copyrighted courses to increase exposure to portions of the text that are fundamental to the learning process and help you pass the test.

*Not all courses currently have review questions or case studies.*
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Introduction

Insurance has evolved over thousands of years—right along with human society. Insurance is not the invention of the modern world nor is it the brainchild of Americans.

The first recorded use of insurance took place in approximately 4,500 BC when Chinese and Babylonian merchants experienced significant losses when vessels carrying their merchandise up and down rivers, or on the sea, often capsized during travel. Merchants and traders began utilizing two forms of risk management to limit their losses. Some used numerous vessels to transport a single shipment to reduce the likelihood of loss. Others, who obtained loans to finance their shipments, paid an additional amount of money to a lender in exchange for the lender’s promise that the loan would be considered satisfied if the shipments was stolen or lost during travel.

Ancient Persians were the first to insure people. Wealthy and influential individuals in their society presented gifts to the monarch. Each individual, and the amount of his gift, was registered in a special office of the monarch. If the presenter of the gift found himself in financial trouble, or wanted to erect a building or have a wedding feast for one of his children, for example, he would contact the registration office. If the gift he’d presented to the monarch exceeded a pre-determined amount, he would receive a sum equal to twice the amount he’d presented to the monarch.

Citizens of ancient Rhodes created the concept of general average, which is used today in ocean marine insurance. This concept involves a number of merchants shipping goods together and paying a sum equal to the proportionate value of their share of the entire shipment. If the ship sunk or the shipment was jettisoned, the merchants were reimbursed for their losses.

The first benevolent and fraternal societies were created in Greece and Rome in approximately 600 AD; these societies gave birth to life insurance by caring for the surviving families of people who died, in addition to paying for funeral expenses. Similar groups cropped up throughout the world for the same purposes: guilds in the Middle Ages and, before the 17th century, friendly societies existed in England. In Genoa in the 14th century, actual insurance contracts were created, and were separate from financial investments, for use extensively in marine insurance.

In the early 1600s in England, individual forms of insurance appeared in London. Some insured the safe arrival of ships transporting merchandise and others insured the lives of wealthy individuals. Because of London’s increasing prominence as a center for trade in during that time, the demand for marine insurance in England grew significantly.

Property insurance, as it is known today, is the direct result of the Great Fire of London in 1666. The tragedy involved a three-day rampage that began in the bakery owned by
Thomas Farynor and which destroyed most of the central city, including St. Paul’s Cathedral, almost 100 churches, the General Post Office, over 13,000 homes, and a number of city prisons. As a result of the devastation, Nicholas Barbon and eleven of his business associates formed the first fire insurance company.

In 1680, Edward Lloyd opened a coffee house on Tower Street in London and it soon became the primary meeting place for ship owners, ship captains, and merchants. As its popularity grew, along with the reliability of shipping information acquired from those who met at the coffee house, others wishing to either insure their shipments and cargoes or underwrite their business enterprises also joined the meetings. Edward Lloyd’s coffee house moved to Lombard Street in late 1691 and became the precursor to Lloyd’s of London, which, although it is not an insurance company, is currently the primary underwriter of reinsurance, marine insurance, and specialty insurance in the world.

Lloyd’s of London is a British marketplace for the pooling and spreading of risk by financial backers, underwriters, and individuals—called members. Lloyd’s of London writes a variety of insurance, including reinsurance, property, liability, marine, aviation, catastrophe, kidnap and ransom, and fine arts. Some of the most famous subjects of insurance written through Lloyd’s of London include:

- The legs of Betty Grable, Tina Turner, and Brooke Shields
- The nose of Jimmy Durante
- The fingers of Keith Richards
- The vocal chords of Celine Dion
- The legs of Irish step-dancer Michael Flatley
- The smile of America Ferrera

The first insurance company in the United States was founded in Charleston, South Carolina in 1732 and sold only fire insurance. Benjamin Franklin was a big proponent of fire insurance and became instrumental in spreading its popularity. In 1752, he founded the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, which is the oldest property insurance company doing business in the United States today. The office of the Contributionship Companies is currently located in Philadelphia, Pennsylvania and the brick building, which is a National Historic Landmark, was constructed in 1835. Franklin is also the founding father of fire and loss prevention. From the beginning, his insurance company warned against fire hazards and refused to insure building that involved a great deal of risk—such as wooden houses.

Life insurance sales became popular in the United States in the late 1760s when two particular insurance companies were formed for the benefit of Presbyterian ministers and Episcopalian priests and their families. Until the Civil War, many life insurance companies actually permitted individuals to insure the lives of their slaves.

In the late 1800s, accident insurance became popular and, at that time, it worked in the same fashion that modern-day disability insurance works. However, it offered coverage for injuries sustained only in railroad and steamboat accidents. Hospital and medical expense insurance policies weren’t established until the early 1920s, when the Blue Cross
and Blue Shield organizations were formed.

The tragic fires in New York (1835) and Chicago (1871) created the realization that insurance was needed for the protection of people and property after catastrophes occurred. The fire in New York was caused by a burst gas pipe in a warehouse and it wiped out the New York Stock Exchange and most of the buildings in southeast Manhattan near Wall Street. Only two people were killed, but the value of property damage was estimated at $20,000,000. Today, the amount of damage would translate into hundreds of millions of dollars. Most of the destroyed buildings had been constructed of wood and replacement buildings were constructed of stone and brick to prevent a future disaster of similar proportions. Several of the insurance companies providing coverage for the destroyed buildings were domiciled in New York; when their home offices perished in the fire, the companies went bankrupt, thus preventing them from paying claims to their policyholders.

The fire in Chicago is rumored to have begun in a shed in an alley bordering DeKoven Street; the precise cause is not known, although several theories exist. It spread to neighboring wood homes and high winds compounded the rapid proliferation of the fire, which eventually consumed approximately four square miles. It jumped over bridges and rivers, caused mass panic, killed between 200 and 300 people, and demolished the central business district of Chicago, City Hall, the opera house and theaters, and numerous hotels, department stores, homes, mansions, and churches. The fire eventually burned itself out after annihilating roughly one-third of the property valuation of the city of Chicago and leaving thirty percent of the city’s 300,000 inhabitants homeless. Immediately after the fire, reform began at the insistence of insurance executives and firefighting forces.

As a result of the New York fire, Massachusetts was the first state to require insurance companies to maintain loss reserves for catastrophic losses. Reinsurance was devised after the Chicago fire to distribute risk among a number of insurance companies to avoid bankrupting individual insurance companies when losses occur in densely populated areas.

The Industrial Revolution and, especially, the invention of the automobile, created the need for public liability insurance and workers’ compensation insurance. Until industrialization in this country, American society placed the responsibility for safety and injury upon the individual: it was a person’s responsibility to purchase only reliable products, to deal with responsible vendors, and to prevent his own bodily injuries. Once people began driving automobiles and factories began utilizing machinery, it became evident that an individual could not control the consequences of the use of such machinery.

Unemployment, Social Security, Crop, and Flood insurance are the most recently created forms of insurance in the United States and were instituted in:

- Unemployment Insurance
  - 1932 in Wisconsin
o 1935, as part of the Social Security Act
• Social Security Act
  o 1935 – Retirement benefits
  o 1950 – Retirement benefits cost of living adjustments
  o 1954 – Disability benefits
  o 1972 – Supplemental Security Income
  o 1972 – Retirement benefits -- automatic cost of living adjustments
• Medicare – 1965
• Federal Crop Insurance Corporation (FCIC) – 1938
• National Flood Insurance Program -- 1968

Regulation, technology, and the evolution of society have significantly affected insurance over the years. The study of insurance regulation, the duties and responsibilities of insurance producers, details of specific insurance products, the effects of technology on insurance, ethics, changes in the economy—along with other factors—all help build a more comprehensive understanding of the state of the insurance industry in American society today.

Looking forward, a number of other issues may significantly affect the insurance industry. Technology continues to advance and will undoubtedly continue to do so: in the late 1970s, insurance company computer mainframes occupied entire rooms and hundreds of square feet—now, those same computers populate only a fraction of the space in business offices and operate much more efficiently. Medical concerns, including diseases and genetic research, generate much attention (and contention) and affect not only rates and availability of coverage but ethics, as well. Politics and the economy further influence insurance products, marketing, and availability.

The purpose of this course is to provide producers with information about, and insights into, the contemporary insurance marketplace. Marketing strategies, interactions with the insurance consumer, sales production, and career growth/development all hinge on the producer’s level of understanding of the ever-changing insurance industry and his ability to utilize tools that are currently available.

It is also essential for professional insurance producers to keep their eyes to the future and the changes that will arise. Will the cash value of life insurance policies continue to be protected? How will advances in the medical sciences affect the availability and pricing of health insurance? Will liability insurance be influenced by tort reform? The answers to these, and many other questions, will have significant impact on both the insurance industry and insurance producers.
Chapter 1

INSURANCE REGULATION

PURPOSE

The purpose of insurance regulation is to protect consumers. Through the establishment of rules, regulatory bodies, and administration, each of the 50 states are able to oversee and manage the insurance industry within its boundaries while also assuring that the welfare of its citizens is safeguarded. What appears to be an acceptable business practice to some people and businesses may actually harm other citizens and corporations. A practice that is acceptable, ethical, and legal in the present can become—over time and after the development of society—quite the opposite.

Take the practice of gambling, for example. In England, The Life Assurance Act of 1774, also known as The Gambling Act of 1774, put an end to the practice of permitting individuals to purchase life insurance on an insured if no real, documented, insurance and financial interest existed. Prior to passage of that law, the basis for purchasing life insurance often focused on speculation (i.e. gambling) about an insured’s longevity rather than on risk-taking and risk-avoidance. The Gambling Act of 1774 prevented abuse of the life insurance system by no longer allowing people to evade gambling laws.

England has always had a fascination with gambling (i.e. dice, cards, and the lottery) and it became very popular in the 1770s for individuals to gamble by purchasing life insurance policies on a total strangers. The policies stipulated whether or not the insured would die before a certain date—relying upon chance to determine whether the insurance company or policyholder would profit from the event.

What originally began as an entertaining and acceptable practice ended up becoming both unethical and illegal.

HISTORY OF INSURANCE REGULATION

Insurance regulation in the United States has been traditionally conducted exclusively by the individual states. It officially began in 1851, when New Hampshire became the first state to appoint an insurance commissioner to oversee the insurance industry within its borders. At the time, fire and life insurance companies marketed their products on a national basis, something most other businesses had not yet begun to do. In order to
promote local insurance activities, many states assigned discriminatory taxes and fees against insurance companies domiciled in other states. These practices were primarily aimed against major insurance companies in the Northeast.

**PAUL V. VIRGINA (1869)**

The National Board of Fire Underwriters financed a test legal case in 1869 to contest the discriminatory practices mentioned above. *Paul v. Virginia* involved an insurance producer, Samuel Paul, who resided in the state of Virginia and who represented several New York insurance companies. He was convicted of selling insurance without an insurance license because he failed to comply with all provisions of Virginia state law when selling fire insurance policies for the New York insurance companies. Insurance company lawyers presented their case in Supreme Court, alleging that Samuel Paul was permitted to sell insurance in the state of Virginia because he represented their corporation, corporations met the definition of citizens as defined in law, and that insurance sales were transactions in interstate commerce under Article I, Section 8. The unanimous Supreme Court decision found against the insurance companies on both counts, allowing state regulation of insurance to continue and exempting insurance from interstate commerce.

**NAIC FORMED (1871)**

In 1871, state insurance regulators decided to organize their endeavors and pool resources by creating the National Association of Insurance Commissioners (NAIC). One of their first responsibilities was to create uniform financial reporting by insurance companies to the NAIC. The primary goal of the NAIC, per their current website (www.naic.org) is “to assist state regulators in serving the public interest and achieving certain basic insurance regulatory goals in a responsive, efficient, and cost-effective manner consistent with the wishes of its members.” Those basic goals are:

- Protect the public interest,
- Promote competitive markets,
- Facilitate the fair and equitable treatment of insurance consumers,
- Promote the reliability, solvency, and financial solidity of insurance institutions,
- Support and improve state regulation of insurance.

**SHERMAN ANTITRUST ACT (1890)**

In 1890, the first federal legislation was passed to curtail restrictions of trade and the spread of monopolies. The Sherman Anti-Trust Act banned monopolistic business practices in interstate commerce, including the establishment of any contract, trust, or conspiracy designed to restrain trade.

The purpose of a monopoly is to maximize profits by obtaining sole possession of a business market for which there is no other market or competition. As a result, the monopoly determines the price of its product or services based purely on its own agenda and at the expense of others. Until Congress enacted this legislation, the banning of such practices had only taken place at the state level and not between the states.
In the 1800s, it was common practice for the stockholders of companies to transfer their shares of stock to a single trust. The stockholders were then issued certificates in the trust that allowed them a specific share of the consolidated earnings of the trust. The trusts eventually dominated a number of business industries and eliminated competition.

An example of this type of venture can be illustrated by explaining the Standard Oil Trust. In 1882, Attorney Samuel Dodd of Standard Oil put together a board of nine trustees and each of the individual Standard Oil properties were placed into a trust managed by the trustees. Each stockholder of the smaller component companies received 20 trust certificates per share of Standard Oil stock. The profits of the component companies funneled into the trust and the nine trustees declared dividends and named the Board of Directors of the Trust, effectively running all nine component companies.

FIRST STATE INSURANCE LEGISLATION – NEW YORK (1907)

In the state of New York in 1905, extensive media coverage depicted extravagant spending and political payoffs by executives of three large insurance companies. These excesses, it was claimed, were taking place at the expense of policyholders and Equitable Life Assurance Company, one of the three large companies, was the major target of several journalists, including Joseph Pulitzer.

The media attention resulted in Equitable’s board of directors appointing a special committee, headed by Henry Clay Frick, to examine Equitable’s business affairs. The committee’s report to the board of directors listed the following:

- Corporate officers and favored employees were receiving excessive salaries
- Excessive commissions were being paid to some agents
- Inadequate accounting procedures existed for expense reimbursements
- Company funds were being used to support prices of Wall Street securities in which Equitable officers were involved

When the committee recommended reorganization of the company and removal of two particular members of the board, the board of directors refused to comply with the committee’s recommendations. As a result, Frick and the supporting members of his committee resigned from their positions with Equitable and leaked details of the report to the press.

After yet more intensive media pressure, New York’s governor asked the state legislature to create an investigatory committee to examine the practices of all life insurance companies in that state. The purpose of the committee, headed by Senator William W. Armstrong, was to review common business practices of insurance companies in that state and suggest legislation necessary for the protection of policyholders in New York.

Although many of the business customs practiced at that time by life insurance companies were acceptable in other business industries, insurance consumers—especially policyholders—were outraged. A number of other states began their own investigations in response to the findings of the Armstrong Committee. In 1907, the New York
legislature issued a series of strict insurance regulations and other states followed suit.

**CLAYTON ACT (1914)**

The Clayton Act (1914) further modified a number of aspects of federal antitrust laws addressed by the Sherman Act. It specifically addressed the prevention of anti-competitive practices in four areas of economic trade and business: price discrimination and price fixing, exclusive dealing, mergers and acquisitions, and when an individual is appointed Director of two or more competing corporations. The Federal Trade Commission (FTC) was also established in 1914 and was one of the major tools President Wilson used to restrict harmful anti-competitive business practices, including coercive monopolies and trusts. It is the Federal Trade Commission Act, a vital antitrust statute, that enforces the Clayton Act.

**GLASS-STEAGALL ACTS (1932 AND 1933)**

In 1932 and 1933, two United States laws—each known as the Glass-Steagall Act—were passed. The first law was enacted to stop deflation (a decrease in the general price level of goods and services when the annual inflation rate falls below 0%) and to expand the Federal Reserve’s ability to provide financing to banks and to offer more government bonds and commercial paper. The second law, also known as the Banking Act of 1933, addressed the collapse of a large section of the United States banking system and introduced the separation of bank types according to the nature of their businesses—either commercial or investing. It also founded the Federal Deposit Insurance Corporation (FDIC) for the purpose of insuring bank deposits. Although primarily addressing banking, these laws also affected the insurance industry—especially after future legislation permitted the merger of banks, brokerages, and insurance companies.

**UNITED STATES V. SOUTH-EASTERN UNDERWRITERS ASSOC. (1944)**

The Justice Department filed suit against the South-Eastern Underwriters Association in 1944, alleging price-fixing of fire insurance premiums in violation of the Sherman Antitrust Act. The Association was accused of controlling ninety percent of the market for fire and other types of insurance in six states and setting rates at non-competitive levels. It was also accused of using boycotting, intimidation, and other illegal tactics to secure and maintain a monopoly.

The Court was charged with determining whether insurance was a form of interstate commerce and, as such, subject to the Commerce Clause of the United States Constitution as well as regulation by the Sherman Antitrust Act. The Court did not overturn previous legislation; instead, it said that Congress needed to address the issue and, if Congress felt the law should be changed, the Supreme Court would support that decision.

**MCCARRAN-FERGUSON ACT (1945)**

In 1945, in response to the Court’s findings in the United States v. South-Eastern Underwriters Association, Congress passed the McCarran-Ferguson Act. In addition to
addressing other issues, McCarran-Ferguson **partially** exempts the insurance industry from federal antitrust legislation, officially allows for state regulation of insurance, allows each state to establish mandatory licensing requirements, and safeguards certain state insurance laws. Federal law still governs insurance with respect to boycotting, coercing or restraining trade, or violating the Sherman or Clayton Acts.

**FAIR CREDIT REPORTING ACT (1970) -- FCRA**

Enacted in 1970, and enforced by the Federal Trade Commission, the Fair Credit Reporting Act (FCRA) regulates the collection, dissemination, and use of consumer information, including consumer credit information. Its purpose, according to Section 602 of the act is: “to require that consumer reporting agencies adopt reasonable procedures for meeting the needs of commerce for consumer credit, personnel, insurance, and other information in a manner which is fair and equitable to the consumer, with regard to the confidentiality, accuracy, relevancy, and proper utilization of such information in accordance with the requirements of this title.” The Federal Trade Commission works with consumers to help prevent fraudulent, deceptive, and unfair business trade practices that violate this legislation.

Prior to passage of this law, insurance companies, prospective employers, and businesses seeking information for the purposes of providing credit all obtained information from a variety of sources. Some of the sources were not legitimate, some of the sources did not provide accurate information, and the parties collecting information were not obligated to inform the consumer about the details of where, how, and from whom the information was collected.

For example, if an applicant applied for life insurance, the insurance company might send a representative to the neighborhood where the applicant lived to verify and/or obtain information about the applicant’s lifestyle, occupation, and habits. If the neighbor provided false information to the insurance company representative, a number of issues could arise:

1. The representative might not know the neighbor lied
2. Underwriting decisions might be made based on inaccurate information and might adversely affect the applicant
3. Inaccurate information might be maintained on file and result in future adverse effects upon the applicant

**CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (1986) – COBRA**

The Consolidated Omnibus Budget Reconciliation Act was enacted by Congress to provide continuation of group health benefits for employees that would otherwise be terminated. COBRA amended the Employee Retirement Income Security Act), the Internal Revenue Code, and the Public Health Service Act. The major provisions of COBRA provide the rights to temporary continuation of health coverage at group rates to certain former employees, retirees, spouses, and dependent children.
When individuals elect to purchase health insurance under COBRA, they often pay more for coverage than they were paying when they were employed, but that is because their employer usually paid a portion of the cost. Quite often, the premiums they pay under COBRA are either less expensive than individual medical insurance or the benefits provided are more comprehensive than on an individual plan.

COBRA benefits are available to individuals who are eligible; eligibility includes:

1. **Plan Coverage** – Eligible plans include group plans for employers with 20 or more employees on more than 50% of the working days in the previous calendar year; employees are defined as workers who are full-time, part-time, self-employed, agents, independent contractors, and directors—so long as they were eligible to participate in group coverage.

2. **Beneficiary Coverage** – An eligible beneficiary is anyone covered by a group plan on the day before a qualifying event; a eligible beneficiary includes an employee, the employee’s spouse and dependent children, and in some cases, a retired employee, and a retired employee’s spouse and dependent children.

3. **Qualifying Events** – These events determine eligibility because, without COBRA protection, the individuals would lose health coverage. The type of event determines who the eligible beneficiaries are.
   a. For Employees:
      i. Voluntary or involuntary termination of employment for reasons other than “gross misconduct”
      ii. Reduction in the number of hours of employment
   b. For Spouses:
      i. Termination of the covered employee’s employment for any reason other than “gross misconduct”
      ii. Reduction in the number of hours worked by the covered employee
      iii. Covered employee becomes entitled to Medicare
      iv. Covered employee becomes divorced or legally separated
      v. Covered employee dies
   c. For Dependent Children:
      i. The same as for spouses, above, and
      ii. Loss of “dependent child” status under the group plan’s rules

COBRA contains special notice requirements for employers, qualified beneficiaries, and plan administrators in the even a qualifying event occurs. The three major notice requirements are:

- The 30-day notice employers must give plan administrators when an employee dies, is terminated, receives reduced hours of employment, or becomes entitled to Medicare
- The 14-day notice plan administrators must provide, in-person or by first-class mail, to employees or family members upon receiving notice of a qualifying event
- The notice an employee must give the plan administrator within 60 days of becoming divorced, legally separated, or experiencing a dependent child’s status change
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (1996) -- HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress and was originally sponsored by Senators Edward Kennedy (MA) and Nancy Kassebaum (KS). Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA addresses Administrative Simplification provisions, specifically requiring the Department of Health and Human Services (DHHS) to establish national standards for electronic health care transactions and the protection, security, and privacy of health data. Titles III, IV, and V, respectively, address Tax-Related Health Provisions, Application and Enforcement of Group Health Plan Requirements, and Revenue Offsets. According to HIPAA, “these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.”

GRAMM-LEACH BLILELY ACT (1999) -- GLBA

Also known as the Financial Modernization Act of 1999, the GLBA was enacted by Congress and repealed parts of the Glass-Steagall Act of 1933. It allowed banking companies, securities companies, and insurance companies to consolidate—something the Banking Act of 1933/Glass-Steagall Act specifically prohibited.

According to the website of the Federal Trade Commission, the GLBA “includes provisions to protect consumers’ personal financial information held by financial institutions.”

The GLBA contains three major parts: the Financial Privacy Rule, the Safeguards Rule, and provisions against Pretexting. The Financial Privacy and Safeguards Rules apply to banks, securities firms, insurance companies, and companies providing other types of financial products and services to consumers, such as lending, brokering, or servicing any type of consumer loan, transferring or safeguarding money, preparing individual tax returns, providing financial advice or credit counseling, providing residential real estate settlement services, collecting consumer debts, etc. All of these types of businesses are regulated by the Federal Trade Commission.

1. **Financial Privacy Rule** governs the collection and disclosure of customers' personal financial information by financial institutions. It also applies to companies who receive such information—whether or not they are financial institutions.

2. **Safeguards Rule** requires all financial institutions to design, implement, and maintain safeguards to protect customer information. The Safeguards Rule applies to financial institutions that collect information from their own customers and also to financial institutions (i.e. as credit reporting agencies) that receive customer information from other financial institutions.

3. **Pretexting** provisions protect consumers from individuals and companies that obtain their personal financial information under false pretenses, a practice known as "pretexting;" pretexting is illegal.
In addition to these federal laws, each state has enacted legislation concerning how the insurance industry may operate. Typical topics addressed by state regulation include:

- The establishment and legal structure of insurance companies
- The insurance contract
- The licensing of insurance companies, producers, adjusters, consultants, and administrators
- Unfair trade practices
- Rate and form filing
- Insurance premium finance companies
- Various lines of insurance (i.e. life, property, casualty, workers’ compensation, etc.)
- Insurance information and privacy protection
- Market conduct

INSURANCE REGULATION TODAY

Although each state regulates the insurance industry within its jurisdiction, the National Association of Insurance Commissioners (NAIC) often provides model regulations and acts upon which the states can build. Some states choose to adopt NAIC model regulation or acts as is, others use them as guidelines, and still others do not use them at all. The NAIC forms numerous committees, task forces, and working groups to address and review topics that are of concern to the insurance industry nationwide. Because of the coordination and cooperation of state regulators, even if the NAIC does not implement model regulation, it facilitates communication and consistency among state regulators.

In a letter to Nancy Pelosi, Speaker, U.S. House of Representatives and Harry Reid, Majority Leader, U.S. Senate in January 2010, the NAIC president, president elect, vice-president, secretary-treasurer, and chair and vice-chair of the NAIC Health & Managed Care (B) Committee stated their beliefs on behalf of fellow state regulators concerning health reform legislation adopted by both the House and the Senate.

Their statements focused on a number of issues concerning consumers today with respect to health care reform and insurance. The NAIC and state insurance regulators continue to see the benefit to consumers for regulation at the state level. To support this position, they believe state regulators “are also closer to consumers and have a better understanding of the markets they regulate than a single national regulator in Washington, D.C. could have.”

State regulators further believe that grandfathering existing group plans will make policies in a reformed marketplace “unaffordable.” It is their expectation that groups with older employees will be the majority of purchasers because they’ll be seeking new policies that offer rules that are more favorable to them. Unfortunately, younger and healthier groups will keep their current policies, thus creating an imbalance that will drive costs higher for the “older” groups seeking coverage.
A number of other issues are addressed in the letter, all of which speak to the changing climate in health care in our country. The federal government is clearly concerned about all citizens, and regulators in each individual state have more personal concerns about their constituency. As an organization, the NAIC tackles a variety of perspectives.

**NAIC AND INSURANCE REGULATION**

The National Association of Insurance Commissioners is an organization of insurance regulators from all fifty states, the District of Columbia, and the five U.S. territories (Puerto Rico, Guam, American Samoa, U.S. Virgin Islands, and the Northern Mariana Islands). As previously stated, its mission is to “assist state insurance regulators, individually and collectively, in serving the public interest…” The NAIC is a pioneer of model laws, which are adopted by most states and territories. It also oversees and maintains a number of databases, committees, and commissions for the protection of consumers.

**INSURANCE REGULATORY INFORMATION SYSTEM (IRIS)**

IRIS has been used by NAIC since 1972 to assist insurance regulators in their assessment of the financial conditions of insurance companies. Currently, more than 5,000 insurance companies file their financial statements with the NAIC through IRIS. Certain financial ratios are calculated based on the information contained in the financial statements. If an insurance company’s ratios fail to meet the requirements of a predetermined range, it may be spotlighted by IRIS for regulatory attention. Some of the audit ratios are concerned with:

- **Property & Casualty Insurance Companies**
  - Current year increase or decrease in net written premiums over previous year
  - Net written premiums to adjusted policyholder surplus
  - Loss ratio for two years
  - Expense ratio for two years
  - Net investment income to average invested assets
  - Liabilities to liquid assets
  - Unpaid premiums to surplus
  - Previous year adjusted surplus to current year adjusted surplus

- **Life & Health Insurance Companies**
  - Yield on investments
  - Nonadmitted assets to assets
  - Net gain to total income
  - Investments in affiliates to capital and surplus
  - Expenses (including producer commissions) to premiums
  - Exchange in capital and surplus
  - Surplus increase or decrease

While IRIS is used as “an early warning system,” the ratios it utilizes are guidelines and not guarantees of performance, financial success, or financial failure.
**INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IIPRC)**

The Interstate Insurance Compact, or Compact, “enhances the efficiency and effectiveness of the way insurance products are filed, reviewed, and approved allowing consumers to have faster access to competitive insurance products in an ever-changing global marketplace. The Compact (www.insurancecompact.com) promotes uniformity through application of national product standards embedded with strong consumer protections.”

Through its multi-state public entity, IIPRC, serves as a “central point of electronic filing for certain insurance products including life insurance, annuities, disability income and long-term care insurance to develop uniform product standards, affording a high level of protection to purchasers of asset protection insurance products.” Insurance companies often rely on the expertise of various states in reviewing the intricacies of many insurance products and regulators believe this method not only speeds up the process of bringing products to the marketplace but also provides built-in consumer protection.

The IIPRC currently represents over half the premium volume nationwide through 36 member states, including the six largest Compacting states based on premium volume: Massachusetts, Michigan, North Carolina, Ohio, Pennsylvania, and Texas. As of the summer of 2009, IIPRC effected more Uniform Standards in both life and annuity products lines, totaling more than 50 uniform standards in effect.

**NATIONAL INSURANCE PRODUCER REGISTRY (NIPR)**

The mission of the NIPR (www.nipr.com) is: “NIPR is a unique public-private partnership that supports the work of the states and the NAIC in making the producer-licensing process more cost-effective, streamlined, and uniform for the benefit of regulators, the insurance industry, and the consumers they protect and serve.” It is a non-profit affiliate of the NAIC that is governed by a 13-member board of directors. The board has 6 members representing the NAIC, 6 industry trade member representatives, and the CEO of the NAIC as its ex-officio voting member.

The Producer Database (PDB) is an electronic database containing information pertinent to insurance producers nationwide. It links participating state regulatory licensing systems into one “common repository of producer information.” Its purpose is to facilitate communication between the states, increase productivity, reduce cost, verify license status on a national basis, and provide a single source of information.

**VALUATION OF SECURITIES TASK FORCE**

Charged with acting as the forum for proposed changes to, or interpretations of, the *Purposes and Procedures Manual* of the NAIC Securities Valuation Office, the SVO Task Force provides assistance to state regulators on issues involving insurance industry investments. In addition, among other things, it:

- Reviews insurance companies’ current and future investments and determines appropriate credit assessments, valuations, and other procedures
- Coordinates the formulatory process of statutory accounting, annual statement instructions, blanks reporting, asset and interest maintenance reserving, risk-based
• Monitors changes in accounting and reporting requirements
• Reviews and monitors ongoing operations of the SVO
• Develops, adopts, monitors, and revises an annual agenda for the SVO Research Unit

REGULATORY INFORMATION RETRIEVAL SYSTEM (RIRS)
All but five states participate in the RIRS, which tracks “final, adjudicated regulatory actions against insurance or non-insurance entities and includes both licensed and non-licensed entities.” The system was established in the 1960s, computerized in 1985, and allows insurance regulators to track the regulatory history of insurance companies, insurance agencies, and individuals. In single or batch inquiries, it tracks the origin, reason, and disposition of adjudicated actions. At present, the database contains over 100,000 entries.

OTHER NAIC REGULATORY COMMITTEES, TASK FORCES, AND WORKING GROUPS
The NAIC coordinates dozens of committees, task forces, and working groups to assist state regulators and others within the insurance industry. Here is a partial list:
• Executive Committee
  o Solvency Modernization Initiative Task Force
  o Speed to Market Task Force
  o Military Sales Working Group
  o Multi-state Enforcement (EX) Task Force
  o Producer Licensing Task Force
  o Long-Term Care (EX) Task Force
• Life Insurance and Annuities (A) Committee
  o Annuity Disclosure Working Group
  o Indexed Annuities Working Group
  o Suitability of Annuities Working Group
• Health Insurance and Managed Care (B) Committee
  o Regulatory Framework Task Force
  o ERISA Subgroup
  o Senior Issues Task Force
• Property and Casualty Insurance (C) Committee
  o Catastrophe Insurance Working Group
  o Catastrophe Reserve Working Group
  o Consumer Guides Working Group
  o Crop Insurance Working Group
  o Earthquake Study Group
  o Surplus Lines Task Force
  o Terrorism Insurance Implementation Working Group
  o Title Insurance Task Force
  o Workers’ Compensation Task Force
• Market Regulation and Consumer Affairs (D) Committee
  o Antifraud Task Force
LONG-TERM CARE INSURANCE REGULATION

Because the majority of people purchasing Long-Term care insurance are older, and older people tend to be the victim of abuse and fraud more often than younger people, state regulators are very concerned with all Long-Term Care insurance transactions. In the past, the NAIC adopted model regulation concerning Long-Term Care to implement consumer protections, such as:

- Policies must be guaranteed renewable
- Certain health issues cannot be excluded from coverage
- A policy outline summary must be provided to the policyholder
- A Free Look period must be provided
- Premium and rate standards apply
- Minimum benefits apply, specifically with respect to custodial care and skilled nursing care

Additional provisions have been added to the model regulation and include:

- Producer training requirements so that producers must complete a one-time eight hour training course before selling any Long-Term Care product
- Producers training requirements so that producers are required to complete four hours of training during each license renewal period in which they sell Long-Term Care insurance
- Required producer training also includes information about Partnership programs and their relationship to Medicaid
- Suggestions for state implementation to fulfill responsibilities under the Federal Deficit Reduction Act by providing assurance that producers selling partnership policies are able to demonstrate their understanding of such policies
• Allows carriers to protect their beneficiaries with respect to nonpayment of benefits to facilities in other states due to proper certification issues
• Provides more options to consumers with respect to new services and new providers and also provide greater flexibility in reducing coverage to make premiums more affordable

According to Mary Beth Senkewicz, who—in October 2009—was the Deputy Insurance Commissioner for Life and Health for the Florida Office of Insurance Regulation and Chair of the NAIC’s Senior Issues Task Force, “Long-Term Care insurance has been a challenging product to regulate.” During her presentation to the Senate Special Committee on Aging and the Senate Committee on Homeland Security and Government Affairs, she indicated that state regulators discovered that during the first years Long-Term Care policies were sold, insurance companies were under-pricing Long-Term Care products because of incorrect assumptions concerning lapse rates and anticipated claims. When this happened, if the premiums collected by an insurance company were unable to cover claims, the insurance company had a choice: face insolvency or increase rates.

During the 1990s, she said, state regulators observed insurance companies as they revised assumptions and premiums during a period of adjustment in the Long-Term Care market. In some states, including Florida, the rate increases were so high that some policyholders could no longer afford Long-Term Care insurance premiums and their policies lapsed. While regulators understood that insurance companies needed to remain solvent, they also recognized the need for fair treatment of consumers when insurance companies set premium rates.

Rate stability standards were added to the NAIC model regulation, along with greater disclosure requirements to consumers. Also added to the model regulation were minimum loss ratio requirements, which serve as a disincentive for insurance companies to under-price Long-Term Care products to increase market share. The NAIC developed a Long-Term Care Buyer’s Guide, with tips for purchasing Long-Term Care products to address the need for educating consumers about the complicated nature of the coverage.

The NAIC formed the Long-Term Care Task Force under its Executive Committee to identify and analyze issues as they arise, and to make recommendations relating to Long-Term Care insurance. The task force is focusing on the following:
• How the NAIC can, or should, address possible reserve deficiencies and rating issues
• Exploring options and monitoring efforts to ensure the fair and equitable treatment of policyholders—including those who live in more than one state
• How regulators should treat the spin-off or transfer of closed blocks of business to another entity

A number of states have either adopted the NAIC model regulation or have implemented their own legislation to protect consumers; among them are Missouri, New York, California, Florida, Massachusetts, Arkansas, South Carolina, and Illinois.
ANNUITY REGULATION

Annuities are financial contracts issued by insurance companies and, therefore, are regulated by each state in which they are sold. Because many annuities are sold as retirement vehicles, they are considered investments if sold through banks, brokerages, or investment companies and are also regulated by the federal government.

The easiest way to determine regulation of an annuity is to identify its type. Fixed Annuities are classified as insurance products and are regulated by state governments. Variable annuities are classified as securities and, in addition to being regulated by state governments are also regulated by the federal government. Indexed Annuities are usually considered Fixed Annuities; however, if an Indexed Annuity is considered a security it will be regulated by both state and federal governments. Beginning in January 2011, all Indexed Annuities will be considered securities products.

The major reasons annuities are the subjects of regulatory concern are the legal and economic consideration of the products. The definition of a security is: An instrument representing ownership (stocks), a debt agreement (bonds), or the rights to ownership (derivatives). Because of the definition, the owner of a security assumes an investment risk because the security’s value is subject to fluctuation. An insurance product, on the other hand, is designed to reduce risk and is controlled by the details contained in the insurance contract.

A variable annuity, for example, is both a security and an annuity and an uninformed consumer may assume that because it is an insurance product it does not involve risk—which is an inaccurate assumption. If an insurance producer did not properly explain the variable annuity product and its features during the sale, a consumer could purchase a product that does not suit his needs and that may, ultimately, be financially harmful.

One of the major concerns of the NAIC with respect to annuities and their sales is suitability. Annuities are complex financial contracts that do not meet the needs of all consumers. Annuity producers are required by both ethical and legal constraints to confirm, before the sale, that the purchase of an annuity is in the best interests of the consumer and that they can show “reasonable grounds” for the appropriateness, or suitability, of their recommendations to the consumer.

The annuity contract is, by necessity, filled with legal terms, exceptions, and contingencies and the average consumer is not equipped to understand them, so he places his trust in the professional recommending and selling the product. This trust is usually well deserved; however, the opportunity for producers misleading or deceiving consumers exists. Suitability requirements were established for the protection of consumers and, specifically, to prevent individuals from entering into contracts that are not appropriate for their particular situations and needs.

According to Kansas Insurance Commissioner, Sandy Praeger, who addressed the Senate Select Committee on Aging in September 2007, the total number of annuity complaints
remains low when compared to other lines of insurance. The number of complaints is still significant, however, and indicates a troubling trend. In light of the rising number of complaints about annuity sales, the NAIC adopted a white paper in 2006 that called for the development of suitability standards for non-registered annuity products similar to those that existed under the Securities and Exchange Commission (SEC) regulations for registered products. The white paper resulted in the creation of a working group under the NAIC Life Insurance and Annuities Committee; that group drafted a model regulation establishing suitability standards for all life insurance and annuity products.

The committee decided to focus first on the area identified as subject to the greatest abuse: the inappropriate sales of annuities to persons over the age of 65. The resulting Senior Protection in Annuity Transactions Model Regulation (Suitability Model) was adopted by the NAIC in 2003. This model is another tool regulators use to protect consumers from inappropriate sales practices.

Purchasing life and annuity products is often a complicated and confusing process for consumers of all ages, not just for seniors, and most regulators believed the protections of the Suitability Model should be extended to other segments of the population. The NAIC membership addressed this issue in 2006 by adopting revisions to the Suitability Model so that its requirements apply to all consumers, regardless of age. As of June 10, 2009, thirty-five states adopted the NAIC Suitability Model or similar suitability regulations. The most recent draft of the Suitability Model is dated December 1, 2009.

The Suitability Model spells out duties of insurance companies and insurance producers with respect to recommending the purchase or exchange of an annuity that result in an insurance transaction (or a series of insurance transactions). The duties require the producer (or the insurance company if no producer is involved) to document his reasonable grounds for believing the recommendation to the client is suitable based on facts obtained by the client, which will be detailed in the next chapter, and which include:

- Potential surrender term and surrender charges,
- Potential tax consequences and penalties if the consumer sells, exchanges, surrenders, or annuitizes the contract,
- Mortality and expense fees,
- Investment advisory fees,
- Potential charges for, and features of, riders,
- Limitations on interest returns,
- Insurance, and
- Investment components and market risk

If a state has adopted the Suitability Model, the requirements listed above are intended to supplement, not replace, the disclosure requirements. The Suitability Model also requires producers to possess adequate knowledge of annuity products before making recommendations to consumers and to comply with regulation concerning product-related training and continuing education. These requirements include familiarity with not only the annuity contracts themselves, but with state law concerning suitability, disclosure, preparation and dissemination of illustrations and prospectuses, replacement,
advertising, direct mailers, prohibited sales practices, special laws concerning seniors, comparison between the types of annuities, and policy cancellations and refunds.

In early 2010, the NAIC had three working groups concerning annuities:
1. Annuity Disclosure Working Group – Review and consider changes to the Annuity Disclosure Model Regulation to improve the disclosure of information and to provide insurance companies with uniform guidance in developing disclosure information/documents and monitoring distribution to better inform annuity consumers about the annuity products purchased and how they work.
2. Indexed Annuities Working Group – Monitor and respond to the SEC’s rule 151A on Indexed Annuities and other insurance contracts; conduct a coordinated, national data call and issue a public report about annuity products that focuses on the sales and marketing practices of indexed annuities; coordinate with the NAIC’s Marketing Actions (D) Working Group concerning formal regulatory actions that result from the data call; and review and analyze any up-and-coming concerns that pertain to Indexed Annuities.
3. Suitability of Annuity Sales Working Group – Review and consider changes to the Suitability in Annuity Transactions Model Regulation to improve the regulation of annuity sales and provide insurance companies with uniform guidance in developing producer training, supervision and monitoring standards to better protect annuity consumers from unsuitable and abusive sales and marketing practices.

Regulation of annuities is an ongoing concern of the NAIC, state regulators, and consumers.

REGULATION CONCERNING SENIORS

Elder abuse is a growing phenomenon and, according to the National Center on Elder Abuse (NCEA), which is a division of the U.S. Administration on Aging, “While we don’t know all of the details about why abuse occurs or how to stop its spread, we do know that help is available for its victims.”

The NCEA cites six major categories of elder abuse:
1. Physical abuse – which is defined as the use of physical force that may result in bodily injury, physical pain, or impairment
2. Sexual abuse – which is defined as non-consensual sexual contact of any kind with an elderly person
3. Emotional or psychological abuse – which is defined as the infliction of anguish, pain, or distress through verbal or non-verbal acts
4. Abandonment – which is defined as the desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder or by a person with physical custody of an elder
5. Self-neglect – which is defined as the behavior of an elderly person that threatens his/her own health or safety
6. Financial or material exploitation – which is defined as the illegal or improper use of an elder’s funds, property, or assets
The National Committee for the Prevention of Elder Abuse (NCPEA) is an association that was founded in 1988 and is comprised of researchers, practitioners, educators, and advocates dedicated to the protection, safety, security, and dignity of elders. It is one of the three partners that make up the NCEA. According the NCPEA, the elderly are targets of abuse for a number of reasons:

- **People over age 50 control over 70% of the wealth in the United States**
  - Elders tend not to realize the actual value of their assets, especially the appreciation of their real property and homes
  - Many elders experience disabilities that require them to depend upon others for assistance, thus depriving them of much of their independence; by necessity, the people upon whom the elders depend often have access fund and property they might otherwise not have
  - Elders often have predictable patterns, which are easy to exploit; for example, the receipt of regular monthly checks—such as from pensions and Social Security—may require them to visit the bank on a routine basis
  - Severely disabled or impaired individuals are less likely to take action against an abuser because of their disability, impairment, or embarrassment
  - Advances in technology, which many elders do not understand, have made managing finances more complicated

What does this have to do with regulation, specifically insurance regulation? Because of the reasons previously cited, some insurance producers target seniors with abusive and predatory sales practices. All fifty states, the District of Columbia, and Puerto Rico, have enacted regulation concerning the protection of seniors. Because most seniors trust the insurance professionals with whom they work, exploitation of elders is relatively easy to accomplish. Regulation requiring specific disclosures, time frames, and the presence or assistance of family members or financial advisors is now the norm.

Here are some statistics on elder financial abuse and exploitation:

- According to John F. Wasik in his article, *The Fleecing of America’s Elderly* (*Consumer’s Digest*, March/April 2000), the overall reporting of financial exploitation at that time was estimated at 1 in 25, suggesting that there were at least 5,000,000 financial abuse victims each year
- According to the NCEA’s 1998 *National Elder Abuse Incidence Study*, for every reported single case of elder abuse, neglect, exploitation, or self-neglect, five more cases are unreported
- According to the U.S. Administration on Aging’s 2003 *National Omnibusdsmian Reporting Systems Data Tables*, state Long-Term Care Omnibusdsmian’s programs investigated over 20,000 complaints of abuse, gross neglect, and exploitation on behalf of nursing home and board and care residents nationally

Financial abuse and exploitation takes many forms. Stealing money, forging a signature, and using property or possessions without permission are the most common types of abuse committed by relatives and individuals close to elders. However, business and financial professionals who operate from a position of trust also exploit and abuse elders.
Convincing an elder to sign a deed, will, or power of attorney through deception, coercion, or undue influence is a common manner of financial exploitation. Other examples of financial exploitation include telemarketing scams, confidence crimes, promising lifelong care in exchange for insurance policy premiums, and various types of fraud and unethical behavior.

Although family members and predatory individuals are the primary perpetrators of elder abuse, unprincipled business professionals—including insurance producers—use deceptive or unfair practices when transacting business. They also use their positions of trust and/or respect to gain compliance with their proposed business transactions.

In order to help prevent senior abuse, the states have enacted legislation based on the NAIC’s model senior regulations. The NAIC’s Senior Issues Task Force (SITF), which was formed under the Health Insurance and Managed Care Committee, states the following as its mission:

The mission of the Senior Issues Task Force (SITF) is to consider policy issues, develop appropriate regulatory standards and to revise the NAIC models, consumer guides, and training material, as necessary, on long-term care insurance, Medicare supplement insurance, senior counseling programs, and other insurance issues that affect older Americans. The task force also monitors the progress of the Federal Long Term Care Insurance Program, and the CMS educational initiative on the need for long term care planning. The SITF is specifically charged to monitor and provide assistance to the States on the implementation of the 2000 rating practices amendments to the Long Term Care Insurance Model Regulation.

Beginning in 2009, the following are the charges assigned to the SITF:

• Review model laws that were previously adopted and recommend whether they be retained, revised, or deleted,

• Continue monitoring and working with federal agencies to move forward with appropriate regulatory standards pertaining to Medicare Supplements and other forms of health insurance,

• Review the Medicare Supplement Insurance Minimum Standards Model Act and Regulation to determine if amendments are required based on changes to federal law and revise if necessary,

• Monitor the Medicare Advantage and Medicare Part D marketplace, assist the states as necessary with regulatory issues, and maintain a dialogue and coordinate with CMS on regulatory issues, including solvency oversight of waived plans and producer misconduct,

• Monitor and assist states in the implementation of changes to the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act to modernize the Medicare supplement market as required by the Medicare Improvement for Patients and Providers Act of 2008 and the Genetic Information Nondiscrimination Act of 2008,

• Market and assist states with implementation of Medicare Supplement Model amendments due to federal statutory changes,
• Provide the perspective of state insurance commissioners to the U.S. Congress and the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services on insurance issues, including concerning the effect and result of federal activity on the senior citizen health insurance marketplace and regulatory scheme,
• Work with the Centers for Medicare & Medicaid Services to revise the annual joint publication, Guide to Health Insurance for People with Medicare,
• Monitor information on legislation impacting the funding of State Health Insurance Assistance Programs (SHIP),
• Assist the states and serve as clearinghouse for information on Medicare Advantage plan activity,
• In accordance with changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, monitor and maintain a record of state approvals of all Medicare supplement insurance new or innovative benefits for use by regulators and others,
• In accordance with changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, periodically review state-approved new or innovative benefits and consider whether to recommend that they be made part of standard benefit plan designs in the model regulation,
• Amend the NAIC Long-Term Care Insurance Model Act and Regulation for independent review for claim denials based upon failure to meet the ADL, cognitive impairment or medical necessity test,
• Review preferred provider arrangements with Medicare supplement policies and determine their legality and their effect on Medicare supplement standardization and take appropriate action as necessary

Because producers sell Long-Term Care insurance, annuities, health insurance, and Medicare Supplement insurance to elders, regulation in all states now affects how a producer not only sells insurance, but how he approaches consumers for the purpose of marketing and selling insurance, discloses information, and actually interacts with elders.

For example, California Insurance Code requires insurance producers to provide seniors with twenty-four (24) hours’ advance written notice before visiting in their homes for the purpose of attempting to sell, or selling, an annuity contract. In addition, producers must disclose to seniors their names and professional titles, and the names and professional titles of all people visiting the senior for the purpose of selling, or attempting to sell, an annuity. The name of the insurance company represented by producers must also be provided to seniors.

Another example involves the Missouri Department of Insurance’s Long-Term Care regulations. Each insurance company must maintain records for each producer documenting the producer’s Long-Term Care replacement sales as a percentage of the producer’s total annual Long-Term Care sales—as well as the number of lapsed policies. These figures do not necessarily indicate a violation of Missouri Insurance Code nor do they imply wrongdoing on the part of producers. The Missouri Insurance Department is
simply using these figures to keep a close eye on the activities of producers who sell Long-Term Care insurance in that state.

**PROPERTY & CASUALTY INSURANCE REGULATION**

**CATASTROPHES**

In 2004 and 2005, hurricanes devastated the gulf coast of the United States. More than 1,000 people died in these hurricanes, over 7,000,000 insurance claims were submitted to insurance companies, and more than $100 billion in insurance losses were paid. It is hard to imagine, and impossible to predict, catastrophes of this nature.

Unfortunately, the insurance industry must plan for them to avoid monumental loss of lives, property, and finances. The NAIC and state regulators, under the NAIC’s Catastrophe Insurance Working Group (which was formed under the NAIC’s Property & Casualty Insurance Committee) have formed a National Catastrophe Response and are working “to develop a comprehensive national plan for managing catastrophe risk that incorporates new risk management techniques with a solid foundation of solvency and consumer protection inherent in state regulation.” Congress has also indicated interest in such a plan. In late 2009, several bills were pending in Congress that dealt with a variety of catastrophe risk management techniques.

The Catastrophe Insurance Working Group is charged with the following goals:

- Monitoring and recommendation of ways to improve the availability and pricing of insurance and reinsurance pertaining to personal and commercial lines catastrophe perils
- Evaluation of potential regional, state, and federal programs to enhance capacity for insurance and reinsurance catastrophe perils
- Monitoring and assessing proposals that focus on disaster insurance topics at state and federal levels
- Update the State Disaster Response Plan Manual to provide a blueprint for state action to respond catastrophes

In response to the NAIC’s attempt to develop a national catastrophe risk plan, the National Wildlife Federation stated its support of some of the items contained in the plan but focused on its issues with the NAIC’s white paper, *National Catastrophe Risk: Creating a Comprehensive National Plan*. Their primary contention pertained to the proposed taxpayer-subsidized wind insurance or reinsurance that will subsidize “even more development in hazard-prone and ecologically sensitive coastal areas and flood plains.” The National Wildlife Federation also has issues with the National Flood Insurance Plan (NFIP), the Florida Hurricane Catastrophe Fund, and Florida’s Citizens Property Insurance Corporation.

The American Academy of Actuaries also had issues with the NAIC’s proposed national catastrophe plan, although it does support parts of the plan. Some of its concerns centered on the proposed all-risk policy, which addressed the peril of Flood but did not address the peril of Earthquake. Rate subsidy of flood insurance was a major drawback,
as was the likelihood of a reduction in availability of homeowner insurance in certain states or areas if mandatory offers of earthquake insurance are required as part of the plan.

In addition to the previously mentioned organizations, a number of other organizations noted both their support and disapproval of certain sections of the recommended plan—as outlined in the white paper—based upon the specific needs and vulnerabilities of the parties they represent. They include the American Insurance Association (AIA), the National Association of Mutual Insurance Companies (NAMIC), the Nebraska Department of Insurance, the Property Casualty Insurers Association of America, the Wharton Risk Center, and the Reinsurance Association of America.

**HOMEOWNERS’ DEFENSE ACT OF 2009, H.R.2555**

In February 2010, the Homeowner’s Defense Act, H.R. 2555 was re-introduced to the 11th Congress and was scheduled for hearing at the Financial Services Committee in March 2010. (The bill was originally introduced in 2007, where it passed in the House but died in the Senate.) The Congressional Research Service prepared this summary:

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Homeowners’ Defense Act of 2009 - Establishes the National Catastrophe Risk Consortium as a nonprofit, nonfederal entity to: (1) maintain an inventory of catastrophe risk obligations held by state reinsurance funds and state residual insurance market entities; (2) issue, on a conduit basis, securities and other financial instruments linked to catastrophe risks insured or reinsured through Consortium members; (3) coordinate reinsurance contracts; (4) act as a centralized repository of state risk information accessible by certain private-market participants; and (5) use a database to perform research and analysis that encourages standardization of the risk-linked securities market. Instructs the Secretary of the Treasury to implement a national homeowners’ insurance stabilization program to make liquidity loans and catastrophic loans to qualified reinsurance programs to: (1) ensure their solvency; (2) improve the availability and affordability of homeowners’ insurance; (3) provide incentive for risk transfer to the private capital and reinsurance markets; and (4) spread the risk of catastrophic financial loss resulting from natural disasters and catastrophic events.

Authorizes the Secretary to establish and collect, from qualified and pre-certified reinsurance programs, a reasonable fee to offset expenses of the program.

Instructs the Secretary to require full repayment of all loans made under this Act.

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Supporters of this bill state, the great majority of whom live in hurricane-prone areas, say that the bill will reduce overall homeowner insurance costs for consumers by creating a national pooling fund for catastrophic losses. The author of the bill, Representative Ron Klein (D-FL), says that rising insurance costs and private insurance companies leaving hurricane-prone areas are indications that the current private homeowner insurance market is not working properly, therefore, federal intervention is required. While many insurers oppose the bill, State Farm, a carrier significantly affected by recent catastrophic homeowner losses, supports the legislation because it believes the private insurance market possesses insufficient capacity to manage catastrophic homeowner losses.

Opponents of the bill include a variety of sectors: environmental organizations, the free
market, and government and taxpayer groups. Their stance is that the bill will encourage home construction in environmentally sensitive areas, crowd out the private insurance market, and provide incentives for building homes in risky, hurricane-prone areas. SmarterSafer.org, which is supported by insurance companies, environmentalists (including the National Wildlife Federation, Sierra Club, Ceres, and the Nature Conservancy), the National Flood Determination Association, the National Fire Protection Association, and a number of consumer and taxpayer groups, sent a letter to the Chairman of the House Financial Services Committee in February 2010 and outlined its concerns with the bill:

- The Act will cost taxpayers billions of dollars, discourage the insurance and reinsurance private markets, and result in incentives to build in unsafe and environmentally fragile areas
- “Creates a federal bailout program principally designed to benefit hurricane-threatened Florida at the expense of taxpayers in all 50 states”
- The bill will shift costs of insuring Florida residents to taxpayers in other states
- Florida’s state insurance and reinsurance markets are under-capitalized, unlike the private insurance and reinsurance marketplaces

As with any type of insurance, homeowner risks need to be priced based on exposure. Many individuals and organizations believe that the state of Florida has been cutting homeowner insurance costs for coastal policyholders and spreading the costs associated with their insurance and losses among other homeowner policyholders, and lines of business, within the state. The inability of the state, and some private insurers, to adequately assess and price homeowner insurance coverage, some say, should not be the target of federal legislation.

**SURPLUS LINES**

Formed under the Property & Casualty Insurance Committee of the NAIC, the Surplus Lines Task Force was formed for the purpose of monitoring the surplus lines market along with its operation and regulation. Of concern to the task force are the activity and financial condition of insurance companies in the United States and other countries.

Many states continue to amend legislation and regulation pertaining to non-admitted insurance companies. Future amendments of legislation, and NAIC model regulation, will take place after continued monitoring and evaluation. Issues of concern to state regulators and the NAIC are:

- Maintaining the International Insurer’s Department (IID) Plan of Operation and standards for inclusion on the NAIC’s Quarterly Listing of Alien Insurers (Quarterly List) – which address, among other things, capital and/or surplus finds, U.S. trust accounts, and the fitness of management criteria
- Providing financial guidance and expertise concerning regulatory policy and practices with respect to individual insurance companies and syndicates of Lloyd’s of London that are currently listed on the Quarterly List or that are seeking addition to the Quarterly List
- Performing financial analyses of the surplus lines market and preparing regulatory reports
• Consider a uniform method of allocating surplus lines insurance premium tax on multi-state risks and any other surplus lines issues

The Non-admitted and Reinsurance Reform Act of 2009 (NRRA) was passed in the House of Representatives in September of 2009 and recommends regulation of both non-admitted insurance and reinsurance. It prohibits regulation by any state other than the home state of an insured with respect to non-admitted insurance and reinsurance contracts. These regulations involve producer licensing, surplus lines taxes, fees, and a number of other topics.

The National Underwriter stated, “The legislation has broad support, both from the industry as well as the ultimate consumers of commercial insurance products, as represented by members of the Risk and Insurance Management Society. The Non-admitted and Reinsurance Reform Act is, in part, aimed at making access to the surplus lines market more efficient for consumers and the brokers and agents who assist them. In addition, the bill could help standardize state regulations facing the surplus lines industry.”

INSURANCE FRAUD REGULATION

According to the Coalition against Insurance Fraud, “measuring insurance fraud is an elusive target.” The U.S. does not have a national agency to collect fraud data; therefore, insurance companies, states, and other organizations collect data pertinent to their own undertakings. Independent watchdog agencies, academics, and insurance industry groups also conduct research on various fraud topics.

Insurance fraud is a crime in every state except Alabama, Oregon, and Virginia. Most states have fraud bureaus that investigate insurance fraud within their boundaries; the states that do not have multi-line insurance fraud bureaus are Alabama, Illinois, Indiana, Maine, Michigan, Oregon, Vermont, Wisconsin, and Wyoming. The Coalition against Insurance Fraud reports the following combined statistics with respect to state insurance fraud bureaus for the calendar year 2007:

- Annual budget was just under $150,000,000
- Number of employees was just under 1,700
- Referrals were just over 115,000
- Cases opened was just over 31,000
- 4,849 arrests were made
- 5,936 presentations to prosecutors were made
- 4,228 convictions were obtained
- 7,672 civil actions were made
- Almost $180,000,000 in restitution was ordered

In November 2008, the Insurance Research Council stated that fraudulent and abusive auto-injury claims (including buildup claims) added approximately $5 billion in excess auto injury claim payments in 2007. Claims with apparent fraud or buildup were more apt to involve disability and sprain or strain injuries than other types of claims.
Claimants were also more apt to be treated by physical therapists, chiropractors, and alternative medical providers than claimants with other types of injuries were.

According to the United States Government Accountability Office (GAO) in 2009, the number of employees misclassified by employers on workers’ compensation policies rose by approximately 30% between 2000 and 2007. In 2007, the Fiscal Policy Institute reported that at least 50,000 construction workers in New York City (one in four, or 25%) are paid wages off the books or are incorrectly classified as independent contractors.

In the California Insurance Department’s 2007 annual report, it cited that for every $1,000,000 invested in workers’ compensation anti-fraud efforts, over $6,000,000 was returned, equaling a total return of over $260 million in 2006-2007.

The National Health Care Anti-Fraud Association announced in 2008 that at least 3% of what the U.S. spends annually on healthcare is lost to fraud every year. In dollars, 3% of $2 trillion represents $68 billion. The Association also said that for every $2,000,000 invested in combating healthcare fraud, over $17,000,000 is returned in recoveries, court-ordered judgments, and unpaid bogus claims.

Over $23 billion in improper Medicare payments were made in 2007, the U.S. Office of Management and Budget announced in 2008. The Miami Herald reported in August 2008 that Medicare and Medicaid loses approximately $2.5 million in South Florida each year. In 2009, the U.S. Department of Health and Human Services said that for every dollar the U.S. government invests in fighting Medicare and Medicaid fraud, it saves $1.55.

In August 2008, a report of the Inspector General, Department of Health and Human Services, stated that 29% of what Medicare paid for durable medical equipment in 2006 was erroneous—that’s one in three claims. Between 2000 and 2007, Medicare paid nearly $92,000,000 in claims to dead physicians—a total of 478,500 claims—as reported by the U.S. Senate Permanent Committee on Investigations, 2008.

Other organizations report the following statistics with respect to the consumer’s attitude about fraud:

• Accenture, Ltd. (2003) survey:
  o 1 in 4 Americans believe it is acceptable to defraud insurance companies
    • 8% of those surveyed said it was “quite acceptable”
    • 16% of those surveyed said it was “somewhat acceptable”
  o 1 in 10 Americans believe it is okay to submit claims for items that are not lost or damaged or for bodily injuries that did not occur
  o 2 in 5 Americans “are not very likely” or “not likely at all” to report someone else who defrauded an insurance company

• Progressive Insurance Company (2001)
  o Nearly 1 in 10 Americans would commit insurance fraud if they knew they could avoid detection
  o 29% of Americans would not report insurance scams by people they know
• Insurance Research Council
  o More than 33% of Americans believe it is acceptable to exaggerate an insurance claim to recoup their deductibles (2000)
  o 33% of Americans believe it is acceptable to stay home from work and receive workers’ compensation benefits because they feel pain, even though their doctors indicate they may return to work (1999)
  o 70% of Americans say that workers’ compensation fraud is pervasive and 45% say it’s increasing (1999)
  o 20% of employed American workers report that they are aware of fraud in their workplace (1999)
  o 75% of Americans are not willing to pay higher insurance premiums to allow for bad-faith third-party lawsuits (2000)

• Journal of the American Medical Association (2000)
  o Nearly 1/3 of physicians report that it’s necessary to “game” the health care system to provide high quality medical care
  o More than 1/3 of physicians report that patients have asked them or other physicians to deceive third-party payers to help them obtain insurance coverage for medical treatment—in the past year
  o 10% of physicians report medical symptoms that did not exist in order to help a patient secure coverage for needed treatment—in the past year

The NAIC’s Antifraud Task Force was formed under the Market Regulation and Consumer Affairs Committee. Its mission involves four distinct areas of serving and promoting the public interest through detection, monitoring, and appropriate referral for investigation of insurance crime committed by and against consumers.

1. Maintaining and improving electronic databases concerning fraudulent activities,
2. Publicizing the results of research and analysis of insurance fraud trends—along with case-specific analysis—to insurance regulators,
3. Providing a liaison between insurance regulators, law enforcement at all levels, and specific antifraud organizations, and
4. Coordinating between state and federal regulators regarding the Patriot Act anti-money laundering amendments to the federal Bank Secrecy Act.

In addition to the items stated above, the Antifraud Task Force plans numerous activities in the future, including: developing and presenting antifraud seminars; developing an agenda for Basic Insurance Fraud Investigation Training for Regulators; evaluating sources of antifraud data and proposing methods for the utilization and exchange of information between insurance regulators, fraud investigation divisions, law enforcement officials, insurance companies, and antifraud organizations; track national insurance fraud trends and provide information on at least a quarterly basis; coordinate with state, federal, and international law enforcement agencies to address insurance antifraud issues; and increase mutual data-sharing between state regulators and the U.S. Centers for Medicare and Medicaid Services (CMS).

REGULATORY SUMMARY

The regulatory concerns of the insurance industry encompass far more than a single
The previously mentioned points are only a few of those facing the insurance industry and regulators today. For a complete list of the most current insurance topics facing the industry today, visit the NAIC’s web site at http://www.naic.org on the Committees & Activities page.

The purpose of insurance regulation is to protect the consumer—both from other consumers and individuals who practice illegal, unfair, deceptive, and predatory business and insurance practices. Some insurance regulations require insurance producers to perform more work, and expend more effort, than some producers deem necessary. In many cases, the insurance producers’ perspectives in this regard are valid—because the producers possess integrity and behave in an ethical and professional manner. In an effort to protect vulnerable consumers from the practices of those few who violate the law, insurance producers, insurance companies, regulators, and other industry organizations must band together to provide fair and equitable insurance regulation and comply with all such requirements, even if they do create extra work and effort. The producer-client relationship, and the insurance industry as a whole, will flourish as a result.
CHAPTER 1 – REVIEW QUESTIONS

1. What state first enacted insurance regulation?
   [a] Nevada  
   [b] New Hampshire  
   [c] North Carolina  
   [d] New York

2. What is the NAIC?
   [a] National Association of Insurance Companies  
   [b] National Assurance Indemnity Corporation  
   [c] Northern Alliance of Insurance Companies  
   [d] National Association of Insurance Commissioners

3. The Fair Credit Reporting Act regulates _____.
   [a] Interstate commerce  
   [b] The collection, dissemination, and use of consumer information  
   [c] Credit reporting agencies  
   [d] Insurance credit scores

4. A variable annuity is both an annuity and a _____.
   [a] Contract  
   [b] Policy  
   [c] Security  
   [d] Bond

5. Insurance fraud is a _____ in all but three states.
   [a] Crime  
   [b] Felony  
   [c] Misdemeanor  
   [d] Common occurrence
AN INSURANCE PRODUCER’S DUTIES AND RESPONSIBILITIES

Insurance producers owe responsibilities to many parties: the insurance companies they represent, consumers, peers, regulatory agencies, and state and federal governments. They are required to be skilled and efficient and must simultaneously exhibit a variety of aptitudes. In addition, insurance producers must possess excellent communication and interpersonal skills for the purpose of establishing good, strong relationships with consumers and other insurance professionals.

The three major categories of responsibilities owed by insurance producers include:
- Ethical responsibilities
- State and federal legal responsibilities
- Contractual responsibilities with insurance companies

This chapter will focus on a producer’s legal responsibilities and the responsibilities required by the insurance contracts they hold with insurance companies. Although unfair trade practices certainly address legal responsibilities, Chapter Four will address those topics, along with basic ethical concerns. Due diligence, and a producer’s duties to disclose, are also considered legal responsibilities. Because of the significance of due diligence and disclosure, and the tremendous impact these duties have on producers, consumers, and insurance companies, Chapter Four will focus on them.

TYPES OF INSURANCE PRODUCERS

Before exploring producer responsibilities in detail, it is important to note the differences between the different categories of insurance producers. The insurance industry, and the law, makes clear distinctions between the types of producers.

AGENTS

An agent is typically defined as an individual who is licensed by the state to sell insurance for one or more insurance companies and who acts on behalf of the insurance companies. Agents and producers are considered by law to be representatives of the insurance companies they represent and must, at all times, act as fiduciaries of the insurance companies.
**BROKERS**

A *broker* is typically defined as an individual who is licensed to sell insurance for several insurance companies and who acts on behalf of his clients by securing the best coverage at the most competitive price. A broker may also be an agent.

**GENERAL AGENTS**

A *general agent* is an agent who acts on behalf of several principals, or insurance companies. General agents typically assume responsibility for an agency operation in a particular geographical area and undertake insurance sales, agent training, servicing policies already sold, and providing administrative support. General agents seldom work directly with consumers; instead, their clients are insurance agents and insurance agencies. The primary function of a General Agent is to assist other agents with securing markets and providing administrative assistance.

**SURPLUS LINES BROKERS/AGENTS**

A *surplus lines broker/agent* is one who holds a special license for providing insurance marketplaces for consumers and agents/brokers who are unable to secure coverage in the standard market; they represent non-admitted carriers. On occasion, a consumer will be unable to find an admitted insurance company to write coverage. These occasions usually involve consumers who are brand new businesses, who have experienced unfavorable claims history, who have credit issues, whose operations pose a higher than normal element of risk, etc. The surplus lines broker/agent monitors the financial condition of non-admitted insurance companies and offers a marketplace that would otherwise be unavailable to agents and consumers alike. Some surplus lines brokers/agents also offer coverage with admitted insurance companies, thus offering wider marketplace availability to smaller insurance agencies.

**AGENT CLUSTERS**

An *agent cluster* is a group of individual agents and/or brokers who join together in a venture or association to offer their collective book of business for the purpose of obtaining a wider market than any of the individual agents or brokers could secure on his own. While agent clusters often help agents/brokers develop benefits such as retention of individual agency ownership, improved profit-sharing agreements, reduced overhead, access to staffing, creating a potential buyer when the agent/broker wants to sell or retire, and access to markets, they are usually devoid of commitment. Individual members are free to leave the venture when they choose, thus creating a market void as well as other problems that include an increase in shared expenses.

**AGENT VERSUS BROKER**

Most states differentiate agents from brokers based on the fact that an agent is usually employed by a specific insurance company and is authorized to sell and bind insurance on behalf of that company (or group of companies) and a broker is not employed by the
insurance companies he represents and is free to place coverage with any insurance company he (or his client) chooses. Quite often, brokers are unable to bind coverage. Agents, therefore, owe a higher degree of responsibility to the insurance companies they represent and brokers owe a higher degree of responsibility to their clients. On the other hand, most states require both agents and brokers to owe a fiduciary responsibility to the insurance companies they represent. Most states also require both agents and brokers to exhibit fiduciary responsibility to their clients.

Both agents and brokers owe consumers a number of duties:

- To know and understand the terms, conditions, limits, and exclusions of the policies he sells
- To attempt in good faith to secure insurance protection as requested by the consumer and to notify the consumer of any policy details that differ from those requested
- To evaluate the consumer’s needs and exposures to risk and make appropriate recommendations
- To write coverage with financially sound insurance companies and report the financial rating of the insurance company writing coverage (i.e. A. M. Best Rating)
- To exhibit due diligence in all transactions
- To act in a fiduciary capacity
- To be skilled and efficient
- To be an effective communicator

Regardless of the nature of the producer’s category of license (agent or broker), and depending upon the laws of the states in which he is licensed, the extent of his responsibilities may vary.

STATE AND FEDERAL LEGAL RESPONSIBILITIES

LICENSING REQUIREMENTS

Before an individual may apply for a license as an insurance producer (producer, agent, broker, surplus lines broker, consultant, etc.), he must meet certain conditions. These conditions are similar in most states and include:

- Meeting a minimum age requirement, such as 18 or 21
- Residing in the state—if applying for a resident license—or residing in a state that grants reciprocal privileges, if applying for a non-resident license
- Paying a fee and passing a license examination
- Being competent, trustworthy, and of good reputation
- Possessing experience or training in the lines of insurance for which seeking an insurance license
- Passing a background check
- Having an insurance company to represent once the license is issued
In addition, a number of circumstances may prevent an individual from receiving an insurance license of any type after application; they include:

- A felony conviction
- Committing fraud or misrepresentation on the insurance license application
- Committing an unfair trade practice, as defined by state law
- Having a similar insurance license denied, suspended, or revoked in another state
- Cheating on an insurance license exam
- Violating insurance code
- In some states: failing to pay income tax or court-ordered child support

Because insurance producers have access to a multitude of personal information when transacting business with consumers, and are held in a position of trust and confidence—not to mention their fiduciary responsibilities—virtually all states require applicants for insurance producer licenses to pass background checks. Certain types of activities and offenses will disqualify an individual for issuance of a license; they include felony convictions, sex offender violations, bankruptcies, certain types of lawsuits, lack of address history, and other financial or credit issues. Some states review and consider other activities and relationships.

Because of the Law of Agency, which will be discussed later in this material, insurance companies are held responsible for the actions of their Agents. If an insurance company fails to determine, for example, that its Agent was convicted of embezzlement and served time in prison for the offense, it would be responsible for any financial offenses committed against consumers by the Agent. State regulators and insurance companies have the best interests of the consumer in mind when pre-screening applicants for insurance licenses.

**PLACE OF BUSINESS**

Once an individual has obtained an insurance license, he must have a business location that is accessible to consumers for the purpose of transacting insurance business. Some states require declared business hours; others allow or prohibit the business location in the producer’s residence. States, such as California, require insurance producers to list their insurance license numbers on their business cards and other written materials, including illustrations, proposals, marketing and advertising brochures. When it comes to displaying an insurance license, state requirements vary. For example, Massachusetts requires producers to carry licenses on their person for display while Montana requires producer licenses to be displayed in the place of business that is accessible to the public.

**LAW OF AGENCY**

The Law of Agency is a legal concept that legally authorizes one party (called an Agent) to act on behalf of another party (called the Principal) to create a legal relationship with a Third Party. In insurance, the producer (including agent, broker, surplus lines broker, consultant, or adjuster) is the Agent, the insurance company is the Principal, and the insured is the Third Party. The legal agreement created by agency is the insurance contract.
Agency can be created in one of four ways:

1. By contract
   a. Express or implied
   b. Oral or written
2. By ratification
   a. Approval is granted to an act performed by an individual who previously had no authority to act, or
   b. Approval is granted to an act performed by an individual who exceeded his authority to act
3. By Estoppel
   a. Approval is given to the actions of an individual to the extent that a third party may reasonably believe an agency relationship exists—although one did not exist at the time
4. By necessity
   a. A person acts on behalf of another without express authority in an emergency situation

According to law, Agents owe their Principals the following duties:

- Loyalty
- To account for financial transactions
- To protect confidentiality
- To notify and share information
- To act with skill and efficiency
- To obey the instructions of the Principal
- To decline new obligations that are inconsistent with duties owed the Principal

Principals owe Agents the following duties:

- Full disclosure of pertinent information to all transactions for which the Agent has authority to conduct
- Payment of commission or a reasonable fee

**AUTHORITY**

A producer’s authority is created by contract. Once a contract is duly signed, dated, and approved, the insurance company grants the producer the legal right to act on its behalf and enter into Third Party agreements (insurance contracts) with clients.

The power of authority is spelled out in the contract and can range from broad to limited. The more limited (specific) the power of authority, the less likely the producer is to act in an unauthorized fashion. Both the legal and ethical consequences of an agent not acting in authorized fashion can be considerable.

The authority granted to an Agent by a Principal can be:

- **Expressed** – Specifically stated either verbally or in writing; generally outlines what the Agent can and cannot do. In an insurance contract, this might include the producer’s ability to solicit, obtain signed applications, and collect premiums or the adjuster’s limits when settling claims.
**Implied** – Result of expressed actions that are generally communicated verbally in order to carry out the goals of the written contract. In insurance, this might pertain to underwriting guidelines or claims settlement practices.

**Apparent** – The Principal permits an Agent to act on its behalf in the absence of Expressed or Implied Authority. In insurance, this might be the insurance company’s acceptance of an application of insurance written by a Producer in a territory outside that stated in the Producer/Company contract or of a loss settlement for losses which the adjuster has not been approved to settle per his contract.

If a producer acts in a manner inconsistent with his authority, significant legal and ethical issues may arise. Because producers are required by the states to be licensed to conduct business within their boundaries, and are also contracted with one or more insurance companies, they are held responsible to the state, the insurance carriers with whom they are contracted, and to the public. They are also held to legal and ethical standards of conduct by all parties involved in their business and are trusted by all parties involved in their business. As a result, they have significant fiduciary responsibilities.

**CLASSIFICATIONS OF AGENTS**

It is generally accepted that three distinct classes of Agents exist:

1. Universal Agents hold broad authority; they may hold a power of attorney or act in a professional capacity for their principal, such as in the capacity of lawyer for a client
2. General Agents hold limited authority to act on behalf of their principals in a series of transactions taking place over a period of time
3. Special Agents hold authority to act on behalf of their principals for a specific transaction or a particular series of transactions taking place over a period of time

**LIABILITY OF AGENTS AND PRINCIPALS**

Agents and Principals may be held liable to each other, or third parties, in particular situations. An Agent is liable to his Principal when he acts without actual authority and the Principal is held accountable because the Agent is deemed to have had apparent authority. An Agent is not liable to a Third Party when acting within the scope of actual or apparent authority and the agency relationship is known by all parties, as is the identity of the Principal. If the agency relationship is not fully disclosed, then both the Agent and the Principal are liable to the Third Party. An Agent will be liable to a Third Party when acting outside actual or apparent authority and the Principal is not held accountable. Finally, a Principal is liable to its Agent if the Agent acts within the scope of actual authority granted by the Principal.

The Presumption of Agency, however, may alter the previous situations. If an insurance company provides an Agent with forms, signs, and other materials that evidence authority, thus making it appear the Agent is, in fact, an Agent of the company, it is probable that a court will state a presumption of agency exists. When a presumption of agency exists, the Principal will be bound by the acts of its Agent, even in the absence of the Agent’s authority to act for the Principal.
The concept of Dual Agency involves independent agencies and brokers, who owe a higher standard of care to their clients that agents do. Because brokers act as Agents for both the insurance company and the consumer, any legal issues that arise can be far more complex than those that arise from an agent’s activities.

**PREMIUM REPORTING AND ACCOUNTING**

Insurance producers are required to report and account for insurance premiums collected by their clients. Most states require the existence of a separate bank account, called a trust account, into which insurance premiums are deposited. Producers are not permitted to commingle their personal funds, or the operating funds of their agency, with client premiums. In most cases, producers may deposit premiums collected from multiple clients into the trust account. Title producers are the notable exception to this practice. Most states consider producers commingling funds to be guilty of theft.

**COMMISSIONS AND PRODUCER COMPENSATION**

Producers receive compensation in the form of commissions, which are payments that represent a specific percentage of the policy premium. Commission percentages vary, depending upon the type of insurance sold and whether the policy is new or a renewal. For example, the first year commission on a life insurance policy might be 60% of the annual premium, the second year renewal commission might be 9%, and the renewal commission in years 5-10 might be 3%. The commission on a homeowner policy might be 20% of the annual premium in the first policy year and at all subsequent renewals. The first year commission on an annuity might be 3.5% and 1% thereafter. Depending upon the annual policy premium, commissions paid might be quite small or, conversely, quite large. Using the preceding examples, the following commission payouts would be considered common:

<table>
<thead>
<tr>
<th>Policy Type and Commission Percentage</th>
<th>Annual Premium</th>
<th>Commissions Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance – 60% First Year</td>
<td>$1,000.00</td>
<td>$600.00</td>
</tr>
<tr>
<td>Life insurance – 9% Second Year</td>
<td>$1,000.00</td>
<td>$90.00</td>
</tr>
<tr>
<td>Life Insurance – 3% Fifth Year</td>
<td>$1,000.00</td>
<td>$30.00</td>
</tr>
<tr>
<td>Homeowner Insurance – 20% Each Year</td>
<td>$1,000.00</td>
<td>$200.00</td>
</tr>
<tr>
<td>Annuity – 3.5% First Year</td>
<td>$1,000.00</td>
<td>$35.00</td>
</tr>
<tr>
<td>Annuity – 1% Thereafter</td>
<td>$1,000.00</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

Assuming each of the three policies shown remains in force for ten years, the producer would receive the following commissions between issue and the end of the ninth policy year—assuming the premium did not change—for precisely the same premium investment by each policyholder:

<table>
<thead>
<tr>
<th>Policy Type</th>
<th>Total Commissions Paid Over 10 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance</td>
<td>$1,110.00</td>
</tr>
<tr>
<td>Homeowner Insurance</td>
<td>$2,000.00</td>
</tr>
<tr>
<td>Annuity</td>
<td>$125.00</td>
</tr>
</tbody>
</table>
The life insurance policy pays less overall commission than the homeowner policy, but the bulk of it is paid in the first year. The homeowner policy pays nearly twice as much commission as the life policy and six times the commission of the annuity, but the producer must retain the client for ten years to earn that higher amount, while the life producer makes the bulk of his money during the first year. The annuity commission appears paltry when compared to the other policies; annuity sales, however, usually generate initial annual premiums much higher than $1,000—which is why the first year commission rates are significantly lower than those for life and homeowner insurance are.

A producer may make his decision about what lines of insurance to sell, and which lines of insurance to become licensed for, based on commission levels. That is a business decision. Selling individual policies, or choosing to sell a policy with one insurance company instead of another, based entirely or primarily on commission levels (instead of the needs of the consumer) is not only unethical it is considered illegal on a number of fronts, including violating fiduciary duties and exhibiting a lack of due diligence.

A number of other legal issues concerning commissions are addressed in state insurance code. Not only does insurance code stipulate who may receive commissions, it also stipulates who may not receive commissions. Code further clarifies that other types of compensation may not be paid in lieu of commission OR to reduce the policy premium. It is especially important for producers to possess a clear understanding of the types of commissions they may receive—and the types of commissions they may share. Commissions may only be paid to, or shared with, individuals and entities licensed to sell the type of insurance for which commissions are being paid. For example, if a producer is licensed to sell surety bonds only, he may receive commissions for the sale and servicing of insurance bonds, but not for the sales and servicing of life or auto insurance policies. Another example involves a producer who is licensed to sell life and health insurance; he may not receive commissions for the sales or servicing of an auto policy unless he also holds a property and casualty insurance license.

Insurance code contains references to premium discrimination and rebates; each state utilizes its own particular verbiage. Insurance companies must file rate requests with the Divisions of Insurance in each state before charging insurance premiums. Once rate filings are approved, insurance companies are not permitted to charge rates that deviate from the approved filings for the particular lines of business and products, as described in the filings. What all states share is the intent to protect the consumer by disallowing certain practices, such as awarding bonuses or abatements to policyholders by reducing policy premiums in any fashion. For example, if a producer had a strong desire to sell a large life insurance policy to a business client, and he agreed to pay the first month’s premium as an inducement to make the sale, he would be in violation of insurance code in most states. Depending upon the state, this practice would be called either discrimination or rebating.

In addition to prohibiting the payment of premium bonuses or abatements to policyholders, insurance code bans the practice of paying, offering, or giving—either
directly or indirectly—a special favor or “valuable consideration” in exchange for, or as inducement to purchase, an insurance policy. Some state insurance codes spell out the value of a special favor or valuable consideration in terms of dollars, such as $25 or $100. Language in other state codes is less specific. The intent, again, is quite clear: consumers are not to be rewarded for purchasing insurance. Such “rewards” lessen the actual premiums paid and are also a form of discrimination.

Commission sharing is another area of legal concern to most states. Not only is it illegal for an individual to receive commission in payment of the sales or service of a policy in a line of insurance for which he is not licensed, it is also illegal for a licensed producer to pay, or share, commission with such an individual. The practice of calling shared commissions the payment of a “finder’s fee” or a “referral fee” does not change the fact that this type of commission sharing is illegal.

An example would involve a mortgage broker who refers clients to an insurance producer. The mortgage broker requests a referral fee of $25 for each client he sends to the insurance producer and for whom the insurance producer sells a homeowner or mortgage life insurance policy. If the mortgage broker is also a licensed producer, it is legal and ethical for the producer to pay the mortgage broker the referral fee—which, in reality, is commission...IF the mortgage broker is licensed in the line of insurance for which he is paid commissions. Meaning he needs to be licensed in Property & Casualty lines of insurance to be paid, and receive, commissions on the homeowner policies and he needs to be licensed in Life lines of insurance to be paid, and receive, commissions on the life policies. In most states, both the licensed producer and the unlicensed mortgage broker have violated the law if any commissions are paid to and/or received by an individual who is not appropriately licensed.

**FIDUCIARY DUTY**

A fiduciary duty requires the highest standard of care in both law and at equity. A person owing a fiduciary duty acts on behalf of another and is required to put the best interests of the person on whose behalf he acts above all other interests, including his own. In addition, a fiduciary may not profit from the relationship unless the party for whom he is acting expressly permits the profit.

Fiduciaries are not permitted to place themselves in a position where a conflict of interest arises, nor are they permitted to conduct themselves as the average person would—they are required to exhibit the highest of ethical and legal care. This requirement is the basis of the legal obligation to report and account for premiums in an appropriate fashion. Insurance producers are fiduciaries of the insurance companies they represent. They are also considered fiduciaries of their clients when handling insurance premiums and when helping clients choose the most appropriate insurance coverages.

One of the areas that producers should avoid at all costs is the placement of insurance coverages based solely, or primarily, on the commission percentage paid by insurance companies. Advising clients to purchase insurance coverage based on the producer’s preference for a higher commission rate is a clear violation of the fiduciary duty owed to
the client—whether the recommendation involves choosing a particular insurance company or a particular insurance product. It also represents a lack of due diligence. The needs of the client—all his needs, as determined by the client and not just those evaluated by the producer—should be the sole basis of a producer’s recommendation.

**FIDELITY BONDING**

Some states require licensed insurance producers to obtain fidelity bonds for the protection of both consumers and the insurance companies they represent. In addition, insurance companies may have their own requirements in this regard.

It cannot be emphasized too strenuously that insurance producers hold a power of trust and confidence with respect not only to the money they accept on behalf of consumers and insurance companies but also to the property and well-being of those same consumers and carriers. The ability to obtain a fidelity bond and pass a background check are two methods of proving to the public that a producer is worthy of the position of trust and confidence he holds in the community.

**CONTINUING EDUCATION**

According to the Insurance Risk Management Institute (IRMI), “Insurance contracts can be simple or exceedingly complex, depending on the risks insured. Regardless, insurance is neither more nor less than a contract whose terms are agreed to by the parties to the contract. Over the last few centuries, almost every word and phrase used in insurance contracts has been interpreted and applied by one court or another. Ambiguities in contract language became certain. However, the average person saw the insurance contract as incomprehensible and impossible to understand.”

In the 1970s, insurance regulators began making concerted efforts to require “easy to read” policy language. Until that time, the average consumer was unable to read and/or understand any of his policies because they contained language specific to the insurance industry. Insurance companies complied with law and discarded verbiage that had been interpreted by courts and court decisions for decades, and replaced it with language understandable by fifth-graders. It was hoped that if both insurance producers and consumers understood policy language, fewer misunderstandings and consumer complaints would occur.

Because of regulators’ concerns with consumer protection, insurance producers are required to be knowledgeable, skilled, and efficient. In fact, insurance code in many states stipulates such requirements of producers, agents, and brokers. Toward that end, each state has enacted continuing education requirements for producers. Certain licensees are exempt from continuing education, depending upon the state, and include those with temporary licenses, individuals who are grandfathered, and other such individuals.

Depending upon the state, insurance licenses are issued for one or more years and are renewable only if the licensee completes a required number of hours of continuing
education. For example, Ohio requires producers to complete twenty hours of approved continuing education every two years. Some states require a specific number of hours based on the lines of authority issued to the licensee. For example, Oregon issues licenses for two years and requires producers to complete twenty-four hours of approved continuing education each license period and of those twenty-four hours, three must be in the area of Oregon law and three must be in the area of ethics. Massachusetts issues licenses for a period of three years. Sixty hours of approved continuing education are required during the first three years of licensure and forty-five hours of approved continuing education are required triennially after that initial period. Of the sixty, or forty-five hours, at least one hour must be completed in a course approved for lines of insurance for which a license is held. In addition, a one-time three-hour approved flood insurance course is required of producers selling flood insurance.

Most states do not require non-resident producers to complete approved continuing education requirements, however, they do require non-resident producers to prove that they’ve met the continuing education requirements of their home states. Some states allow licensees to carryover some or all excess credits; other states do not allow carryover at all. One trend that seems to be growing nationwide is the requirement for producers to complete a specific number of approved continuing education hours on the subjects of ethics, E & O prevention, and/or state-specific laws.

Statistics provided by several major carriers of insurance producer’s E & O insurance report that the insurance producers least likely to submit E & O claims are those with insurance designations—in other words, producers who regularly attend insurance continuing education courses and seminars.

The more knowledgeable a producer becomes, and the more skilled and efficient he is, the better he’ll be able to assist consumers in a beneficial manner. The last chapter in this material addresses the subject of E & O claims and, specifically, the reasons producers become the victims of lawsuits. In the majority of cases, the lawsuits and claims could have been avoided had the producer been better educated or trained.

**STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION**

Not only is a producer ethically bound to safeguard the financial information provided by consumers, he is legally bound to do so, as well. The Gramm-Leach-Bliley Act (GLBA), which is enforced by the Federal Trade Commission (FTC), was enacted by Congress to regulate privacy protections of consumers’ nonpublic personal information. The Safeguards Rule spells out precise details of who must comply and how to comply.

“Financial Institutions” are required to provide their customers with disclosures and notices that include their information-collection and information-sharing practices with respect to “nonpublic personal information.” Insurance companies fall under the definition of “financial institutions,” as do businesses such as check cashing firms, payday lenders, mortgage brokers, nonbank lenders, real estate appraisers, professional tax preparers, courier services, credit reporting agencies, ATM operators, and insurance producers. Once notified of the practices of a business subject to the GLBA, consumers
may choose to “opt out” of sharing practices that are not listed as specific exceptions in the GLBA and Safeguards Rule. Depending upon the state, insurance agencies may be required to provide their own notices to clients, in addition to the notices required of their respective insurance companies.

“Nonpublic personal information” is defined by the GLBA as personally identifiable financial information – (i) provided by a consumer to a financial institution; (ii) resulting from any transaction with the consumer or any service performed for the customer; or (iii) otherwise obtained by a financial institution. Examples of this type of information include bank account numbers, credit card numbers, income information, credit histories, and Social Security numbers. Nonpublic personal information does not include information that is available to the public, such as addresses or telephone numbers that appear in the phone book. In addition, the protected nonpublic personal information includes lists, descriptions, and other groupings of consumers that are derived using any nonpublic personal information other than that which is publicly available and does not include lists, descriptions, and other groupings of consumers that are derived without using any nonpublic personal information.

Protected consumers are defined by the GLBA to include individuals who obtain from “financial institutions” financial products or services, including insurance products and services, that are to be used primarily for personal, family, or household purposes. A consumer’s legal representative also falls under this definition. Consumers purchasing homeowner, auto, life, and other types of insurance policies fall into this protected class of consumer.

“Financial institutions” are not permitted to disclose to “nonaffiliated third parties” any nonpublic personal information unless it meets conditions that comply with the GLBA. A “nonaffiliated third party” is defined by the GLBA as being an entity that is not an affiliate of, or related by common ownership or affiliated by corporate control with, the financial institution. A joint employee of the “financial institution” is not considered a “nonaffiliated third party.” Information may be shared under the following conditions:

• The “financial institution” clearly and conspicuously discloses in writing to the consumer in an approved format that information may be disclosed to the third party, or

• The consumer directs the “financial institution” to disclose information to the third party before disclosure of the information, or

• The consumer is given an explanation about how to exercise a nondisclosure option

Independent insurance agencies would be considered nonaffiliated third parties unless they were entirely owned by the “financial institution” or insurance company. Employees of direct writers, who do not own their own businesses, would be considered affiliates. In addition, “financial institutions” are not permitted to disclose account numbers or similar form of access numbers or codes to any nonaffiliated third party, other than a consumer-reporting agency, for use in direct mailings, telemarketing, or electronic mail marketing.
Some exceptions to the foregoing include disclosure of nonpublic personal information:

- Necessary to transact business as requested or authorized by the consumer,
- Pertinent to maintaining the consumer’s account with the financial institution
- At the direction of, or with the consent of, the consumer
- To protect the confidentiality or security of records pertaining to the consumer or his transaction(s)
- To prevent or protect against fraud and unauthorized transactions
- For required risk control or resolving customer disputes and inquiries
- To individuals holding a legal interest pertaining to the consumer
- To individuals acting as fiduciaries of, or on behalf of, the consumer
- To provide information to insurance rate advisory organizations, guaranty funds, and attorneys, accountants, and auditors of the financial institution
- As required or permitted under the Right to Financial Privacy Act of 1978, to law enforcement agencies, State insurance authorities, the FTC, and for investigations into matters of public safety
- To a consumer reporting agency in compliance with the FCRA
- In connection with an actual or potential sale of the book of business of the financial institution
- To comply with Federal, State, or local laws

Disclosures of the information-collection and sharing practices must be made at the time of establishing a customer relationship and at least once a year thereafter during the course of the business relationship. In the insurance industry, these disclosures are usually included in the mailings of new and renewal insurance policies.

The GLBA also requires businesses to secure nonpublic personal information against unauthorized access or possession. The Federal Trade Commission recommends the following methods of securing information for the protection of consumers’ information:

- Performing background checks before hiring employees who will have access to customer information
- Requiring employees to sign a confidentiality statement
- Limiting access to customer information to only those employees needing the information to transact business for or on behalf of the customer
- Using “strong” computer passwords and changing them frequently
- Developing and implementing security policies for appropriate use and protection of computers, laptops, PDAs, cell phones, and other equipment that transmits electronically
- Training employees
- Locking files cabinets and rooms where customer information is stored
- Encrypting nonpublic personal information before transmitting it electronically
- Immediately deactivating terminated employees’ access to computers, files, etc.
- Dispose of customer information and files in a secure manner that is consistent with the FTC’s Disposal Rule (www.ftc.gov/os/2004/11/041118disposalfrn.pdf)

The standards for safeguarding consumers’ nonpublic personal information are not only enforced by the GLBA, but also by:
• Federal functional regulators,
• State insurance authorities,
• Federal Trade Commission,
• The Comptroller of the Currency (certain banks),
• Federal Reserve System (member banks),
• Federal Deposit Insurance Corporation (banks insured by the FDIC),
• Board of the National Credit Union Administration (federally insured credit unions),
• Securities and Exchange Commission (investment companies, broker/dealers, and investment advisors)

The following sources provide additional information about The Safeguards Rule:
• Computer Security Resource Center, National Institute for Standards and Technology (NIST), www.csrc.nist.gov
• United States Computer Emergency Readiness Team (US CERT), www.us-cert.gov/resources.html
• Carnegie Mellon Software Engineering Institute CERT Coordination Center, www.cert.org/other_sources

CONTRACTUAL RESPONSIBILITIES

When insurance companies hire agents—as either employees or independent contractors—they spell out the details of the authority they are willing to confer in contracts. Because of the legal workings of the Law of Agency, the written contract provides protection for both the insurance company (Principal) and the agent (Agent). The contract also provides protection for the consumer, because it spells out the duties and responsibilities of each party.

Most professionals within the insurance industry have a clear understanding of the differences between agents and brokers, employees and independent contractors, the intricacies of the Law of Agency, and how—and when, authority is granted. Unfortunately, most consumers do not share that clear understanding. If a consumer walks into an insurance agency to find a man sitting behind a desk, he automatically assumes the man is a qualified insurance agent who will be able to answer all his questions and assist him with all his insurance needs.

Nothing could be further from the truth. The man sitting behind the desk could be the insurance agent’s husband. He could be a client using the computer. He could be the newly hired maintenance man. If the consumer asks a question, and the man sitting behind the desk answers it, doesn’t the consumer have a reasonable expectation that the person answering his questions is qualified to do so and that the answer will be correct?
The law says he does. The law also says that it is the insurance agency’s responsibility to inform and educate the consumer. It is the insurance agency’s duty to comply with all federal and state laws—as well as the requirements spelled out in the contract between the agency and the insurance companies it represents. Whether or not the man sitting behind the desk is a licensed insurance producer, the agency is responsible for the practices taking place on its behalf. The agency is also responsible for communicating to its own agents and employees the exact nature of the authority granted by the insurance company.

In today’s marketplace, it is essential for an insurance agent to not only familiarize himself with insurance laws and products but also with his contractual responsibilities to the insurance companies of the products he sells. In many cases, especially when an agent is a producer for an agency, the producer may never have the opportunity to read and review the contracts between his employer and the insurance companies represented by the agency.

This is often because the agency, itself, grants different authority to its producers than the authority it receives from the insurance company. For example, an agency/company contract may grant the agency binding authority up to $1,000,000 on commercial policies. The agency principals, however, may not wish to grant the same limit of authority to their producers. They may decide to grant their producers binding authority up to $500,000 and only grant managers binding authority between $500,001 and $1,000,000. Another example might involve verbal binding authority. An agency/company contract might confer an agency verbal binding authority for 48 hours with respect to personal lines products. The agency principals may choose not to extend that authority to producers at all.

Even in the absence of access to the agency/company contract, producers should be familiar with their contractual obligations. Contracts between insurance agents and companies contain a number of usual clauses. Although they can, and do, vary from contract to contract, the following are the most commonly found clauses:

- The contracted agent may sell insurance and collect premiums
- The contracted agent must submit insurance business subject to published underwriting guides and manuals
- The contracted agent must work in a location that is adequate to handle the business needs of the company and its clients:
  - Collecting premiums
  - Accepting loss notices and processing claims
  - Completing applications and other paperwork
  - Servicing the needs of policyholders
- The contracted agent must allow insurance company representatives to review books and records
- The contracted agent must follow insurance company guidelines with respect to advertising
- The contracted agent must purchase and maintain E & O insurance
- The contracted agent will maintain, at all times, individual, corporate, and/or agency
licenses required to do business in the state(s) licensed

- The contracted agent must provide copies of all insurance licenses to the insurance company at issue and renewal
- The contracted agent must comply with all state replacement, and other, laws
- The contracted agent will, at all times, exhibit due diligence and ethical business conduct
- The contracted agent will operate in a specific marketing territory, if applicable
- The contracted agent will respect the limits of authority granted by the contract
- Both parties agree the contract does not create or comply an employer/employee relationship (unless the contract is between a direct writer and its agent employee)
- Both parties agree to the ownership terms of the book of business
- Both parties agree to the contract termination details
- The insurance company will pay commissions as set forth in the commission schedule
- The insurance company will provide approved company manuals, forms, and records necessary for the contracted agent to perform his duties

Clearly, the agent has more contractual responsibilities than the insurance company does. It is also clear that the agent is the party working directly with the consumer, therefore, the bulk of the legal and ethical requirements rest squarely on his shoulders.

THE CONTRACTED AGENT MAY SELL INSURANCE AND COLLECT PREMIUMS

Contractual responsibilities for selling insurance and collecting premiums will vary based on the type of contract. For example, if a producer represents a direct writer and is not permitted to sell insurance with another insurance company, the contract language will specify that the producer may ONLY solicit and sell insurance on behalf of the insurance company. The contract language could also allow the producer to solicit and sell insurance on behalf of other companies so long as they are not offered by, or available from, the contracted insurance company. In the case of independent agents and brokers, contract language usually stipulates that the producer can solicit and sell insurance in the lines stated either in the contract or on the attached (and subsequent) commission schedules.

This section of the contract often states that the contracted agent is only granted authority to solicit and sell insurance in the lines of authority that appear on his license.

Obligations with respect to the collection of premiums vary based on either the individual company or the type of contract. In all cases, the agent is required to remit premiums promptly, to hold them in trust, and to act in fiduciary capacity on behalf of the insurance company and the client. Many contracts spell out that premiums are not to be commingled with the agent’s personal or business funds.

Contracts of any type, but more often with General Agents/Brokers or Surplus Lines Brokers, may also include any one or more of the following references to premium
collections:

- The agent is granted authority to collect only initial premiums, not subsequent installment or regular premiums
- The agent must remit the total policy term premium to the agent/broker with a set number days, such as 20 or 30
- The agent may, or may not, secure financing of the policy premium in lieu of collecting the entire annual premium in advance or at application
- Coverage may not be bound without the collection of an established premium amount or percentage of the annual premium

Contracts seldom discuss requirements for agents when providing receipts to clients when accepting premium payments. In light of recent E & O claims, however, agents would be wise to follow a few guidelines in this regard:

- Always provide a client with a receipt; if the client declines a receipt, prepare one and file it in the client’s file with a note indicating the client chose not to take it
- Always include the date and time on the receipt, especially when binding or reinstating coverage on the same day the premium is being accepted
- When accepting a life or health insurance application, be familiar with the language contained in the conditional receipt, as well as the company’s requirements with respect to collection of premium (or not collecting premium) and providing the applicant with a conditional receipt—the language can vary significantly from company to company

THE CONTRACTED AGENT MUST SUBMIT INSURANCE BUSINESS SUBJECT TO PUBLISHED UNDERWRITING GUIDES AND MANUALS

In today’s marketplace, most insurance companies publish their manuals and underwriting guidelines on their websites, thus eliminating paper documents. Of course, some companies publish their guides and manuals only in paper or in both electronic and paper formats.

In the days before the Internet, insurance companies published updates to their underwriting guides and manuals and mailed them to agents, requiring tremendous amounts of time and effort on the part of agents to remove outdated pages from existing publications and insert new and/or updated pages. Today, information can be updated in online guides and manuals in a matter of seconds. While most insurance companies send bulletins to their agents to notify them about pending [important] updates, it is the agent’s responsibility to monitor underwriting guides and manuals regardless of an insurance company’s notification process. When a producer makes a decision to bind coverage or accept an application, he is not only committing himself to the transaction, he is committing his employer and the insurance company, as well.

One topic of contention among some producers is that insurance companies seldom make exceptions to underwriting guidelines. Because a producer may want to enhance an already strong relationship with a client—or begin a new client relationship—and will generate premium for the insurance company and commission income for himself, he
may become upset when the insurance company refuses to make an exception on his behalf. *It should be noted that insurance company underwriting guidelines are usually a direct reflection of previous loss history and/or reinsurance requirements and not a reflection of personal opinion about the submitting producer.*

Loss history statistics are evaluated by insurance company actuaries and often predicate the types of risks insurance companies are willing to accept, as well as the premium rates charged. If, over a number of years, an insurance company experienced higher than anticipated losses for a class of business, for example, roofers, it may decide to do increase premiums. On the other hand, it may decide not to accept roofers as a class of business in the future. Of course, the insurance company’s rate filings would reflect its decision and changes to current underwriting practices and rates wouldn’t be initiated until rate filings were submitted and approved.

Reinsurance treaties also play a part in insurance company underwriting guidelines. If an insurance company has a contract with a reinsurer, it is possible that the contract indicates the writing insurance company will not insure certain classes of business, for example, roofers. As in the previous example, it is likely that the reinsurer’s decision not to insure roofers is based on previous loss history.

Regardless of the reason for the insurance company’s decision, if it issued insurance on a class of business contrary to its state rate filing or its reinsurance contract, the insurance company would be either violating state law or breaching a contract—or both. In each instance, the insurance company would become legally liable for the consequences of its actions in addition to financially responsible for any outcome of the decision that involved a loss.

*Insurance industry loss control and risk management studies show that the more often an insurance company accepts risks outside its published underwriting guides, the higher its loss experience will be. Insurance companies working within the boundaries of their underwriting guides usually experience lower loss ratios than insurance companies regularly making exceptions do.*

Another reason for insurance producers to familiarize themselves with published underwriting guides and manuals is to ensure that they are offering the most timely and accurate policy and coverage information to consumers. If an insurance company made changes to a policy form, and a producer was not aware of the changes, he could negatively affect a client’s coverage.

For example, if an insurance company decided to remove Sewer & Drain Backup coverage from its Businessowners Policy form and offer coverage as an optional endorsement requiring the payment of additional premium, a producer unaware of the change would tell business clients buying property policies that they had this coverage when, in fact, they didn’t. Another example might include medical underwriting guidelines for life insurance. If an insurance company lowered the minimum face amount requirement for paramedic exams and a producer was not aware of the change, he
might issue a conditional receipt indicating life insurance coverage was in effect when, in fact, it wouldn’t become effective until completion of the paramedic exam—which was never scheduled.

With today’s technology, it is much quicker for producers to secure insurance quotes and proposals via computer software than to prepare them manually using rate manuals and rate cards. Electronically prepared quotes and proposals are usually contain fewer mathematical errors than manually completed documents and are far more likely to comply with disclosure requirements. While this is terrific news on several fronts, it does create one issue: some producers mistakenly believe the process of electronically preparing proposals negates the need for them to become acquainted with underwriting and rate manuals.

Insurance rating and quoting software does not include every, single underwriting issue or premium charge for every single consumer. For example, life insurance quoting software asks for a rate classification. The producer is required to choose the underwriting rate classification when preparing an illustration: i.e. nicotine user or non-nicotine user, preferred or standard (based on medical history, build, etc.)

**EXAMPLE:** The producer never read the online life insurance manual or underwriting guide because he believed the computer system signaled an alarm if he entered incorrect information and/or that all appropriate questions would be asked during the process of inputting information. When he enters the applicant’s rate classification—which includes the producer’s understanding of eligibility based on build (height and weight)—he might choose an incorrect rate classification and the illustration would show a much lower premium that is actually appropriate. Or, if he chooses the right rate classification, he might not know that he has to insert manually either a code or a rate-up percentage because the applicant’s weight exceeds the maximum allowed for that rate classification by 20 pounds. Again, the illustration would reflect an incorrect premium.

Had such a producer read the underwriting guide and manuals, he would understand the entire process involved in preparing a proposal and, when the computer screen did not prompt him, would realize extra information was needed anyway. He’d also know where to go to obtain that information.

Such mistaken understandings can give the producer the appearance of being lacking in knowledge and competence, thus damaging his reputation and, by extension, that of his employer and the insurance company he represents. Consumers need to trust their insurance producers because much of their planning and the security they derive from their business relationships is built on that trust.

**THE CONTRACTED AGENT MUST WORK IN A LOCATION THAT IS ADEQUATE TO HANDLE THE BUSINESS NEEDS OF THE COMPANY AND ITS CLIENTS**

How professional is a business location operating from the back seat of a car or at a bistro table in a coffee shop—even one that has Internet access? How secure is such a business
location?
Okay, very few insurance producers conduct business from their cars or public coffee shops. However, some producers do conduct business from their homes—which is permissible in some states. What if an insurance producer had two friendly Rottweilers who became so overjoyed by visitors that they barked and danced around the front yard whenever a car pulled into the driveway? Although the state might permit the producer to conduct business from his pet-friendly home, would the state and the insurance company view this particular scenario as being professional, acceptable, and in the public interest? Would consumers?

In order to prevent situations that are inappropriate, unprofessional, or not compliant with public policy, most agent/company contracts require agents to conduct business in a professional manner—in a professional location that is easily accessible to the public. The location must include facilities that allow the agent to provide all the services consumers might require, along with space that affords privacy when handling claims, obtaining new business insurance applications, or accepting premium payments. If a consumer is applying for medical insurance, chances are he’d prefer a private office in which to conduct the interview rather than a public room where agency staff and other consumers are present.

Legal, professional, and ethical standards demand that the consumer has that privacy. If a consumer wants to provide his current, or a prospective, agent with paperwork concerning his insurance account, the consumer deserves to have at his disposal a place to visit or an address at which he can send it—whether it be a postal address, an e-mail address, or a fax number. An insurance agent who conducts business via only a website with an e-mail address and phone number is going to have a difficult time finding an insurance company to appoint him. By the same token, if an insurance company discovers that an appointed, contracted agent has abandoned his business office in favor of working from a location not accessible to the public, it is likely the company will terminate the contract.

It is reasonable to expect an insurance agent to choose his business location to suit his convenience and business needs, but those needs cannot supersede the needs of the client or legal and contractual obligations.

**THE CONTRACTED AGENT MUST ALLOW INSURANCE COMPANY REPRESENTATIVES TO REVIEW BOOKS AND RECORDS**

Audits are a fact of life. Insurance companies audit the payroll of clients for whom they issue workers’ compensation policies. State insurance departments audit insurance companies. And insurance companies audit insurance agents.

Insurance producers should always bear in mind that they are the embodiment of the insurance companies they represent. Consumers often believe producers *ARE the company*. For this reason (remember the Law of Agency?), insurance companies reserve the right to review the books and records of their agents. Quite often, agent/company contracts spell out that while companies provide manuals, forms, software, and other
materials to agents so they can do their job, such materials and all books and records pertaining to the book of business belong to the insurance company. Even when the books and records do not belong to the insurance company, because of the fiduciary duty the agent owes the insurance company and the consumer, he must make books and records available for review per the terms of the contract.

**THE CONTRACTED AGENT MUST FOLLOW INSURANCE COMPANY GUIDELINES WITH RESPECT TO ADVERTISING**

Words are powerful tools: they not only communicate thoughts, wishes, and expectations, they are used to encourage other people to act. Think about nationwide marketing campaigns that use words to convey a message about a particular business: Have it Your Way (Burger King), Reach Out and Touch Someone (AT & T), and Don’t Leave Home Without It (American Express).

Sometimes, words communicate information other than as intended—different perceptions, understandings, languages, and other factors impact how a message is sent and received. On occasion, words are deliberately manipulated to distort a message for the benefit of the person sending the message. Because misrepresenting a policy or its benefits, values, and features is harmful, agent/company contracts often include guidelines for advertising.

Some, though not all, agent/company contracts stipulate that insurance agents may not use the insurance company’s name or logo without prior written approval. Other agent/company contracts permit the agent to use only advertising materials supplied by the insurance company. In addition, some states contain specific language about the contents of proposals, illustrations, business cards, and other marketing materials.

These concerns reflect the insurance companies’ concerns with the protection of copyright, trademark, and consistency in branding. These guidelines are especially important when selling insurance products that are also regulated by the SEC and FINRA, because of the additional legal responsibilities and duties required of registered representatives and broker-dealers.

**THE CONTRACTED AGENT MUST PURCHASE AND MAINTAIN E & O INSURANCE**

In the event of an E & O claim, insurance companies are generally held responsible for their producers because…well, they’re Agents! Not just insurance agents, but individuals who, through the legal concept of Agency, are authorized to act on their behalf. In the event an insurance producer is sued, or a claim is submitted against him, insurance companies want the insurance producer’s insurance policy to respond first. Their reasoning is no different from that of a general contractor requiring a plumbing sub-contractor to obtain general liability insurance.

**THE CONTRACTED AGENT WILL MAINTAIN, AT ALL TIMES, INDIVIDUAL, CORPORATE, AND/OR AGENCY LICENSES REQUIRED**
TO DO BUSINESS IN THE STATE(S) LICENSED

An agent/company contract is issued for the sole purpose of authorizing an agent (or agency) to act on behalf of an insurance company. In order to solicit, sell, and service insurance policies, producers and agents must be licensed. This clause seems to be redundant; however, it clearly places the responsibility for licensing on the shoulders of the producer/agent.

Would an insurance company issue a contract to a non-licensed individual? No. Would the insurance company knowingly pay commissions to an unlicensed individual? No. It is for these reasons the contract emphasizes the insurance company’s desire to comply with all appropriate laws and its commitment to continued compliance. If a producer or agent fails to obtain or renew required licenses, not only is he in violation of state law, he is also considered in breach of contract and jeopardizes not only his standing with the state, but with his insurance company, as well.

THE CONTRACTED AGENT MUST PROVIDE COPIES OF ALL INSURANCE LICENSES TO THE INSURANCE COMPANY AT ISSUE AND RENEWAL

Some agent/company contracts allow for the insurance company to demand copies of licenses from time to time at their specific request; others require license copies at issue and renewal. This requirement appears in contracts to document the company’s compliance with state law in paying commissions only to licensed producers and also to exhibit the insurance company’s degree of due diligence in many other respects, including the standard of care owed to its policyholders, employees, and other producers.

THE CONTRACTED AGENT MUST COMPLY WITH ALL STATE REPLACEMENT, AND OTHER, LAWS

Although each agent is personally required to comply with all federal and state laws, this—and other—contract provisions are included for the express purpose of allowing the insurance company to terminate the agent in the event the agent is negligent or willfully insubordinate in the carrying out of his legal, ethical, and/or fiduciary duties.

THE CONTRACTED AGENT WILL, AT ALL TIMES, EXHIBIT DUE DILIGENCE AND ETHICAL BUSINESS CONDUCT

Although most people in the insurance industry will agree that the vast majority of insurance producers fully intend to exhibit due diligence and conduct their business affairs in an ethical fashion and with integrity, lapses sometimes occur—more due to a lack of understanding of terms on the producer’s part than because of any ill intent.

An insurance producer may believe he understands what due diligence means, or that he has a clear grasp of what is, and is not, ethical business conduct. However, without proper education and training, a producer may find himself operating under a misapprehension. As times change, and society evolves, interpretations of due diligence
also change and evolve.

For example, there once existed a time when courts held that if an insurance producer placed a sticker on an insurance policy that stated *Read Your Policy*, the policyholder was responsible for doing just that. If, in addition to placing the sticker on the policy, the insurance producer advised the policyholder to call or contact the producer with any questions he might have after reading his policy, and documented that advice, and the policyholder did not do so, the courts also held that the policyholder would be partially responsible for any misunderstandings or gaps in coverage that arose. The courts do not hold the same viewpoints in the current marketplace.

Some agent/company contracts spell out their perceptions of *ethical business conduct*—others do not. For example, these requirements appear in a particular Broker Agreement:

- Agent must conform to all rules and guidelines referred to in the Agreement, rate books, manuals, and other materials supplied by the insurance company;
- Agent must comply with all federal, state, and local laws, rules, and regulations where the agent does business;
- Agent must aid in the care and conservation of business written under the terms of the Agreement;
- Agent must provide service to the policyholders of insurance written under the terms of the Agreement;
- Agent must train and educate its employees and ensure they comply with all company laws, rules, and regulations;

If an agent/company contract spells out specific requirements of business conduct, then the agent is bound to additional responsibilities—per the contract. Due diligence and ethics/business conduct will be discussed in more detail in Chapters 3 and 4, respectively.

**THE CONTRACTED AGENT WILL OPERATE IN A SPECIFIC MARKETING TERRITORY**

This particular provision does not appear in all contracts. In fact, in some contracts, it is stated that the agent does NOT have a specific marketing territory.

In the instances where a particular marketing territory is referred to, especially if an insurance company is a direct writer, the operating territory of the insurance company is sometimes divided into sub-territories among its agents. For example, certain counties may be assigned to specific agents. Areas are sometimes assigned based on zip code.

If marketing territories are assigned, the agent violates the agent/company contract when selling or soliciting insurance to consumers who live or conduct business outside his assigned marketing territory.

**THE CONTRACTED AGENT WILL RESPECT THE LIMITS OF AUTHORITY GRANTED BY THE CONTRACT**

Most contracts spell out the precise limits of authority granted to the agent by the
insurance company and/or the types of authority that are NOT granted. They also make clear the consequences of violating that authority. Some examples of the types of authority that are NOT granted include:

- To make, alter, or discharge an insurance contract on behalf of the insurance company,
- To set special premium rates, waive policy provisions, guarantee dividends, bind insurance on behalf of the insurance company, make or issue endorsements, or extend the time provided during which policyholders may pay premiums,
- Publishing or disseminating advertising that has not been approved in advance, in writing, by the insurance company,
- Waiving an answer on an application for insurance, submitting underwriting information to the insurance company in an fashion other than on an application or approved form,
- Soliciting insurance in any state, or for any product, for which the agent is not licensed and appointed

**BOTH PARTIES AGREE THE CONTRACT DOES NOT CREATE OR COMPLY AN EMPLOYER/EMPLOYEE RELATIONSHIP**

Other than in situations where the contracted agent is an employee of the insurance company (usually in cases of direct writers or captives), the agent/company contract states that the agent is not an employee of the insurance company and is free to conduct business as he sees fit—subject to the terms of the contract and all applicable state laws. Most agents and agencies are independent contractors, operating their own business and making their own decisions.

Insurance companies do not assume responsibility for the running of their agents’ operations, including paying for the agents’ expenses, handing the hiring/firing of the agents’ staffs, overseeing the agents’ training and education, managing the agents’ licensing and other administrative affairs, etc.

The payment of commissions to the agent, as described in a separate contract provision, is a further clarification of this clause, since commissions—unlike wages—are not guaranteed.

**BOTH PARTIES AGREE TO THE OWNERSHIP TERMS OF THE BOOK OF BUSINESS**

Regardless of the type of contract (i.e. agent/company, general agent/broker, direct writer, etc.), the contract designates the owner of the book of business. In situations where the insurance company contracts with captive agents, the contracts will state that the insurance company owns the books of business—meaning ownership of the policies and renewals. In situations where the insurance company contracts with independent agents, the contracts spell out that the agent owns the books of business, including all policies and renewals.

This provision is very important because the valuation of the agent’s investment is
contingent upon this clause. If the agent is a captive agent, a separate contract provision usually defines the value of the contract at termination. Value, in these cases, is usually based on the number of policies in the book of business, how many years have transpired since execution of the contract, and the policy premium values. If the agent is an independent agent, and the contract is terminated, the agent is free to place the book of business with another company or to sell it to a buyer. No value is stated in the contract. The number of policies in the book of business, and the premiums they generate, will be the basis of the book’s value should the agent decide to sell instead of simply placing the book with another insurance company.

**BOTH PARTIES AGREE TO THE CONTRACT TERMINATION DETAILS**

In all cases, agent/company contracts provide for circumstances under which the contract can be terminated by either party and what happens in the event of termination. Some states do not permit insurance companies to cancel agent/company contracts without giving a certain number of days’ advance written notice to the agent, such as 180 days. Other states don’t place such restrictions on insurance companies.

Most contracts allow either party to terminate the contract, without cause, with advance written notice; the time frame for advance notice usually runs from ten to ninety days. The majority of contracts permit immediate termination by the insurance company for cause, such as embezzlement of company funds, conviction of a felony, willful misrepresentation to the company, and failure to comply with company rules. Some contracts will automatically terminate upon the agent’s death (if the agent is an individual) or other specific circumstances.

**THE INSURANCE COMPANY WILL PAY COMMISSIONS AS SET FORTH IN THE COMMISSION SCHEDULE**

One of the few obligations of the insurance company is the contractual provision requiring the insurance company to pay the agent commissions. This clause may describe when and how commissions will be paid but most insurance companies attach a commission schedule to the contract as an addendum, thus allowing for changes to the schedule without having to amend the contract. The contract usually spells out that commissions will only be paid to the agent if the agent is duly licensed in the appropriate lines of business.

Commission levels are seldom guaranteed, in either the contract or the commission schedule, because insurance companies reserve the right to change commission levels at any time. In lines of life and health insurance, commission percentages are often higher in the first year than in subsequent years. Sometimes the decrease is gradual, such as a set level in policy years 2-4, then a lower level in years 5-9, and then nothing thereafter. In property and casualty lines of insurance, it is more common to find commission percentages to be the same throughout the life of policies. If they do reduce in renewal years, the decrease is usually not as significant as those decreases seen in life insurance.

Some insurance companies provide commission bonuses based on production levels,
years of service, persistency, and other criteria. These details are usually spelled out in the contract and/or commission schedule.

THE INSURANCE COMPANY WILL PROVIDE APPROVED COMPANY MANUALS, FORMS, AND RECORDS NECESSARY FOR THE CONTRACTED AGENT TO PERFORM HIS DUTIES

Another provision requiring an obligation on the part of the insurance company states that the insurance company will provide the agent with certain supplies, forms, manuals, guides, and other materials. This provision usually indicates that these materials are the property of the insurance company and must be returned in the event the agent/company contract is terminated.

Several other provisions in the contract refer to these manuals, forms, and records and are dependent upon the agent’s receipt of, and familiarity with, them. Agents representing several insurance companies are responsible for more contractual duties than agents representing one or two carriers. They have the responsibility to possess and maintain the company manuals, forms, and records of multiple companies and also to understand them and effectively compare the differences and make appropriate recommendations to consumers. This higher degree of responsibility places them in a position that requires them to offer a higher standard of care to both their companies and their clients.

SUMMARY

Keep in mind that the legal and contractual responsibilities and duties listed in this chapter are generic in nature and may not apply in every state or to every agent/company contract. They are, however, representative of what is considered “average” within the insurance industry.

An insurance agent must constantly do his homework, including continuous review of legislative changes in the states in which he is licensed, and regular reviews of insurance company underwriting guides, manuals, and bulletins. The insurance industry is constantly changing and failing to keep pace with those changes puts an agent in jeopardy of endangering consumers, insurance companies, and their own livelihoods.
CHAPTER 2 REVIEW QUESTIONS

1. An insurance producer owes responsibilities to all of the following parties EXCEPT _____.
   [a] Insurance company
   [b] Regulatory agencies
   [c] Consumers
   [d] Auto body repair shops

2. Which of the following types of agent acts on behalf of several principals?
   [a] Broker
   [b] General Agent
   [c] Surplus Lines Agent
   [d] Agent Cluster

3. Which of the following defines authority that is communicated in writing?
   [a] Implied Authority
   [b] Guaranteed Authority
   [c] Express Authority
   [d] Presumption of Authority

4. All of the following businesses fall under the definition of “financial institution,” per the GLBA EXCEPT_____.
   [a] Insurance company
   [b] Insurance agency
   [c] Credit reporting agency
   [d] Hairdresser

5. An agent is required to conduct business in a location that _____.
   [a] Is in the agent’s home
   [b] Is easily accessible to the public
   [c] Offers privacy
   [d] Is in the same building as the insurance company
Chapter 3

AGENT DUE DILIGENCE

An insurance agent’s duties, as discussed in the previous chapter, are to know, understand, and comply with all insurance laws while also knowing, understanding, and complying with the provisions of their agent/company contracts. In addition, an insurance producer owes a standard of care to the consumer.

This standard of care is termed due diligence. Because of the evolution of the insurance industry and consumer rights, due diligence has become—in some states and under certain circumstances—a legal obligation, as well. More often, however, it is a voluntary obligation.

Briefly, due diligence is the standard of care a reasonably prudent individual would exhibit given the same set of circumstances. The purpose of due diligence is to require a person to act in such a way that his actions (or failure to act) will not prove harmful, or detrimental in any way, to another person or persons.

The precise definition of due diligence varies by business industry. In manufacturing, for example, it requires environmental standards to be documented and verified in a site assessment called a “Due Diligence Report.” In venture capitalism, it requires investigation into the history of the individuals involved, as well as into the history and structure of the companies requesting funding. A “Due Diligence Checklist” is required, citing the areas that must be addressed by the investigation.

HISTORY

The term due diligence became popular as a result of the U.S. Securities’ Act of 1933. The Act was enacted by Congress in response to the stock market crash in 1929 and its purpose was twofold:

1. To require that salespersons give the public informational material when offering securities for sale, and
2. To prohibit misrepresentations, deception, and fraud in the sale of securities to the public

In the U.S. Securities Act of 1933, a defense was included that could be used by broker-dealers if they were accused of failing to properly disclose material information about securities to investors during the sale of those securities. The defense was titled the “Due
Diligence Defense.” So long as broker-dealers exercised due diligence as described in the Act, they would not be held legally liable for the failure to disclose if an investigation were launched against them alleging an improper standard of care during the sales process. The securities industry soon banded together and promoted the standard practice of carrying out due diligence investigations of any stock offerings in which they were engaged.

The term *due diligence* was initially used only with respect to the public offerings of equity investments. Since then, however, it has been used in the investigations of private mergers and acquisitions, in the insurance industry, and in other business arenas. In today’s society, due diligence is required in business transactions of all types. The standard of care required will depend upon a number of things, primarily the business industry, and also such business concerns as:

- Financial matters,
- Legal, labor, and tax issues,
- IT departments,
- Intellectual property,
- Real and personal property,
- Insurance coverages,
- Employee benefits,
- Debt instrument review,
- Labor matters,
- Immigration,
- International transactions,
- Business environment, and
- Marketing

**STANDARDS OF CARE**

Most consumers are not familiar with the laws governing insurance agents and the duties and responsibilities with which they are charged. Consumers, however, share the expectation that their insurance agents will be knowledgeable. Not only about the products they sell, but also about the intricate details of each policy: terms, conditions, limits, and exclusions.

Of course, consumers doesn’t use the insurance terms agents use, but when asked to define their expectations in this regard, it is clear they want their insurance agents to be able to answer their questions, explain how the policy works, and provide examples of what will, and will not be, covered by the policy.

Being *knowledgeable*, however, goes a step further than simply having the ability to understand and explain all facets of an insurance policy. It also encompasses the agent’s ability to communicate effectively with consumers. Meaning: the agent not only needs to know how to make himself understood, he also needs to understand the consumer—
regardless of the quality of the consumer’s communication skills.

When a consumer visits with an insurance agent and says he wants to insure the new car he just bought, he seldom tells his agent precisely why he’s decided to buy an insurance policy or what coverages he wants to buy—and at what limits. Most consumers visit with insurance agents and although they know they want to be treated well and work with a professional, knowledgeable agent, they rarely take the lead in conducting the insurance interview: they expect the agent to do so.

**EXAMPLE:** Mr. Smith strolls into an insurance agency and informs the insurance agent, Miss Jones, that he just bought a vehicle and wants to insure it. Mr. Smith pulls a piece of paper from his pocket and tells Miss Jones that he has written down the coverages he wants.

Is it reasonable for Miss Jones to believe Mr. Smith simply wants her to act in the capacity of an order taker? Or is it reasonable for her to ask him some questions to determine a few things, such as:

*Why did he choose her agency?*
*Why does he want the particular coverages listed on the piece of paper?*
*Does he want her to show him a list of all available coverages and limits?*
*Does he want her to evaluate his lifestyle and needs so she can make insurance recommendations based on those issues?*

When recalling the concept of *due diligence*, what might come to an agent’s mind is the question: *What would a reasonably prudent insurance agent do given this precise circumstance?*

Some agents may believe that simply taking the order is exhibiting due diligence. After all, the client is an adult and he communicated what he wanted. Other agents may choose to go the route of asking questions and taking the risk of offending the consumer because they believe exhibiting due diligence involves asking questions and making recommendations.

In the case of the agent who chooses to be an order-taker, and who interprets the consumer’s behavior and statements as belonging to an individual who knows precisely what he wants, what if the agent is wrong? What if the consumer never purchased auto insurance before and was embarrassed to admit his lack of familiarity with it? What if the consumer copied the coverages and limits from his mother’s insurance policy onto the piece of paper, believing his mother was bound to have appropriate coverage? The agent would comply with the consumer’s request, believing she did precisely what the consumer wanted.

On the other hand, what if the consumer *did* know precisely what coverages and limits he wanted because he’d purchased auto insurance a number of times before? What if he wasn’t interested in “reviewing his options” and receiving recommendations from the agent? What if he would appreciate the agent simply taking his order and saving him the
time and aggravation of a Q & A session he believed was unnecessary? The agent might irritate that consumer if she asked questions and make recommendations. Her questions might even encourage him to leave and take his business elsewhere: to an agency that simply took his order. Or, the consumer might thank the agent for her show of professionalism and conscientiousness and affirm that he knows what he wants and doesn’t require her assistance in making his decision.

How does an agent figure out which route to take in such a situation? Asking herself the question, *What would a reasonably prudent insurance agent do given this precise circumstance?* isn’t necessarily going to provide her with a solution. Some reasonable agents will opt to be an order-taker and other reasonable agents will opt to be an advisor/consultant. The best way to evaluate how to exhibit due diligence would be for the agent to consider the potential consequences of each option available to her.

After a loss, the primary concern of a consumer is his need: how much insurance does he need to avert financial disaster? He’ll want to know what types of coverage he has—and at what limits. Unfortunately, in far too many instances, the consumer’s primary concern *before* the loss—when choosing coverages, limits, and premium—is not need so much as it is the ability or willingness to pay OR the consumer’s capacity for envisioning himself the victim of catastrophe or financial disaster. When an insurance agent explains what could happen, or what might happen, a consumer may have a difficult time translating the hypothetical situation into his own life. Quite often, the consumer’s estimation of the likelihood of catastrophe occurring are quite small—even when he’s looking at a guaranteed annual outlay of X number of dollars to buy more insurance.

**EXAMPLE:** The consumer in the previous example, Mr. Smith, left the insurance agent’s office after purchasing insurance. On his way home, he ran down three pedestrians, sideswiped two parked cars, and crashed his car through the front window of a restaurant. Would the way the agent have handled the consumer’s auto insurance purchase have any effect on how the claim would be handled? Absolutely!

**Scenario #1: Agent was an order taker.** After the accident—when the consumer is sued by the parents of the teenage pedestrians, the owners of the two parked cars for damages to their vehicles, and the owners of the restaurant for damage to their building and business personal property, and their business interruption loss—will the consumer believe the insurance agent treated him appropriately and helped him secure the insurance coverages he needed?

Will he believe the agent understood how an auto insurance policy works and all the ramifications of his purchase of the coverages and limits he chose? Will he understand that the limits of liability he purchased are all the protection he has and, if the claims of the injured parties exceed the limits of insurance he purchased, he will be personally responsible for the excess? Unlikely.

What *is* likely to occur is that the consumer will sue the agent for failing to exhibit due diligence. The suit will likely claim that the agent did not explain the consumer’s options
and did not offer coverages and limits other than those jotted on the piece of paper the consumer showed her. The consumer will state that the agent, in fact, was an order-taker and exhibited none of the knowledge of a professional insurance agent and that she offered none of the professional advice and recommendations a reasonable and prudent insurance would have made. Even though the agent will claim she did precisely what the consumer asked—no more and no less—it is very likely she will lose the lawsuit because she is unable to document that she did do precisely what the consumer asked.

**Scenario #2: Agent asked questions and made recommendations.** Using the same accident, will the consumer believe the agent knew and understood the auto insurance policy she sold? Maybe yes, maybe no. However, if he claims the agent didn’t explain his options or the potential negative consequences of purchasing minimum limits, and he alleges the agent failed to exhibit due diligence, she’ll be able to defend herself. If the agent asked questions and/or made recommendations, [one would hope] she documented her actions. If the consumer declined to answer her questions and rejected her offer to make recommendations, she’d have had him sign a form indicating that he chose his minimum limits freely and didn’t care for her advice OR she showed him a proposal with additional coverages and higher limits and had him sign off on it. Such documentation is proof that she was a knowledgeable and professional agent and that she did exhibit due diligence.

Of course, the two previous scenarios are used simply for illustrative purposes. The balance of this section is devoted to actual claims and lawsuits that involved situations where agents were accused of failing to exhibit due diligence. The outcomes of each situation will be noted, along with details about how the agent was determined to have acted diligently or what the agent could have done to be considered duly diligent.

**OBTAIN ALL INFORMATION DIRECTLY FROM THE INSURED/APPLICANT**

Carvie and Joseph Mason owned a home and purchased a homeowner insurance policy written by Augusta Mutual Insurance Company. The agent who sold them the policy was Herbert Jones and he worked as an agent for Lee-Curtis Services, Inc.

The Masons’ home was destroyed in a fire on Christmas day in 2004 and the insurance company subsequently denied coverage. According to Augusta Mutual, they had in their possession a Woodburning Stove Inspection Report completed and signed by Carvie Mason indicating, incorrectly, that the stove’s flue was made of tile-lined masonry material. The Masons claimed they never completed the report and that the signature appearing on the report was not Carvie Mason’s signature. The Masons filed suit against the insurance company for wrongful denial of coverage.

The insurance company, in turn, filed suit against Herbert Jones and Lee-Curtis because, it claimed, Herbert Jones completed the report and signed Carvie Mason’s name on it, knowing the information it contained was inaccurate. The insurance company won a breach of contract suit because Herbert Jones and Lee-Curtis violated the agency agreement, which required “due diligence in obtaining accurate information and making
It is quite possible that Herbert Jones believed the information he entered on the report was accurate based on previous conversations he’d had with the Masons or his personal inspection of the wood stove. In fact, it is also possible he called the Masons to obtain the information necessary to complete the report. Unfortunately, the fact that he completed the report and signed Carvie Mason’s name gives the appearance that he committed fraud and forgery.

*Due diligence* requires the agent, at all times, to obtain information directly from the client, and to avoid guessing when completing applications, forms, surveys, and reports. It also requires the agent, at all times, to secure the client’s signature.

(Augusta Mutual Insurance Company vs. Mason--No, 061339-Supreme Court of Virginia--June 8, 2007)

**COVERAGE RECOMMENDATIONS**

David and Pamela Waleri purchased an insurance policy from State Auto Mutual Insurance Company in April 1997 to cover The Island House Inn. Their agent was Roland Chapman.

In January 1999, six low-pressure boilers at the inn failed, causing the inn to close until repairs could be completed. The Waleris submitted their claim for business interruption and the claim was denied by the insurance company because their policy did not provide coverage for business interruption losses resulting from mechanical failure of the boilers.

Court records show the following facts:

- Prior to the purchase of the policy in 1997, the Waleris and Roland Chapman did not have a business relationship
- After making arrangements to purchase the Inn, the Waleris told Roland Chapman what insurance coverages they wanted to purchase
  - The Waleris did not request business interruption insurance
  - Roland Chapman did not offer business interruption insurance
- David Waleri held a college degree in business and finance from Ohio State University, was an experienced businessman, and had previously owned several businesses
  - David Waleri did not ask Roland Chapman to offer insurance advice or recommendations
- Prior to purchasing the property, David Waleri ordered a property inspection, which revealed issues with the boilers
- After receiving their new policy, neither David nor Pamela Waleri reviewed it
- At renewal of the policy, neither David nor Pamela Waleri indicated they wanted coverage for business interruption
- At no time after purchasing their policy and before the loss did either of the Waleris read or review their policy
The court agreed with the Waleris’ charge that an insurance agent has a duty to advise his client but it also stated that an insured also has a duty to review his policy and to request insurance advice if he wants it. The court entered judgment in favor of the insurance company and the agent.

Because of the extent of the information available in this case, and the fact that David Waleri was a businessman who’d owned, and presumably insured, previous businesses, the consumers did not prevail. It is quite possible that Roland Chapman had documentation indicating that the Waleris simply placed an order.

It is recommended in all cases that the agent secure the consumer’s signed statement indicating he does not want insurance advice or recommendations in situations where the consumer is simply placing an order.

(The Island House Inn, Inc., et al., Appellants, v. State Auto Insurance Company, a.k.a State Automobile Mutual Insurance Company-No. OT-02-022-Court of Appeals of Ohio, Sixth District, Ottawa County-December 20, 2002)

NO SIGNED APPLICATION

A national E & O carrier reports that an agent obtained insurance coverage for a client who rented space in a building. After the policy was issued, the client accidentally caused an explosion and fire that destroyed the building. During the insurance company’s investigation of the loss, the adjuster learned that during the course of the insured’s regular operations, dust from highly flammable material was emitted into the air. It was the ignition of the flammable dust that caused the explosion and resulting fire. The insurance company denied the claim, citing that it would not have insured the client had it known the true nature of the operations.

The client sued the agent, claiming the agent was fully aware of his operations and should have reported it to the insurance company. The agent, on the other hand, claimed the information on the application correctly represented the information the client had provided. Unfortunately, the agent never obtained the insured’s signature on the application. Because of the agent’s failure to secure the insured’s signature, he was unable to prove that he had exhibited due diligence.

INSPECTIONS AND RECOMMENDATIONS

A landmark court case took place in 2006 that clearly details the scope of the duty owed by insurance brokers when assisting them with the placement of insurance coverages.

The facts of the case are:
- Mark and Elizabeth Wisniski owned commercial property in Millersburg, Dauphin County, PA
- In 1994, they purchased commercial property and liability insurance coverage from the Brown Agency, an insurance brokerage, after engaging in several telephone conversations with two different representatives of the Brown Agency
• Neither representative of the Brown Agency inspected the property; both recommended the purchase of both property and liability insurance; neither recommended flood insurance or explained that the peril of flood was excluded on the policy the Wisniskis purchased
• The policy renewed each year from 1994 to 1998
• In 1995, the insurance company inspected the property to perform a risk analysis; the inspector identified certain risks, brought them to the attention of the Wisniskis, and made recommendations to mitigate the risks
• The inspector also noted the presence of the Susquehanna River on the opposite side of the highway from the insured property and that a stream leading to the river ran across the insured property beneath the insured building; the inspector did not recommend the purchase of flood insurance
• A flood occurred in September 1999, allegedly causing building and personal property damage in excess of $375,000, and the Wisniskis submitted a claim to the insurance company
• The insurance company denied coverage due to the flood exclusion in the policy
• The Wisniskis brought suit against the insurance company and the Brown Agency, alleging that the Brown Agency failed in its duty to inspect the property and make coverage recommendations based on the inspection

The trial court decision was appealed and the Supreme Court considered a number of factors before making final judgment in favor of the Brown Agency:

1. No Principal/Agent relationship existed between the Brown Agency and the Wisniskis; because the Brown Agency was a broker, it “lacked the power to bind to any particular insurance contract;” the Court further cited: “…for ordinary negligence purposes, the relationship between an insurance broker and a client is an arm’s length business relationship.”

2. No social utility can be derived from the Brown Agency’s inspection of property before make insurance recommendations; while a property inspection may assist a broker in better understanding a client’s risks and exposures, the value of the property to be insured, and the overall extent of coverage that may be necessary—a broker is not necessarily a specialist in either risk assessment or property inspection.

3. Although the Wisniskis claimed the Brown Agency should have foreseen that a flood loss would occur and should have recommended insurance coverage to protect them from such a loss, the Court held that the nature of the risk versus the foreseeability of harm did not weigh heavily either for or against the Wisniskis’ position.

4. The Court considered the consequences of imposing a duty upon the Brown Agency and held that it would be “onerous” to require insurance brokers to owe the duty to inspect commercial property they insure and to make insurance recommendations based on their inspections. The distinction, the Court further stated, was pertinent because the Brown Agency was a broker—and not an insurance company or an insurance agent. It also said that if the duty is required of brokers with respect to commercial property insurance, it would be reasonable to expect that same duty to extend to insuring homes, cars, boats, and other
tangible property.

5. The Court’s final consideration pertained to the public interest in its final decision. It held that it doesn’t believe a strong public interest exists in requiring insurance brokers to inspect commercial property before insuring it and provide insurance recommendations based on its inspections.

The two major deciding factors in this case had to do with the Brown Agency’s status as insurance broker (not agent) and the fact that if a duty were imposed with respect to commercial property inspections, it would be reasonable to impose that same duty when insuring other types of property. The Court found in favor of the Brown Agency, however, if it had made a flood insurance coverage recommendation or, at the very least, informed the Wisniskis that flood was an excluded peril on their policy, it is likely the question of due diligence and their duty to the Wisniskis would not have been questioned.


FAILURE TO PROVIDE ACCURATE INFORMATION

One of the things insurance agents know is that insurance companies do not insure every risk that seeks coverage. Sometimes a building has issues that make it uninsurable: an inadequate electrical system, no central heating system, or an ineligible occupancy. Sometimes a consumer has issues that make him uninsurable: he conducts business operations that disqualify him from coverage or he has an unacceptable loss history.

While it is frustrating to have a relationship with a “good” client and be unable to secure insurance coverage on his behalf, failing to inform the insurance company of material information pertaining to the risk in an effort to “help” the client secure coverage is not interpreted as exhibiting due diligence. The client might appreciate being able to insure his home with a particular agent when four previous agents were unable to secure coverage, but it’s a sure bet that if a claim is denied because of a material misrepresentation, that client will view his agent’s “help” in a different light.

A national E & O carrier reports that Mrs. X applied for homeowner insurance. Although Mrs. X informed the agent she had a German Shepherd when he asked her if she had any dogs, the agent did not include her truthful answer on the electronic application he submitted to the insurance company. Instead, he selected “no.”

Sometime later, the dog chased and bit Mrs. X’s mail carrier. The mail carrier fell, suffered a serious leg fracture, and submitted a claim under Mrs. X’s homeowner policy. The insurance company denied coverage because of the material misrepresentation on her part, citing it would not have issued the policy because ownership of a German Shepherd dog is listed as an ineligible exposure in its underwriting guidelines. During investigation of the claim, it became evident that the agent was liable and his E & O carrier paid the claim.

In situations such as this, the agent may believe securing coverage is helping his client
and that withholding information, or providing false information, is acceptable. The agent may have all good intentions; however, the best interests of a consumer are never served by misrepresenting anything about him, his exposure, or any insurance transaction.

Remember the question: *What would a reasonable and prudent insurance agent do in these precise circumstances?* *Tell a lie* is not the correct answer.

**WHAT AN AGENT KNOWS, THE INSURANCE COMPANY SHOULD KNOW**

It is especially important to note that agents who hold an agent’s license are considered fiduciaries of the insurance companies they represent. Yes, they owe consumers fiduciary duties, but their primary loyalty is owed to the insurance companies. In fact, many state insurance codes spell this duty out.

In addition, agent/company contracts usually contain a provision requiring the agent to report promptly all information pertinent to underwriting risks and claims. For example, if an agent drives by a client’s home and sees a trampoline in the back yard, the agent is required by both the agent/company contract and his fiduciary duty to the insurance company to report the existence of the trampoline. In another example, the agent watches a client exit from his car in the parking lot. Although the client is smoking in the parking lot, he does not have a cigarette in his hand when he enters the office. Ten minutes later, when the agent and the client are completing a life insurance application, the client claims to be a non-smoker. The agent should inform the insurance company that he saw the agent smoking.

Why should the agent “tattle?” Because, first of all, the agent/company contract says so! Secondly, the insurance company’s underwriting guidelines indicate that trampolines are an ineligible liability exposure and that individuals who are nicotine users are rated higher than those who are not nicotine users. Insuring a homeowner with a trampoline, and issuing a nicotine user a policy with non-nicotine rates, places the insurance companies in financial jeopardy. Since the agent is the insurance company’s fiduciary, he is required by law to place the insurance company’s interests before his own and those of his client. Thirdly, if an agent fails to provide information he knows, he could be committing “concealment,” which is defined as *the willful holding back or secretion of material facts pertinent to the issuance of an insurance policy or a claim, even if the insured or applicant was not asked about the subject*. Concealment is considered a serious breach of contract, duty, and ethical principles. It can result in cancellation of the policy or denial of a claim.

In keeping with this aspect of *due diligence*, a national E & O carrier reports that an agent issued a homeowner policy to Mr. Y, as he requested. Although he was married, Mrs. Y’s name was not on the policy. After the couple divorced, Mr. Y moved from the home. The insurance agent asked the couple to change the names on the policy but Mr. Y refused, insisting that he and his ex-wife would reconcile.
The home was destroyed by fire and, when Mrs. Y submitted a claim, the insurance company denied the claim because Mr. Y, the named insured, was not a resident at the time of the fire. Mr. and Mrs. Y sued the insurance agent, claiming he was an agent of both Mr. and Mrs. Y (Law of Agency; Mr. and Mrs. Y were the Principals and the agent was the Agent) and he should have rewritten the policy upon learning of the divorce.

Now, on one hand, agents aren’t authorized to make policy changes without the consent of their clients. On the other hand, however, the agent could have sent letters to both Mr. Y and Mrs. Y, asking for details about any change in ownership and residency—and sending a copy of the letter to the insurance company. The letters should also have spelled out the consequences of failing to change the policy to reflect any ownership and residency changes.

In cases of divorce, which are rife with tension and the potential for insurance difficulties, it is especially important for agents to remember they owe a standard of care to all named insureds and not just one person of the divorcing couple.

**SPECIFIC COVERAGE RECOMMENDATIONS**

In 1995, the case of Southwest Auto Painting and Body Repair, Inc. v. Binsfeld addressed the duty an agent owes to recommend or advise the need for particular types of insurance coverage. The Court found that the duty an agent owes is to “exercise reasonable care, skill, and diligence in carrying out the agent’s duties in procuring insurance.”

Robert Lanzon was an owner of Southwest Auto Painting and Body Repair, Inc. He purchased insurance coverage for his business from Joe Binsfeld in 1987, after having met with Binsfeld in 1986 and deciding to do business with him because he hoped that Binsfeld would refer clients to his business for auto body repair work.

Binsfeld recommended certain coverages for Southwest, Lanzon was satisfied with the coverages and premiums quoted, and—because Lanzon claimed to rely upon Binsfeld’s expertise and advice—he purchased coverage. The issue of employee dishonesty, embezzlement, or theft was never discussed between the two and Lanzon later claimed that he neither knew his policy lacked such coverage or that it was available for purchase.

Between 1986 and 1989, when Southwest was insured with the agency for whom Binsfeld worked, one of Southwest’s employees embezzled approximately $150,000. When Lanzon discovered the embezzlement, he contacted the agency for whom Binsfeld worked to inquire if his policy provided coverage for embezzlement and was informed that it did not.

Southwest sued both Binsfeld and his employer, claiming their failure to offer or give advice about the need for employee dishonesty coverage lacked a standard of care expected of an insurance agent or broker who obtained insurance coverage on behalf of a business. Southwest further alleged that Binsfeld and his employer held themselves out as experts in the insurance business and, as such, they should have been advised properly to purchase employee dishonesty coverage. The Court recognized that the general duty
of an insurance agent is to “exercise reasonable care, skill, and diligence in carrying out the agent’s duties in procuring insurance.” Because no “special” relationship existed between Southwest and either Binsfeld or his employer, they did not owe a “special” standard of care to offer specific coverage.

**COVERAGE OR EXPOSURE CHECKLIST**

Although many court cases indicate that agents and brokers do not have a legal responsibility to offer or recommend specific insurance coverages unless a special relationship exists between themselves and consumers, providing a coverage or exposure checklist may help eliminate claims of failing to offer a reasonable standard of care to consumers.

For illustrative purposes, the following shows a commercial coverage checklist:

<table>
<thead>
<tr>
<th>COMMERCIAL INSURANCE CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check any of the following activities or coverages that apply to your business OR that you are interested in insuring:</td>
</tr>
<tr>
<td>Leasing or renting vehicles</td>
</tr>
<tr>
<td>Using personal vehicles on the job</td>
</tr>
<tr>
<td>Employee dishonesty</td>
</tr>
<tr>
<td>Theft</td>
</tr>
<tr>
<td>Computer fraud</td>
</tr>
<tr>
<td>Bodily Injury Liability</td>
</tr>
<tr>
<td>Personal Injury Liability</td>
</tr>
<tr>
<td>Medical Payments</td>
</tr>
<tr>
<td>Products Liability</td>
</tr>
<tr>
<td>Contractual Liability</td>
</tr>
<tr>
<td>Pollution or asbestos liability</td>
</tr>
<tr>
<td>Leased or temporary workers</td>
</tr>
<tr>
<td>Additional Insures</td>
</tr>
<tr>
<td>Building</td>
</tr>
<tr>
<td>Other structures</td>
</tr>
<tr>
<td>Property rented to others</td>
</tr>
<tr>
<td>Flood</td>
</tr>
<tr>
<td>Earthquake</td>
</tr>
<tr>
<td>Computer equipment</td>
</tr>
<tr>
<td>Personal property off-premises</td>
</tr>
<tr>
<td>Records/valuable papers</td>
</tr>
<tr>
<td>Off premises power, water, communication</td>
</tr>
<tr>
<td>Employee benefits liability</td>
</tr>
<tr>
<td>Directors &amp; Officers Liability</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

Many agents/agencies include a disclaimer on their checklists to indicate that the list of coverages is not exhaustive and that any specific coverage inquiries and
recommendations should be discussed in a face-to-face meeting between client and agent.

DUTY TO DISCLOSE

In the insurance industry, insurance companies, agents, and brokers are required to disclose information to the consumer. In fact, insurance companies often transfer their legal obligation in this regard to the agent, because the agent is the individual who meets face-to-face with the consumer. Required disclosures include those mandated by the federal government (i.e. Fair Credit Reporting Act and the Health Insurance Portability and Accountability Act) and those ordered by state legislators (i.e. sales of annuities and long-term care insurance).

Why is the duty to disclose required of insurance professionals and what, specifically, do they need to disclose to consumers?

HISTORY OF DISCLOSURE

In England in the 1700s, when the first insurance legislation was passed for the protection of the public, it usually addressed practices that were considered to be fraudulent or gross malpractice on the part of insurance practitioners. In fact, based on the implementation of that early legislation, a clear disparity appeared between what occurred in practice and the legal position.

Many insurers at that time were fellow merchants of the insured parties who underwrote risks as a part-time venture. Their actuarial and statistical data for determining premiums was weak—or non-existent—affording the insurers a far less advantageous bargaining position than policyholders when a dispute arose, especially since the policyholder knew more about the risk than the insurer did. As a result, the majority of the legal decisions and principles handed down by the courts were in favor of insurers.

William Murray 1st Earl of Mansfield took office as a Lord Chief Justice in the highest court in England in 1756 and, during his time in that position (through 1788), many of the case decision and principles he established are still in practice today—both in England and the United States: insurance contracts must be contracts of good faith, the duty of disclosure, how misrepresentation and non-disclosure affect the insurance contract, the effect of fraud on the insurance contract, and how warranties affect the insurance contract.

In the United States, the duty disclose in the sales of life insurance products began to become a concern in the late 1800s. In April 1870, the New York insurance commissioner made his eleventh annual report to the Insurance Department and stated: “Each new company announces some new feature in its business, which is to inure greatly to the advantage of the insured, and thus, with some seventy different companies, each urging their superiority over all others, he who seeks insurance, if he stops to hear all the arguments, and deliberately determine which is really the best company, is likely
to die before he reaches a conclusion.”

In 1905, Miles Menander Dawson, a well-known insurance actuary who published many books, criticized the marketing of life insurance as an investment to the public. He said in *The Business of Life Insurance*: “It can be marketed, therefore, only by pretending that in some subtle way, not easily comprehended, the deductions from the principal are going to be made good out of the earnings and a round profit be realized on the entire payments.”

In 1968, Juan B. Aponte and Herbert S. Denenberg stated in "A New Concept of the Economics of Life Value and the Human Life Value: A Rationale for Term Insurance as the Cornerstone of Insurance Marketing," *Journal of Risk and Insurance*, September 1968: "Perhaps the entire structure of life insurance marketing needs retooling, as it relies almost exclusively on a marketing force promoting an investment, yet basically untrained in matters of investment. In making an investment use of life insurance, the insurance oriented salesman is generally more conversant with the advantages than the disadvantages of his recommendations. What is needed is an insurance-investment counselor who has no special financial interest in any investment alternative and is also conversant with all major alternatives. Today, the typical insurance salesman not only does not fully appreciate investment alternatives, but he often has little understanding of the investment element of life insurance. And his limited knowledge is strongly warped by his interest in the commission structure of his product."

According to Glenn Daily (on his web site [www.glenndaily.com](http://www.glenndaily.com)), a consulting actuary offered some advice to life insurance companies in a meeting of the Society of Actuaries in May 1997: "Companies need to become much more consumer oriented. This is going to allow consumers to understand the products more, which will make the sales easier, which allows us to pay agents less per sale. I think we need to try to improve the quality of information. If you ask your friends from outside the insurance industry what insurance products they have, ask them to explain why they have those products. See how many can give you anything more than vague answers. Then, read the material the insurance companies are giving these people. See how many paragraphs you have to read over three or four times to understand what the product is and how it works. What chance does your average consumer have of understanding these products?"

The sales of annuities is a hot topic in the current marketplace, with not only the Securities and Exchange Commission (SEC) and the Financial Industry Regulatory Authority (FINRA)--formerly the NASD--stepping in to increase protection afforded to consumers, but state regulators doing so, as well. Annuities were first sold in the United States in the mid-1700s when a Pennsylvania insurance company formed for the benefit of Presbyterian ministers and their families. In addition to selling life insurance products, the company also sold annuities. In 1912, the first insurance company to sell individual annuities, instead of group annuities, also formed in Pennsylvania: the Pennsylvania Company for Insurance on Lives and Granting Annuities.

It wasn’t until the 1930s, and worries about the condition of the nation’s financial
markets persuaded consumers to purchase financial products from insurance companies. FDR’s New Deal Program offered several plans to encourage the populace to save for its own retirement.

The original annuity contracts were very basic when compared with today’s policies; they:

- Guaranteed a return of principal,
- Offered a fixed rate of interest during the accumulation period,
- Offered settlement options that allowed a fixed income for life or payments for a specific number of years

One of the benefits of annuities has always been their tax-deferred status; as insurance contracts, annuities always allowed policyholders to take advantage of the time-value of their money.

The annuity landscape began changing in the 1950s, when the first variable annuities were introduced. Instead of guaranteeing a return of principal and a fixed rate of interest, variable contracts credited interest based on the performance of separate investment accounts within the annuity contract. The contract holders were able to choose their own investment accounts and, in exchange for fewer guarantees, were able to assume both a greater risk and the potential for greater returns.

Since the first variable annuities were established, a number of features have been added to the contracts, thus increasing their complexity. Because of the increasing popularity of mutual funds, fund managers began creating separate accounts insurance companies were able to use for annuities. Again, the tax-deferred status awarded to annuities, because they are defined as insurance contracts, made them very attractive to the public.

As annuity contracts grew more complex, so did the task of explaining them to the consumer. Although insurance agents are aware of the technical aspects of insurance and annuity products—the average consumer is not. Many consumers simply assume that if they purchase an annuity and choose to cancel it, they will receive all their money back, plus interest. Even though agents perform suitability evaluations before the purchase by asking the consumer numerous questions about his goals, objectives and needs, and even though the agent completes a risk tolerance questionnaire before the purchase to determine the consumer’s investment philosophy, the consumer doesn’t always understand precisely what agents mean or how his decision will affect him at some undetermined point in the future.

**TYPES OF DISCLOSURES**

Regardless of the line of insurance, agents have duties to disclose a myriad of information to consumers. Some agents choose to provide all clients with a disclosure notice upon entering into a business relationship. A sample disclosure is later in this material provided here for educational purposes. Please note: before providing any type of disclosure letter, be sure to obtain approval from both an attorney and the insurance companies being represented.
The obligations of both the insurance company and agent should be fully disclosed in the agency contract, general agency contract, or other documents such as underwriting guides and employee or agent handbooks. Agents should be clear on the following issues:

1. What the agent is permitted and not permitted to do
2. What waivers, if any, are given and under what circumstances they are given
3. Which laws prevail in the states in which the agent does business
4. Supervision, commissions, audits, indemnification, special conditions, termination conditions, etc.
5. What disclosure documents are required by the insurance company and state and federal governments, including:
   a. During the proposal process,
   b. During the sales process,
   c. During the application process,
   d. During delivery, or at issue, of the policy
   e. After delivery/issue of the policy,
   f. At policy change,
   g. At policy renewals or anniversaries

As an agent’s responsibility grows, so does his accountability. Some agent/company contracts now include clauses that hold the agent responsible for E & O claims that result from his activities. Other contracts contain clauses that require personal indemnification.

**AGENT/CLIENT DISCLOSURES**

A disclosure appears on the next page and is clearly between a broker and his client. While an agent’s duty to disclose is, according to law, higher than that of a broker, some agents choose to utilize an agent/client disclosure to illustrate their awareness of, and willingness to comply with, such duty.

An agent/client disclosure could also contain provisions in addition to those shown below that document the client’s declination of some or all of the services the agent/broker is willing to provide. The disclosure might also contain specific references to policy coverages and endorsements that are available, with the client’s signature attesting to the fact that the agent/broker discussed their availability with the client.

Agents and brokers also find disclosures valuable when they want to disclose the limited nature of their duties. For example, brokers might want to disclose that they do not perform property inspections or offer insurance recommendations unless specifically requested to do so in writing. Agents might want to disclose that while they may offer coverage recommendations, they are not responsible for making the final determination of the client’s exposures or insurance needs. Either disclosure might also contain reference to the fact that the agent or broker is not responsible for reviewing leases, agreements, and other documents they may affect the client’s insurance needs obligations.

Another type of disclosure form often used by property and casualty agents and brokers is an Exposure and Analysis Checklist. This form asks a number of questions about the
client’s potential for loss, specifically in areas that might expose the client to gaps in coverage or policy exclusions. These forms are similar in design to risk management checklists, loss control checklists, and suitability checklists. The purpose is the same on all checklists: bring to the client’s attention areas of exposure he might not otherwise be aware of. When providing a client with this type of disclosure, it is always recommended to secure the client’s signature and the date signed.

Dear Client,

You should be aware that we not an insurance company but are an insurance agency. This means that our services are limited to pricing and presenting a variety of insurance coverages designed to suit your needs, in addition to submitting insurance application(s) to various insurance companies. Our services, however, have certain limitations, such as:

- The calculations of quotations and premiums are performed by the insurance companies and may change from time to time. We do not guarantee that any coverage or premium quoted will be identical to those of policies the companies issue. The terms of the policy contracts will contain the details of coverage the policies will provide. Your acceptance of any policies will supersede all earlier agreements, either verbal in writing.

- We are happy to present and explain insurance industry financial ratings of certain companies or alternate insurance companies to you at your request, but we do not undertake to make any independent verifications of a particular company’s financial condition. We offer no guarantees that a particular insurance company will stay financially sound while you remain a policyholder; neither can we be accountable to any client for an insurance company’s failure to pay claims.

- Insurance companies depend on the accuracy of information provided in the applications and forms they receive; it remains your sole responsibility to provide accurate information in all applications and forms. If the insurance companies determine that a claim made by you is inconsistent with the facts given in the applications or forms you provided, we are not responsible for such inaccuracies.

We ask our clients to confirm their understanding of the above-mentioned details by signing and dating this form where indicated below and returning it to us.

Accepted by ______________________________

On ____________

In a 1988 California legal case, the agent’s agreement with his client contained, in part, the following disclosure: “This proposal is written for your convenience and is not meant to be a complete document detailing your policy terms or coverage. Actual policy language will spell out the extent and limits of coverage and protection provided.” The agent believed this statement would resolve him of any liability should the insurance
coverages purchased prove to be inadequate. Unfortunately, he was found accountable for the client’s subsequent loss because, although his proposal listed eight specific policy exclusions, it did not list the exclusion that pertained to the peril that caused the client’s loss.

A dissatisfied client might resort to legal action at any time. An agent, however, may be able to avert lengthy and costly litigation by knowing, and complying with, all disclosure requirements of his insurance company, as well as those of state and federal regulations.

**AGENT/BROKER COMPENSATION DISCLOSURES**

On February 10, 2010, the state of New York enacted regulation that requires insurance agents and brokers to disclose details of their compensation to consumers. The new rule goes into effect in January 2011 and was hotly contested by the Independent Insurance Agent and Brokers Association of New York (IIABNY).

According to New York insurance commissioner, James J. Wrynn, “This regulation will provide New Yorkers buying insurance with an important tool to use in making an informed decision. Almost everyone buys insurance at some point, and in these difficult economic times, consumers should understand any incentives that may potentially affect the recommendations from their agents or brokers.”

IIABNY threatened to sue New York regulators if an earlier and stricter version of the proposed regulation was enacted. The earlier version of the disclosure would have required the agent or broker to state whether he represented the insurance company or the consumer in the transaction and would also have required compensation disclosure on all policy renewals.

The currently published version of the rule requires producers to disclose to the consumer:

- The agent or broker’s role in the transaction;
- Whether the agent or broker will receive compensation from the insurer based on the sale;
- That the compensation insurers pay to agents or brokers may vary depending on the volume of business done with that insurer or its profitability; and
- That the purchaser may obtain more information about the compensation the agent or broker expects to receive from the sale by requesting that information from the agent or broker.

If the consumer asks for particular information about compensation, the agent or broker must provide it in writing within five business days of the request. Many members of the insurance industry believe that such disclosure only fosters confusion among consumers rather than clarifying issues.

Consumers do not realize that insurance agents are paid solely on commission and commission payments are only made when agents sell policies. Even if they understand
the concept, they sure won’t understand or appreciate the amount of time agents spend preparing proposals, collecting information, comparing the products offered by a variety of company, and completing paperwork—in addition to the actual time spent face-to-face with consumers.

Efforts to bring transparency to agent compensation in New York began when its State Attorney General, Eliot Spitzer, joined with New York state insurance regulators to investigate a number of brokerage firms because of alleged bid-rigging schemes. The investigation led to bans on contingent commissions. (Contingent commissions rely upon certain factors, such as satisfactory loss ratios or production requirements.) Other states that have passed legislation requiring agent/broker compensation disclosures include Nevada and California.

LIFE INSURANCE DISCLOSURES
The NAIC adopted model state law for the disclosure concerning the cost and benefits of life insurance policies being considered for purchase. Most states have enacted legislation requiring similar disclosure that requires the insurance company and agent to:

• Provide a buyer’s guide and policy summary to the consumer
• Buyer’s guide language must conform to regulation and include:
  o The appropriate amount of life insurance to purchase,
  o A comparison of the costs between the proposed plan of insurance and other similar policies, and
  o Various other types of life insurance policies that are available and that may fit the proposed insured’s needs for life insurance
• Policy summary language must include:
  o Premiums to be paid during the first five years of the policy,
  o Cash values at the end of each year for the first five years of the policy,
  o Dividends (if applicable) at the end of each year for the first five years of the policy,
  o Death benefit at the end of each year for the first five years of the policy, and
  o The name and address of the insurance company issuing the policy, along with the generic name of the insurance policy (i.e. Universal Life)

Different states also require additional disclosures. For example, the state of Utah also requires disclosures for Universal Life and similarly structured policies to include the following: “…indicate when the policy will expire based on the interest rates and mortality rates and other charges guaranteed in the policy and the anticipated or assumed annual premiums shown in the policy summary.” Ohio law requires policy summary disclosures to state, among other things: “The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is adjustable, the policy summary shall also indicate that the annual percentage rate will be determined by the company in accordance with the provisions of the policy and the applicable law.”

One of the most commonly found disclosure requirements involving both the sales of
both life insurance and annuity contracts are replacement forms. In order to halt the proliferation of unfair and unethical trade practices when replacing these types of insurance, all the states have adopted language and the completion of mandatory forms when agents replace life insurance or annuities. The following language is excerpted from a replacement form issued by the Texas Insurance Department.

**IMPORTANT NOTICE:**

**REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant. You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.
While it is understood and agreed by most insurance professionals that the duty to disclose helps protect both the consumer and the agent, some requirements seem to contain an element of absurdity. How far will disclosure requirements extend? For

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<th>The existing policy or contract is being replaced because</th>
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<td>_________________________________________________________</td>
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I certify that the responses herein are, to the best of my knowledge, accurate:

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:** Are they affordable? Could they change? How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:** New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

**INSURABILITY:** If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**
How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:** Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**
What are the tax consequences of buying the new policy? Is this a tax-free exchange? (See your tax advisor.) Is there a benefit from favorable “grandfathered” treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?
example, in the preceding Texas replacement form, the agent is required to read the replacement form aloud to the consumer. However, if the consumer does not want the form read aloud, he may initial the form.

**ANNUITY DISCLOSURE**

Most insurance agents are aware of the technical aspects of annuity products--the average consumer is not. Many consumers simply assume that if they purchase an annuity and choose to cancel it, they will receive all their money back, plus interest. Even though agents are required to perform suitability evaluations before annuity purchases by asking consumers numerous questions about their goals, objectives and needs, and even though agents complete risk tolerance questionnaires before annuity purchases to determine consumers’ investment philosophies, consumers do not always understand precisely what agents mean or how their decisions will affect them at some undetermined point in the future.

Annuity disclosure documents are required by most states, the SEC, and FINRA to protect consumers and to promote consumer education. When an agent reviews these disclosures with a consumer, one more brick in the foundation of understanding and trust is put into place. The consumer needs to understand the basic features of the annuity contract he purchases and his signature on the disclosure document is one method of confirming that understanding.

The consumer is legally and ethically entitled to certain information about the annuity product before he purchases it. Because of the variety of annuity products available, and the complexity of the contracts and their terms, conditions, riders, and other enhancements, it is often confusing for a consumer to distinguish between the products discussed during a sales interview. Annuity disclosure forms and buyer’s guides help the consumer confirm that the decision he made is in his best interests and that he has purchased precisely the product he wants.

Annuity disclosure forms must contain information indicating that the contract being purchased is an annuity, its generic annuity name (i.e. fixed, variable, or indexed), and the insurance company product name and number (i.e. Annuity Plus, form number ABCDEF-1). The insurance company name and address are also required on the disclosure form. These details provide specific information to both the consumer and the insurance company when reviewing specific terms, conditions, limits, and uses for the annuity.

Revealing to the consumer that the purchase of an annuity is designed to be a long-term venture, and should not address short-term goals, is essential. Failure of the agent to disclose these facts is both unethical and illegal. Failure on the part of the consumer to understand these facts may lead to undesirable taxable events and the loss of principal.

The following information concerning annuity contract benefits and features is typically contained in an annuity disclosure form and should be reviewed with the applicant, along with an offering by the agent to the consumer of pertinent examples and consequences for
each element in the contract:

- The guaranteed, non-guaranteed, and determinable elements of the contract—along with their limitations and how those limitations operate
- The initial crediting interest rate of the annuity, including any bonus or introductory interest rates, the duration of such rates, and the fact that interest rates may change in the future and are not guaranteed
- Guaranteed and non-guaranteed periodic options
- Value reductions caused by withdrawals from, or surrender of, the annuity
- How contract values may be accessed by the consumer
- Any available death benefits and the method of their calculation
- A summary of the federal tax status pertinent to the contract and any applicable tax penalties for withdrawal from the contract

Impact of any rider, specifically a long-term care rider, should also be disclosed. If any charges and fees apply at any point during the term of the annuity contract, the annuity disclosure form should clearly state either specific dollar amounts or actual percentages and explain how they apply. A variable annuity disclosure (since the product is a securities product) is required to contain more details of fees and/or charges than fixed annuity or equity indexed annuity disclosures. An example showing this difference involves premium taxes.

The variable annuity will disclose the premium taxes while the fixed annuity generally will not. The fixed annuity disclosure is not attempting to hide the premium tax—the tax is included in the cost structure of the fixed annuity and affects the guarantees of the product, therefore, it is not readily apparent. On the other hand, it would not be a fair comparison to state that the variable annuity has a charge for premium taxes and the fixed annuity does not. While the charge for premium taxes is not disclosed separately in the fixed annuity, it is part of the product’s overall costs. Agents should understand this difference (and other differences) and be able to explain them in a fair, understandable manner.

A clear notice containing information about the current guaranteed interest rate for new annuity contracts must be included on the disclosure form and must state that the interest rate is subject to change. Whether the annuity is qualified or non-qualified is also very important. The disclosure MUST contain information indicating whether funds deposited into the annuity are pre-tax (qualified) or after-tax (non-qualified).

In a fully deductible qualified annuity, all proceeds are included as ordinary income for tax purposes when withdrawn, while in a non-qualified annuity, only the earnings are taxed as ordinary income when withdrawn. A consumer cannot exchange or transfer a qualified annuity for a non-qualified annuity without first paying taxes on all earnings and previously deducted premiums flowing from the qualified annuity. When dealing with qualified annuities (except a Roth annuity), minimum distributions will be required at some point. The existence, or waiver, of a surrender charge designed to allow required minimum distributions without penalty is very important. As with most contracts, each annuity contract designs benefits for a particular set of
circumstances. The contract contains limitations to more clearly define the intent and parameters of each benefit. Limitations commonly include a required holding period, a surrender charge, upward limit on the benefit, etc.

When annuities are also securities, the SEC requires certain disclosure documents to be provided to consumers, including prospectuses, which contain specific financial information about the product being sold. Some of those documents must also be filed with the SEC. In 2009, new regulations were adopted by the SEC to enhance disclosures to the purchasers of mutual funds—including those who purchase annuities with mutual fund investment accounts. The purpose of these “enhancements” is to provide consumers with significant information in easy-to-read language while “layering” disclosure to improve the means of delivering more detailed information. The new disclosure rules are being phased in over a number of years.

COURT CASES CONCERNING DISCLOSURE

Cecena v. Allstate Insurance Company - A U.S. District Court in California found against an agent when its insured alleged fraud and bad faith with respect to a homeowner insurance claim. Eduardo and Maria Cecena purchased homeowner insurance from Allstate Insurance Company through one of its agents, Michael Romero and filed suit in 2005 for breach of contract, bad faith, and negligence.

Their suit was based on their claim that Allstate did not pay benefits owed them under their policy in a timely fashion after their home sustained damage in a fire. They also claimed that their agent, Romero, negligently breached his duty to advise them of the coverage requirements for their home.

At the time of the loss, Romero explained to the Cecenas that their Additional Living Expense coverage would pay benefits for them to stay at a motel while their house was being repaired. He did not explain that the Cecenas had the right to stay in a house comparable to their own home, the one that was damaged in the fire.

The case was appealed and according to the Summary Judgment issued in 2009 by the U.S. Court of appeals, the District Court ruling was overturned for several reasons:

- When a party alleges promissory fraud (in California) it must detail the particular circumstances of the fraudulent act or acts, including the time, place, and content of the false representations; the Cecenas were unable to do so
- The Cecenas demanded restitutionary relief, however, restitutionary relief may only be granted when a plaintiff lost money that was in his possession or money in which he had a vested interest (i.e. unpaid wages); since the Cecenas did not have any interest in money Allstate could have paid them had the Cecenas stayed in a house instead of a motel, they were not entitled to restitutionary relief
- The Cecenas did not request payment or compensation for housing comparable to their home, nor did they request mileage from Allstate; as a result, Allstate could not be found in breach of contract of guilty of bad faith. In addition, the Cecenas’ policy required Allstate to disclose benefits beyond those contained in the policy.
• Court records contained no evidence that Michael Romero misrepresented the policy he sold to the Cecenas, failed to procure coverage as requested, or held himself out as “having special expertise to give rise to an independent duty of care.”

• California Insurance Code does not contain a regulation requiring an insurance agent to discuss potential types of Additional Living Expenses with an insured. Section 2695.4 of CIC requires disclosure of “all benefits, coverage, time limits, or other provisions of any insurance policy.” The disclosure requirements refer to policy provisions, not examples of how the policy provisions may be carried out.

• The Court of Appeals found that while Romero and/or Allstate may have made a mistake or exercise bad judgment in not explaining methods of how to utilize the Additional Living Expense coverage, an “honest mistake, bad judgment, or negligence” couldn’t be defined as bad faith.

The lesson to be learned from this case is that while state and federal law, and the concepts of both due diligence and the duty to disclose, indicate that “mistakes” or “bad judgment” don’t constitute fraud, bad faith, or negligence, an agent’s honest failure to disclose information a consumer may later consider to be material can result in costly litigation.

**Harts v. Farmers Insurance Exchange** - In 1999, a Michigan high court found in favor of an insurance agent and the insurance company when the insured alleged that the agent was negligent when he sold them an inadequate policy because it did not include uninsured motorist coverage. The Harts purchased auto insurance from an insurance agent who represented only the Farmers Insurance Group of companies. Their policy did not include uninsured motorist coverage, although the agent sent them notices that coverage was available after their purchase and before the loss. The Harts also knew coverage was available, as evidenced by their previous removal of uninsured motorist coverage from a policy insuring another vehicle.

Because the Harts’ insurance agent was an agent, and not a broker, his primary fiduciary obligations were to his Principal, not to the Harts. Under common law, he had no duty to advise them—although he did just that in sending notices to them about the fact that uninsured motorist coverage was available. The Court held that the nature of the relationships between the agent and the insurance company, and the agent and the Harts, was the primary factor in determining the case. The agent clearly had contractual obligations to the insurance company and his relationship is also governed by the laws of agency.

This case is a clear example of the agent exhibiting due diligence and exceeding his duty to disclose. Unfortunately, agents have no control over who is going to sue them or what they’ll sue for.

**Fillinger v. Northwestern Agency** - The Montana Supreme Court held, in 1997, that a policyholder does not have an absolute duty to read a policy. Steve Fillinger was an outfitter who had a contract to provide outfitter services to the Burlington Northern
Railroad. These services included horseback riding to customers and employees of Burlington Northern. Fillinger was required by Burlington Northern to carry insurance to cover any injury that might occur on the horseback riding trips, not just injuries resulting from negligence, and specifically for injuries from horses.

Fillinger purchased coverage from the owner of the Northwestern Agency, Joyce Jenkins, at the beginning of his contract with the railroad in 1983 and renewed it annually thereafter. At trial, Fillinger and Jenkins offered differing reports about how the policy was obtained, the representations about coverage made by Jenkins, and the coverage afforded by the policy. Fillinger testified that he told Jenkins he “needed insurance that would cover everything, especially if anybody got hurt on a horse” and that she secured coverage that she said would do precisely that.

Fillinger also testified that Jenkins told him his policy had a “horse rider” and that although he did not read his policy when it was issued or renewed, he did check the policy each year to confirm that the “horse rider” was still part of the policy. In 1991, Fillinger requested “only a regular outfitter’s policy” without the extra coverage for injuries cause by horses because he did not renew his contract with the railroad that year. Jenkins testified throughout the trial that Fillinger had never asked for anything other than “a regular outfitter’s policy.” Fillinger did testify that Jenkins told him in 1991, for the first time, that she could not provide a policy to coverage everything that might happen and that his current policy was a liability policy that only provided coverage for negligent acts.

Fillinger sued the Northwestern Agency because, in 1989, a railroad employee named Mike O’Shaughnessy was injured in a horse-related accident. In 1991, O’Shaughnessy’s claim for injuries had not yet been paid and the railroad cancelled its contract with Fillinger. The following year, in 1992, the railroad renegotiated a new contract with Fillinger, which eliminated the use of horses and generated a lower fee. Fillinger sought compensation for the concessions made in the renegotiated 1992 contract with the railroad and the loss of income in 1991 because of the loss of the contract in that year.

The Montana Supreme Court found against the Northwestern Agency for several reasons. The major reason had to do with its opinion that a policyholder has no duty to read an insurance policy unless, under the circumstances, it is unreasonable not to read it. In light of previous court cases, it was held that if a client asks an agent to procure specific coverage, it is reasonable for him to expect that the agent has done so. Jenkins herself testified that an agent owes a standard of care to obtain coverage as specifically requested and, if unable to do so, should advise the client. Fillinger, Jenkins, and an office manager working at the Northwestern Agency all testified that Fillinger regularly called the insurance office to confirm coverage and to verify that his coverage applied to accidents involving horses. After O’Shaughnessy’s accident, Jenkins told Fillinger the railroad employee would be paid for his injuries since the policy provided coverage. The court found that Jenkins negligently misrepresented Fillinger’s policy since it did not provide the coverage Fillinger believed he had purchased.
Furthermore, the Court held that Jenkins’ misrepresentations of the policy met the definitions of an Unfair Trade Practice because “no person may (1) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue.”

This particular case is an excellent example of the agent failing to exhibit due diligence and making proper disclosure. If a client asks for a specific type of insurance, the agent is required by law and ethics to procure that coverage—if it is available. If it is not available as requested, the agent should be sure to confirm, in writing, the facts surrounding the differences between the requested coverages and those issued.

The documentation of the case clearly indicates the conflicting testimony of Fillinger and Jenkins in several key areas. Did Fillinger lie? Did Jenkins lie? Did one, or both, have faulty memories? After the fact, and without documentation, it is impossible to tell. Jenkins’ failure to document her actions gave the appearance that she did misrepresent the policy, as did her own testimony and that of her office manager that Fillinger regularly called the office to express his concern about coverage.

The duty disclose not only includes the particular details of what should be disclosed at the time a sale is made, but also requires the agent to disclose when coverage is not available or when it changes.

**Insurer Insolvency**—In 2001, a California U.S. Court of Appeals case found that an insurance broker was responsible for the insurer insolvency of one of its clients when it failed to disclose to the client that the insurance company was a non-admitted carrier and not a member of the California Insurance Guaranty Association. At the time the policy was issued with Philadelphia Reinsurance Limited, the insurance company was solvent.

After the general liability policy was issued to cover a restaurant, a personal injury action was filed against both the insured and its landlord, who’d been named additional insured on the policy. Philadelphia agreed to defend the insured parties and appointed defense counsel. Shortly afterward, however, Philadelphia became insolvent, ceased providing coverage and defense. Because of the insolvency, the insured and its landlord became liable for all damages and defense costs associated with the suit.

As a result, the insured and the landlord filed suit against the broker, citing professional negligence, negligent misrepresentation, fraud, and breach of duty for failing to secure safe and adequate insurance coverage and failing to inform the insured of Philadelphia’s non-admitted status and lack of membership in the California Insurance Guaranty Association.

The broker faced two significant issues in this case. First, his E & O carrier denied coverage because of an insolvency exclusion common to insurance agent E & O policies. Second, when he appealed his E & O carrier’s denial, he lost on all counts. A number of court cases have held that insurance agents and brokers have the duty to disclose the financial condition of the insurance companies they represent. Financial condition does not only include the financial rating assigned to the insurance company by organizations.
such as A.M. Best, but also includes their status as an admitted or non-admitted insurer and whether they participate in the state’s Guaranty Fund.

Had the broker provide the client with a disclosure indicating that Philadelphia was non-admitted and did not participate in the California Insurance Guaranty Fund, the insured may not have prevailed.
CHAPTER 3 REVIEW QUESTIONS

1. The term due diligence became popular as a result of _____.
   [a] The U.S. Securities’ Act of 1933
   [b] The Fair Credit Reporting Act
   [c] The Gramm-Leach-Bliley Act
   [d] The Sherman Act

2. Due diligence requires the agent to _____.
   [a] Guess when the insured isn’t sure of an answer to a question on an application
   [b] Sign an application when the insured isn’t available to do so
   [c] Obtain information directly from the client
   [d] Withhold information from the company if sharing it is not beneficial to the client

3. Efforts to bring transparency to agent compensation in New York led to a ban on _____ in New York and other states.
   [a] Agent/broker commissions
   [b] Contingent commissions
   [c] Bid-rigging schemes
   [d] Brokerage fees

4. Annuity disclosures are required by all of the following, EXCEPT _____.
   [a] State regulatory agencies
   [b] Securities Exchange Commission
   [c] FINRA
   [d] GLBA

5. When annuities are also securities, the SEC requires certain disclosure documents to be provided to consumers, including _____.
   [a] Prospectuses
   [b] Contracts
   [c] Mutual funds
   [d] Rider
Chapter 4

ETHICS & UNFAIR (ILLEGAL) TRADE PRACTICES

DEFINITION OF ETHICS

If a person were asked to provide the definition of an orange, he’d respond immediately: *It’s a round, orange fruit that grows on trees in warm climates.* If a person were asked to provide the definition of rain, he’d reply: *It’s water that falls from the sky.* Very few insurance producers, however, would be able to respond so promptly or succinctly when asked to define *ethics.*

Not because insurance producers don’t understand what ethics is, but because the principle of ethics is not tangible—like oranges and rain are. The vast majority of insurance producers automatically know what the ethical thing to do is when presented with an insurance scenario and an ethical dilemma. They could respond to the request for a definition with one or more examples that clearly depict ethical, or unethical, behavior.

For example, if you lived in the Old West and someone stole your horse, it was accepted practice by settlers, ranchers, and law enforcement to hang the horse thief. In fact, the punishment horse theft was more severe than the punishment for murder was. Why? Because stealing someone’s horse was not only a deliberate insult, in most cases, it also severely handicapped the individual to the point that he’d be unable to survive. Automobiles had not yet been invented and horses were the principal mode of transportation; they were also instrumental in the running virtually all of the business ventures taking place. The culture and citizenry of the Old West sympathized with the victims and *abhorred* the horse thieves.

In the United States today, even in the west, society responds differently to horse theft. While the victim of a horse theft might *want* to hang the thief, actually doing so would result in far more serious consequences to the person hanging the perpetrator of the crime than to the criminal himself. As our society has evolved, the technology resulting from the industrial revolution gave birth to a new values system; what had previously been considered conventional ethical behavior is now considered not only unethical, but also criminal.

*Ethics* is a philosophy that studies behaviors, along with the attitudes and beliefs motivating the behaviors. Depending upon the branch of ethics and a number of other factors, judgment about behaviors varies.
Depending upon the source, *ethics* can be defined in varying ways; all, however, contain a similar theme:

- **Webster’s Dictionary**: “1: the discipline dealing with what is good and bad and with moral duty and obligation; 2a: a set of moral principles: a theory or system of moral values <present-day materialistic ethic> <an old-fashioned work ethic>; b: the principles of conduct governing an individual or a group <professional ethics>; c: a guiding philosophy; d: a consciousness of moral importance <forge a conservation ethic>; 3: plural: a set of moral issues or aspects (as rightness) <debated the ethics of human cloning>”

- **Encyclopedia Britannica**: “A branch of philosophy concerned with the nature of ultimate value and the standards by which human actions can be judged right or wrong. The term is also applied to any system or theory of moral values or principles. Ethics is traditionally subdivided into normative ethics, meta-ethics, and applied ethics.”

- **Wikipedia**: “(from the Ancient Greek "ethikos", meaning "arising from habit") is one of the major branches of philosophy, one that covers the analysis and employment of concepts such as right, wrong, good, evil, and responsibility. It is divided into three primary areas: meta-ethics (the study of what ethicality is), normative ethics (the study of what ethical truths there are and how they are known), and applied ethics (the study of the use of ethical knowledge).

The preceding definitions illustrate that ethical behavior conforms to accepted standards of behavior and encourages moral sanction; unethical behavior does not conform to accepted standards of behavior and invites moral condemnation. Essentially, ethical decisions require the process of differentiating between good and bad, right and wrong, and after due deliberation, opting to do what is good, or right. It should be noted that while ethical acts and decisions are almost always considered “bad” or “wrong,” they are not always illegal.

When a society creates and enacts laws, the process is the result of a collective decision concerning acceptable standards of activities and behavior: what is considered acceptable by one group of people may be considered just the opposite by another group of people. Culture, religion, the place in time, and a number of other factors all affect how different societies make judgments—as seen in the previous example about horse thievery in the Old West versus horse thievery in our current society. Illegal activities and behaviors are characterized and assessed based on law. The law establishes the boundaries of what is considered acceptable, along with defining the penalties for breaking the law.

Ethical behavior, however, is characterized by values—those of goodness, badness, morals, scruples, and guiding philosophies. These fundamentals are not as transparent or easily understood as law, which appears in black and white and is more easily assessed.
UNIQUE ETHICAL AND COMPLIANCE ISSUES

Legal obligations are defined and judged by law. Whether or not an individual is aware of a particular law, it exists—in black and white: law books document a law’s existence, online versions of legal code are easily available to anyone with access to a computer, and entities such as law enforcement and the judicial system are exceedingly familiar with legal code. The consequences of violating a legal obligation (breaking a law) also appear in black and white. Sometimes they vary—depending upon the decisions made by judges, juries, and others with the power to mete out justice—but a generalized view of consequences is readily apparent to most people in our society.

For example, a sign on a highway states: 55. Drivers [should] know the sign is posted to display the legal speed limit. In other words, the jurisdiction has a law stating it is unlawful to drive in excess of 55 miles per hour on that highway. If a law enforcement officer witnesses an individual driving in excess of 55 miles per hour, the officer is entitled to issue the driver a moving violation for speeding. The recipient of the moving violation must pay a fine—unless he takes issue with the citation and appeals its issuance.

Cut and dried, right? Since drivers know it’s illegal to drive faster than 55 miles per hour on that highway, no one does. Right? Wrong. The majority of people driving that highway travel at speeds in excess of 55 miles per hour. One person puts the car on cruise control at 59 miles per hour because he knows law enforcement doesn’t stop drivers until they’re driving at least five miles an hour over the speed limit. Another person drives at speeds up to 65 miles per hour because he knows that even if he does get a citation for speeding, tickets for traveling between one and ten miles per hour over the speed limit are held locally and not reported to the state for purposes of appearing on his driving record. Each of these people feels justified in breaking the law because each has made a personal determination that the speed limit is too low. Neither person feels he is breaking the law although, technically, each is and—when pressed, will admit it.

Unlike legal obligations, ethical obligations aren’t always defined and seldom appear in black and white. They are a consensus, by society, of what is acceptable conduct. One person’s set of moral values is considered Puritan to another person. One group’s assessment of what constitutes acceptable principles of conduct sets another group gasping in disgust.

For example, Jane is walking on a busy city sidewalk. The fellow in front of her pulls something from his pocket and a wad of cash falls onto the sidewalk and bills scatter at her feet. The teenager walking beside Jane snatches handfuls of bills off the ground and stuffs them into her purse. Jane gathers the remaining bills and races after the man who dropped the money, calling after him.

Not so cut and dried, is it? Maybe the teenager didn’t see the money fall from the man’s pocket. Maybe she did. Either way, she obviously felt entitled to the money. Jane, on the other hand, did not. This illustration paints a vivid picture of different ethical values.
Why do the teenager and Jane have different ethical values? Because of a number of factors, including differing perceptions of good versus bad and right versus wrong. They also experience dissimilar levels of self-interest, awareness of consequences and results, and concepts of what is moral. Perhaps Jane was raised in a loving family by parents who regularly attended religious services; perhaps the teenager was raised with seven other siblings by a mother on public assistance. Or, maybe the teenager’s house was recently burgled and she’s still upset when she thinks about the $500 cash that was stolen. Regardless of our speculation about the reasons for Jane and the teenager behaving differently, neither the teenager nor Jane seemed to experience an ethical dilemma when faced with all that cash at her feet. Each plunged into action without dithering. A third person might have had a terrible time deciding what to do.

Maybe he would have wanted to keep the cash because he’s behind on his rent but would have felt guilty because he saw it fall out of the other fellow’s pocket. He could justify keeping the cash if he simply found it on the sidewalk but, keeping it when he knew the person to whom it belonged just isn’t something he could live with. This third person’s dilemma is a direct result of his personal opinion of what is right, his level of social responsibility, and his degree of self-interest.

Applying this understanding to the world of insurance and, the insurance industry accepts the following phrases as being right—or ethical:

- **Doing what’s right for the client**
- **Looking out for the client’s best interests**
- **Putting the client’s best interests first**
- **Do no harm**
- **Always leave the client in a better position than he was in before you did business with him**

Some insurance professionals, however, choose to believe that the following phrases are right—or ethical:

- **If no one knows, it’s okay**
- **If I don’t get caught, it’s okay**
- **Who will it hurt?**
- **Everyone does it**

Two sincere, informed, professional insurance producers can legitimately have different views about whether a particular transaction is right or wrong. While these same two individuals might agree that they should do “right” by the client, they may vigorously disagree about what is “right.”

Many ethical considerations surround the sales of insurance contracts. **Ethics** is hard to define in practice and equally hard to enforce because it requires an agreement about what is right and fair and in the client’s best interests. While the facts of some situations may be viewed and considered by most to be unethical, the real test of defining or enforcing ethics comes in the more grey areas. Ethics also requires a commitment to a set of values and principles that, by nature, are vague. Ethics requires each producer to
read or hear these principles, interpret them, and incorporate what he thinks they mean into his daily business practices.

The easiest way to determine if something is in the client’s best interests is to ask him. Yes, come right out and ask, *Does that work for you? Does it make good sense? Will it help you or will it make things worse for you?* Another way to determine if something is in the client’s best interest is to encourage him to talk with his accountant, attorney, or a family member. If issues are brought up by these individuals, they need to be addressed—what better way to address them than with the client’s full cooperation and with the assistance of another trusted advisor or family member?

**HISTORY OF ETHICS**

As with the horse thievery illustration discussed earlier, a society changes its values as it evolves. If *ethics* is defined as accepted standards of behavior, and those accepted standards are not documented in the same fashion laws are documented, how are the standards created? Who creates them? Who enforces them? Who is responsible for seeing that that change—or don’t change?

Philosophers have expounded upon their opinions about ethics and *the science of conduct* for thousands of years. *The science of conduct* is the framework inside which a society lives its lives: it contains the fundamental and basic rules that govern the society. Moral and legal values have often formed the center of the philosophers’ opinions. These opinions have changed with time and also differ among societies and cultures.

Ethics is divided into three major branches: meta-ethics, ethical theory, and applied ethics. Meta-ethics is involved with the knowledge of ethical properties, statements, attitudes, and judgments. Ethical theory and applied ethics are considered *normative* ethics. Normative ethics answer questions that involve the choice a person makes, such as, *How should I act in this situation?* Meta-ethics answers questions that seek the knowledge of values and principles, such as, *What makes something bad?* or, *How do I recognize when something is bad?* Other branches of ethics include Moral Psychology (the study of the nature of moral capacity and how it develops) and Descriptive Ethics (the actual moral values people adopt in their lifestyles).

**META-ETHICS**

Meta-ethics focuses on the intrinsic makeup of *good* and *bad* and how to define what is morally right and morally wrong. Scholars of meta-ethics do not always share opinions about moral facts. “Moral realists” believe moral facts have a life separate from people and their opinions and that moral facts simply exist and people are either aware of them or unaware of them. “Moral antirealists” believe moral facts are created by people and their behaviors, conduct, and beliefs.
NORMATIVE ETHICS

The Greek philosophers Socrates, Plato, and Aristotle (500 – 300 BC) were the first to address ethics as a principle. Socrates believed knowledge was the source of good behavior and happiness; evil deeds and bad behavior, he contended, were caused by ignorance. He linked knowledge with virtue, and successively lined virtue with happiness. His guiding philosophy centered on the belief that a wise man knows what is right and good; as a result, a wise man will only do what is good and right. Therefore, a wise man will be happy.

A student of both Socrates and Plato, Aristotle formulated an ethical belief system dubbed “self-realization.” According to the theory of self-realization, if a person acts upon the impulses of his innate character and realizes his full potential, he will ultimately achieve happiness. Aristotle postulated that happiness was the ultimate goal of all people and that everything a person did or achieved, such as living within the framework of society and accumulating material possessions, was a method of reaching that goal.

A number of other philosophies thrived during the period from 300 BC to 30 BC, most notably hedonism. Hedonists theorized that the primary ethical objective was maximizing pleasure and minimizing pain. Different schools of thought branched out from this guiding philosophy, including the belief that the pursuit of self-gratification did not require consideration of its effect on others to the pursuit of spiritual bliss. Epicurus rejected the pursuit of self-gratification to the exclusion of all other efforts because, he felt, it frequently caused pain. Instead, Epicurus adopted the practices of prudence and moderation, preferring to avoid pain and fear at all costs.

Stoic philosophy was the next major ethical tenet of major note. Epictetus (55AD – 135AD) asserted that happiness and peacefulness constituted the greatest good. According to his beliefs, self-control over wants and emotions was the method of achieving peace of mind and spiritual serenity. The fundamentals of Stoic philosophy involved acceptance of things that will not change, including death. The “unconquerable will” was Epictetus’ primary focus, which advanced the notion that people live independent and pure lifestyles.

Consequences and acts are separate concerns of the two schools of thought that divide Modern Ethics. Consequentialists believe that the consequences of an act should define the ultimate moral or ethical judgment. For example, if an act or behavior is responsible for a “good” or “right” result, then it is morally and ethically right. The ends justifies the means is a clearer way to define this principle. Deontologists believe that the innate “goodness” or “rightness” of an act or behavior defines the ultimate moral or ethical judgment. For example, if the act or behavior is, in itself, “good” or “right,” then it is morally or ethically right. Its result, or consequences, need not be considered. The Golden Rule is a clearer way to define this principle, focusing more on the intent of the act or behavior than the outcome.

Substantial development on critical thinking took place during the 1900s, as did a further amplification of what ethics is:
• The Marxist Theory focuses on the struggle between social classes, capitalism, and collective ownership
• Modernism focuses on self-consciousness and the appraisal of the past when compared with the Modern Age
• Postmodernism focuses on the reaction to modernist principles by drastically reappraising art, architecture, literature, and/or business and either reintroducing traditional elements into these mediums or exhibiting extremes in their presentation

APPLIED ETHICS

The philosophy of applied ethics takes ethical judgments and employs them based on bona fide situations. Essentially, applied ethics searches out public policy within the framework of which it is utilized rather than as a big-picture judgment that doesn’t consider particular situations or conditions. For example, attempting to determine whether euthanasia is moral is a function of applied ethics in our society.

Military Ethics - The values and principles established by the military are determined solely by the standards of behavior and conduct within the military. Military ethics is evolutionary in nature and certain elements pertain specifically only within its framework, such as the justification for using force, gender equality, and political influence.

Bioethics – The debates arising from advances in medicine and biology are the subject of the studies of bioethics. Topics addressed by bioethics include abortion, animal rights, assisted suicide, cloning, confidentiality of medical records, contraception, disability, euthanasia, gene therapy, infertility treatments, life support, lobotomy, medical malpractice, organ donation, pain management, sperm and egg donation, recreational drug use, stem cell research, suicide, surrogacy, and transexuality.

Corporate/Business Ethics – The examination of ethical and moral principles that are cultivated within a business environment are the focus of corporate, or business, ethics. Sometimes corporate/business ethics apply only to a particular business industry or company. Corporate/business ethics often overlap with corporate and business philosophies that are used to define the basic purpose of an industry or company. The study of corporate/business ethics includes:
  • corporate social responsibility
  • corporate governance and leadership
  • political contributions
  • accounting practices
  • insider trading
  • executive compensation
  • kickbacks
  • human resource management
    o discrimination
    o harassment
Moral psychology is based on an individual’s personal philosophy and is studied in the fields of philosophy and psychology. The reason for the concern in both fields is its relation to morality, or moral development, which have their foundation a person’s religion (or lack of religious beliefs), conscience, and what a person believes is good or bad behavior. Moral psychology entails seven levels of functioning:

1. moral intuitions
2. moral emotions
3. moral virtues/ vices
4. moral identity
5. moral values
6. moral reasoning
7. and moral willpower

Basically, moral psychology studies what factors persuade a person to make a moral, or ethical, decision.

DESCRIPTIVE ETHICS

Instead of focusing on what people do and how they behave, descriptive ethics is a process whereby the attitudes of a group of people are observed and research. Descriptive ethics focuses on what people think is right or wrong. It seeks beliefs and attitudes about values, what actions are right or wrong, and what characteristics are judged as being virtuous.

ETHICAL FACTORS

When presented with a situation, two individuals will respond differently based on a number of factors. Each may deem their own behavior to be ethical and that of the other
individual to be unethical. Why is that?

Based on their particular upbringings, lifestyles, and past experiences, each individual has a different perspective about life, people, and relationships. Their personal philosophy guides their decision-making. In the study of any field of ethics, the following factors come into play:

- Morals
- Values
- Religious beliefs
- Good versus Bad
- Right versus Wrong
- Sociological Factors
- Degree of self-interest
- Pleasure and happiness
- Consequences and results
- *Prima facie* (all things being equal)
- Virtue
- Liberal rights
- Justice versus communal values

The following scenario is offered to illustrate how different people respond differently given the same set of circumstances. This is a true recounting of an event that occurred at an insurance agency. The agency owner (Doris) arrived at the office on a Monday morning to find an envelope wedged into the mail slot. The envelope had been folded in half and actually held the mail slot open—the client (Warren) who’d placed the envelope in the mail slot did not push it all the way through so that it dropped to the floor. Doris removed the envelope from the mail slot and extracted its contents: two $100 bills and a payment stub. The payment stub was the bottom half of an auto insurance invoice that had been issued by an insurance company. The pre-printed information indicated that the policy’s outstanding balance was $400 and that the policy would be cancelled for non-payment of premium if the $400 weren’t paid by 12:01am on the following day. In the space provided, Warren had handwritten in blue ink that the payment made was $400.

Before Doris reached her desk, the phone rang. The caller was Warren. He asked Doris if she’d received his $400 payment. She replied that she’d just found an envelope in the mail slot and that it contained a paystub and two $100 bills. Warren became agitated and emphasized that he’d left a $400 payment; he further stated that he couldn’t believe someone actually came along and stole $200 of his $400. Doris stated that she found it odd someone would steal only half the money in the envelope instead of the entire thing. Warren agreed it was an odd occurrence but that you never could figure people out. He asked if anyone else had dropped off a payment, implying that, perhaps, one of Doris’ other clients had stolen the $200. Doris indicated that Warren’s was the only payment she’d found that morning. Warren then went on to ask Doris what she was going to do.

She said she’d record Warren’s $200 payment and issue a receipt for that amount. She further explained that unless Warren paid an additional $200 before her office closed that
day, the policy would be cancelled. Warren thought that was unfair, since he’d actually 
made a $400 payment. Doris said that she thought it unfair of him to expect her to 
replace the $200 that was “stolen.” She suggested that if he believed $200 had been 
stolen, Warren should visit the office and they should call the police to investigate the 
matter. Warren vehemently objected to Doris’ suggestion. She then asked him if he 
thought she’d stolen the money. Warren said that such a thing had never crossed his 
mind and they should just forget about the missing $200. He wasn’t happy that she’d 
only be crediting him with a $200 payment, but said he didn’t see any other alternative 
given the circumstances.

This seems like a very straightforward, although touchy, situation. The vast majority of 
insurance producers would have behaved exactly as Doris did, right? But what if more 
background information were revealed? Would it impact a producer’s decisions about 
how to act? Would it create a different perception about what is right and wrong? 
What if Warren were the type of client who always paid his bills late? What if, in fact, he 
paid his bills so late that the insurance company often issued notices of cancellation for 
non-payment of the policy premium? What if his policy had actually been cancelled and 
reinstated several times? Might these actions have created a lot of extra work for Doris—
or any other producer?

What if Warren had experienced a number of previous losses? What if, during the 
process of investigating and settling the losses, the producer became aware that Warren 
had lied to the insurance adjuster? What if the producer decided that the next time 
Warren’s policy cancelled, s/he wasn’t going to reinstate his policy?

If all the previous what-ifs were true (which they were), might Doris—or another 
producer—have acted differently upon finding the $200? Recalling the factors listed 
earlier in this section, other producers might very well have experienced a different 
thought process than Doris did.

Here is an alternative scenario involving Irene, Doris’ fictitious producer. Knowing that 
all the previously cited what-ifs are true, and that Irene knew about them, Irene is the first 
to arrive at the agency that Monday morning. She rolls her eyes when she realizes 
someone was actually foolish enough to leave cash stuck in the mail slot. Then, when 
she sees that it’s Warren who did so, she becomes angry. She just knows he’s being 
manipulative and trying to get his policy reinstated without paying the entire required 
premium. Warren’s a liar and everyone at the agency knows he’s an E & O claim 
waiting to happen. Irene then wonders what would happen if Warren’s payment weren’t 
received at all. He’s surely going to claim that someone at the agency stole $200 of the 
$400 he paid. But what will he do when he learns that his payment was never received—
as in: someone came along and stole the whole darn envelope before the office opened? 
Warren can’t prove that he left $400 cash in the mail slot and, even if he could, he can’t 
disprove that someone stole it. Neither will he be able to prove that one of the agency 
employees stole the envelope. No one will suspect Irene of stealing the $200; after all, 
she has an excellent reputation. Her mind spins. She can donate the $200 anonymously 
to a local animal shelter so something good can come of the situation. In addition, maybe
Warren will learn his lesson. He’s a liar and a cheat and he deserves to see what it feels like to be the victim of a liar and a cheat.

Does this sound like something that might happen? People tend to justify their actions and Irene has her rationalizations tied up in a nicely wrapped package:

- Warren’s a liar and a cheat, so he doesn’t deserve to be treated honestly
- No one will know what she’s doing, so it’s okay to do
- Someone will benefit from what she’s doing, so there’s no real harm in it
- Warren will learn a lesson, be reformed, and the story ends happily-ever-after

Irene has convinced herself she’s doing good; therefore, her theft isn’t bad. Unfortunately, in our society, and within the insurance industry, very few people are going to share Irene’s perspective. Irene behaved not only unethically, but also illegally.

Ethical dilemmas crop up because individuals perceive events and circumstances through the eyes of their own personal philosophies, as shown in the previous scenario. People behave differently because they do not share the same morals, degrees of self-interest, level of social responsibility, perception of right and wrong, etc. Although it never even crossed Doris’ mind to steal Warren’s $200, Irene not only considered it, she rationalized why stealing would actually be the right thing to do.

Good people do bad things. While we might understand the rationale behind the bad decision, “bad” and “wrong” acts don’t magically transform into “good” and “right” because we sympathize with the intent. Our ethical values help us determine how to behave in appropriate fashion.

HISTORY OF INSURANCE ETHICS

Gambling was rampant in England during the 1600s and 1700s, and citizens in the middle class would bet on anything. One type of popular betting situation involved the illnesses of prominent persons in society. People would place wagers on the anticipated date the sick person would die. The wagers often took the form of the purchase of a life insurance policy that would pay out only if the individual died before a certain date. (At that time, the concept of insurable interest had not been incorporated into the underwriting process of life insurance policies—which was why life insurance was outlawed in most of Europe.) During the same time period, merchants, ship owners, and underwriters met to conduct business, including the sales of life insurance and insurance on shipments of goods.

Meeting places, such as Lloyd’s Coffee House in London, accommodated both gamblers and businessmen. Because they didn’t want to be associated with individuals involved in what they perceived to be unethical practices (i.e. gambling in the form of purchasing a life insurance policy on a sick person), a number of influential merchants, ship owners, and underwriters stopped meeting at Lloyd’s Coffee House in 1769. They began meeting at a new location, and named it the “New Lloyd’s Coffee House.” That new meeting
place is the precursor of the underwriting syndicate, Lloyd’s of London. In 1774, England outlawed the practice of wagering on people’s deaths, which demonstrates another situation where a group of people collectively decided a practice was so unacceptable and unethical that it should be considered illegal.

Extensive media coverage revealed the routine habits of extravagant spending and political payoffs practiced by three major insurance companies in the beginning of 1905 in the state of New York. The insurance companies were the Equitable Life Assurance Society, New York Life Insurance Company, and Mutual Life Insurance Company. Several journalists, including Joseph Pulitzer, targeted these insurance companies because the expenses, they claimed, were exploiting the insurance companies’ policyholders.

Because of the negative media attention, Equitable’s board of directors appointed a special committee to examine the company’s business affairs. After its examination, the committee reported to the board of directors the following:

- Corporate officers and special employees were receiving excessive salaries
- Commissions were being paid to some agents at higher levels than were being paid to others
- Accounting procedures did not adequately document expense reimbursements
- Company funds were being used to support prices of Wall Street securities in which Equitable officers were involved

When the committee recommended reorganization of the company and removal of two particular members of the board, the board of directors refused to comply with the committee’s recommendations. The committee chair and his supporters resigned from their positions with Equitable and leaked details of their report, and the board’s response, to the media.

Because of mounting pressure from the media, the New York governor asked the state legislature to investigation the business practices of all life insurance companies in the state. It was hoped that the evaluation of insurance company practices would result in the suggestion of legislation for the protection of policyholders in the state of New York. Although many of the business practices of life insurance companies were no different from those of other business industries, the public was outraged with the nepotism, favoritism, lavish spending, and the excessive compensation of insurance company corporate officers and agents.

As the findings of the Armstrong Committee were published, other states launched their own state investigations. In 1907, in response to the Armstrong Committee’s findings, the New York legislature issued a series of strict insurance regulations. Other states soon followed their example.

The previous two illustrations cite insurance practices that were not originally considered unethical. The societies of their times evolved and called for laws to prohibit the practices and declare them illegal.
As stated previously, ethical dilemmas exist because people have differing morals, degrees of self-interest, levels of social responsibility, perceptions of right and wrong (or good and bad), etc. In the insurance workplace, ethical dilemmas can be many-sided and generate much controversy. It is often difficult to solve quandaries that involve contradictory interests concerning an issue of significant value.

If a business, or a business industry, adopts a code of ethics, many benefits result:
- A moral compass is provided to those who grew up without one
- Uniform moral guidelines are established
- Teamwork and productivity are endorsed
- Individual growth and development are promoted
- Compliance with laws and regulations, and avoiding criminal acts, are ensured
- A strong and affirmative reputation and public image is encouraged

An ethical individual, organization, or business industry possesses:
- A feeling of comfort when relating to diverse groups of people
- Concern with fairness
- Complying with rules and standards of conduct
- A sense of responsibility for its actions
- A purpose, or goal, tied to a values system based on integrity
- The clear understanding that every action, and every decision, generates results and consequences

Ethical people and businesses have the best interests of their business partners and clients in mind at all times. In any given situation, an ethical insurance producer will follow procedure, guidelines, rules, regulations, accepted standards of conduct, and the law. The ethical insurance producer will place his own interests behind those of the insurance company, the consumer, and his employer.

Ethical insurance producers sell products based on the consumer’s needs and financial ability while upholding the insurance company’s rules, regulations, underwriting guidelines, and business practices. Ethical insurance producers will not recommend an insurance product based primarily on the amount of commission he’ll receive after the sale is made.

PUBLISHED CODES OF ETHICS FOR INSURANCE PROFESSIONALS

While the insurance industry as a whole does not have a published code of ethics as do the legal and accounting professions, certain organizations within the insurance industry possess codes of ethics.

CPCU CODE OF PROFESSIONAL ETHICS

The Chartered Property Casualty Underwriters (CPCU) Society maintains published
canons and ethics. It also adheres to the Code of Professional Ethics of the American Institute of CPCU. The Society of CPCU, according to its web site, “is a community of credentialed property and casualty insurance professionals who promote excellence through ethical behavior and continuing education.” Its mission is to “meet the career development needs of a diverse membership of professionals who have earned the CPCU designation, so that they may serve others in a competent and ethical manner.”

In order to earn the CPCU designation, insurance professionals must, in two years, complete five foundation courses and three additional courses concentrating either in personal or commercial lines of insurance. Once the CPCU designation is earned, mandatory compliance with its Code of Professional Ethics is required.

The CPCU Code of Professional Ethics is contained in the CPCU by-laws and lists the following specified and unspecified unethical practices; commission of any of the following acts is subject to disciplinary action and may result in an individual’s expulsion from membership:

- **Specified Unethical Practices**
  1. To violate any law or regulation duly enacted by any governmental body whose authority has been established by law.
  2. To willfully misrepresent or conceal a material fact in insurance and risk management business dealings in violation of a duty or obligation.
  3. To breach the confidential relationship that a member has with his client or with his principal.
  4. To willfully misrepresent the nature or significance of the CPCU designation.
  5. To write, speak, or act in such a way as to lead another to reasonably believe that the member is officially representing the Society or a chapter of the Society unless the member has been duly authorized to do so.
  6. To aid and abet in the performance of any unethical practice proscribed under this Section.
  7. To engage in conduct which has been the subject of a presidential or Board of Directors directive to cease and desist.
  8. To engage in any act of a retaliatory nature against another person reporting or providing evidence of an ethics violation.

- **Unspecified Unethical Practices:**
  1. A member shall not engage in practices which tend to discredit the Society or the business of insurance and risk management.
  2. A member shall not fail to use due diligence to ascertain the needs of his or her client or principal and shall not undertake any assignment if it is apparent that it cannot be performed by him or her in a proper and professional manner.
  3. A member shall not fail to use his or her full knowledge and ability to perform his or her duties to his or her client or principal.

**NAIFA CODE OF ETHICS**

Another industry organization that possesses a published Code of Ethics is the National
The Association of Insurance and Financial Advisors (NAIFA). According to its web site, NAIFA “comprises more than 700 state and local associations representing the interests of 200,000 members and their associates nationwide. NAIFA members focus their practices on one or more of the following: life insurance and annuities, health insurance and employee benefits, multiline, and financial advising and investments. The Association’s mission is to advocate for a positive legislative and regulatory environment, enhance business and professional skills, and promote the ethical conduct of its members.”

The preamble to the NAIFA Code of Ethics states: Those engaged in offering insurance and other related financial services occupy the unique position of liaison between the purchasers and the suppliers of insurance and closely related financial products. Inherent in this role is the combination of professional duty to the client and to the company as well. Ethical balance is required to avoid any conflict between these two obligations.

It goes on to state: Therefore, I Believe It To Be My Responsibility:
- To hold my profession in high esteem and strive to enhance its prestige.
- To fulfill the needs of my clients to the best of my ability.
- To maintain my clients' confidences.
- To render exemplary service to my clients and their beneficiaries.
- To adhere to professional standards of conduct in helping my clients to protect insurable obligations and attain their financial security objectives.
- To present accurately and honestly all facts essential to my clients' decisions.
- To perfect my skills and increase my knowledge through continuing education.
- To conduct my business in such a way that my example might help raise the professional standards of those in my profession.
- To keep informed with respect to applicable laws and regulations and to observe them in the practice of my profession.
- To cooperate with others whose services are constructively related to meeting the needs of my clients.

NAHU CODE OF ETHICS

The National Association of Health Underwriters, according to its web site, “represents more than 100,000 licensed health insurance agents, brokers, consultants, and benefit professionals through more than 200 chapters across America. NAHU members service the health insurance needs of large and small employers as well as people seeking individual health insurance coverage. Every day, NAHU members work to obtain insurance for clients who are struggling to balance their desire to purchase high-quality and comprehensive health coverage with the reality of rapidly escalating medical care costs. As such, one of NAHU's primary goals is to do everything we can to promote access to affordable health insurance coverage.”

NAHU’s published code of ethics is:
- To hold the selling, service and administration of health insurance and related
products and services as a professional and public trust and do all in my power to maintain its prestige.

- To keep paramount the needs of those whom I serve.
- To respect my clients' trust in me, and to never do anything which would betray their trust or confidence.
- To give all service possible when service is needed.
- To present policies factually and accurately, providing all information necessary for the issuance of sound insurance coverage to the public I serve.
- To use no advertising which I know may be false or misleading.
- To consider the sale, service and administration of health insurance and related products and services as a career, to know and abide by the laws of any jurisdiction Federal and State in which I practice and seek constantly to increase my knowledge and improve my ability to meet the needs of my clients.
- To be fair and just to my competitors, and to engage in no practices which may reflect unfavorably on myself or my industry.
- To treat prospects, clients and companies fairly by submitting applications which reveal all available information pertinent to underwriting a policy.
- To extend honest and professional conduct to my clients, associates, fellow agents and brokers, and the company or companies whose products I represent.

SEC ADVISORS CODE

According to the Investment Advisers Act of 1940, Rule 204A-1, “investment advisers registered, or required to be registered, under Section 203 of the Act, must establish, maintain, and enforce a written code of ethics that, at a minimum, includes:

1. A standard (or standards) of business conduct that you require of your supervised persons, which standard must reflect your fiduciary obligations and those of your supervised persons;
2. Provisions requiring your supervised persons to comply with applicable federal securities laws;
3. Provisions that require all of your access persons to report, and you to review, their personal securities transactions and holdings periodically as provided below;
4. Provisions requiring supervised persons to report any violations of your code of ethics promptly to your chief compliance officer or, provided your chief compliance officer also receives reports of all violations, to other persons you designate in your code of ethics; and
5. Provisions requiring you to provide each of your supervised persons with a copy of your code of ethics and any amendments, and requiring your supervised persons to provide you with a written acknowledgment of their receipt of the code and any amendments.”

Rule 204A-1 also includes reporting requirements, transaction reports, pre-approval of certain investments, rules pertaining to “small advisers,” and definitions.

Brokerages and broker-dealers either draft their own codes of ethics or adhere to codes that are published by organizations such as the New York State Society of CPAs.
SUMMARY OF ETHICS

During the process of acting as an insurance producer, the following considerations should be always at the forefront of a producer’s mind, because they are the basis of the producer’s ethical conduct:

- Understanding the insurance products sold and serviced
- Understanding insurance company rules, regulations, and procedures
- Understanding how to support the policyholder while representing the best interests of the insurance company (if an Agent)
- Understanding the contractual obligations of all interested parties
- Understanding the producer’s fiduciary obligations to all parties
- Evaluating the needs of the policyholder and making appropriate coverage recommendations
- Motivating people to make appropriate decisions
- Exercising due diligence and the highest level of care while performing needs analyses, policy delivery, claims investigations, and service to the policyholder
- Striving to grow and develop all necessary skills, utilize training, and avail oneself of all applicable avenues of continuing education

UNFAIR TRADE PRACTICES

In an effort to promote fair competition among insurers and for the protection of consumers, each state has enacted legislation that establishes certain insurance business practices to be illegal. The NAIC created its Model Unfair Trade Practices Act and most states’ legislation is fashioned after its contents.

These unfair trade practices have been deemed illegal because they were once regularly practiced by insurance agents but are considered harmful to consumers. Although some differences do exist between the laws of each state, a number of practices are universally considered illegal—and unethical.

FILING A FALSE APPLICATION, CLAIM OR PROOF OF LOSS

In addition conforming to all legal requirements concerning contracts, insurance companies issue policies after reviewing and approving statements made in applications for insurance. Insurance companies also issue claim settlements after reviewing insurance applications, loss notices, proofs of loss, and after conducting investigations. Because an insurance policy is a contract, it is incumbent upon all parties to the contract to be honest and truthful when making statements that will form the basis of an insurance company’s underwriting or claims decision.
The statements contained in insurance applications are called *representations*. A representation is an incidental statement of fact on the faith of which a contract is entered into. The individual making the representation does so to his *best knowledge and belief*. Representations are not promises or guarantees but they should be accurate and, more importantly, truthful.

A representation contained in an insurance application, claim document, or proof of loss is made for the sole objective of acquiring an insurance policy or claim settlement. If an individual knowingly makes a false representation in an insurance application, claim document, or proof of loss, for the purpose of deceiving or misleading, then he is making a *misrepresentation*.

An insurance policy may be voided if the insurance company discovers that a *material misrepresentation* was contained in an application, claim document, or proof of loss. A material misrepresentation is one that the insurance company based the issuance of a policy or claim settlement. If the insurance company had known the truth, instead of the information contained in the material misrepresentation, they would NOT have issued the policy or paid the claim. Misrepresentations are often considered fraud.

*Fraud* is, according to Webster, *intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right*. It is also defined as an act of deception or misrepresentation.

If an individual knowingly lies to an insurance company for the purpose of securing an insurance policy or claim settlement is inducing them to part with something of value (for example: money) or to surrender a legal right (for example: NOT making the claim payment because coverage should never have been in effect).

**Scenario #1:** A business applies for a fleet auto insurance policy on a number of pickup trucks. The vehicles are not available for the producer’s inspection because they are all at job sites. When the producer asks the applicant if any of the trucks have prior damage, the applicant claims they are all in good shape and have not sustained any type of body or glass damage. Unknown to the producer, on the previous day, one of the trucks sustained damage when its driver collided with a deer. Within a matter of days, the applicant reports that one of employees was involved in a deer collision. This applicant is guilty of misrepresentation and, perhaps, fraud.

Now, if the applicant had revealed the prior damage to the producer and the producer had withheld the information from the insurance company, in addition to breaching his agent/company contract, the producer would also be guilty of misrepresentation and, perhaps, fraud.

**Scenario #2:** An individual is applying for a personal life insurance policy. During the process of completing the application, the insurance producer asks the applicant this question, which is one of many he reads right off the application: *Has any family member, parent, or sibling, before the age of 60, been diagnosed with or died as a result*
of any type of cancer, diabetes, heart disease, or stroke? The applicant wants to know why the insurance company asks that question and the producer responds that the information is taken into consideration as part of the underwriting process. The applicant then responds, So, if my father had a heart attack when he was 55, I’ll have to pay more money for my life insurance? If the applicant answers the question truthfully, no problem exists. However, if he lies, he makes a misrepresentation and might be considered to have acted fraudulently. If the producer knows the applicant lies and submits the application without informing the insurance company, he is guilty of breach of contract, misrepresentation, concealment, and quite possibly, fraud.

Although the individuals making the above misrepresentations benefit from their actions—which is why they make them, the payment of undeserving claims has an adverse effect on premium rates. Other policyholders, not to mention insurance companies, suffer financially from such adverse effects. Premium rates are calculated based on a number of legitimate and statistical data, including anticipated losses. When fraudulent claims upset the rate calculations, every policyholder assumes the unnecessary burden of increased premium. The misrepresentations and concealments noted above are unethical—in addition to being illegal—because they harm other people.

**TWISTING**

<table>
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<tr>
<th>When a producer misrepresents policy terms, conditions, or benefits, or when he makes incomplete policy comparisons, he has committed twisting if he does so to induce a consumer to:</th>
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<tr>
<td>• Lapse or cancel a policy</td>
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<tr>
<td>• Surrender, convert, or exchange a policy</td>
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<tr>
<td>• Retain or keep a policy</td>
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Insurance producers may sometimes possess incomplete or inadequate knowledge of the policies they sell or review. Although producers are required to be skilled and efficient, they sometimes make honest mistakes. Making an honest mistake is not the same thing as deliberately misstating the definitions, terms, conditions, benefits, or features of a policy for the benefit of the producer instead of for the benefit of a consumer.

For example, a producer and a potential client are discussing the potential replacement of the consumer’s business policy that was issued by another producer. The consumer asks for an “apples-to-apples” comparison of a particular “value added” endorsement on his policy. Because the producer knows the pricing of a comparable policy with his company will cost more money than the consumer is paying for his current policy, the producer deliberately avoids discussing some of the provisions in the value added endorsement of his competitor. He also exaggerates the benefits of the policy he proposes to sell the consumer.

This producer is twisting because he both misrepresents and makes incomplete comparisons of the policies to convince the consumer to cancel current policy and buy a new policy so he can earn commission dollars on its sale. Not only will this consumer
wind up paying more premium dollars than he currently pays if he follows the producer’s recommendations, he has been deprived of the benefits of the more comprehensive policy. The producer’s actions are both illegal and unethical.

UNFAIR DISCRIMINATION WITH RESPECT TO REBATES AND PREMIUMS

Insurance rates must be approved by the insurance commissioner in each state. Some states actually require the insurance commissioner to establish rates for certain types of insurance, such as auto and workers’ compensation insurance. Unlike other business industries, the insurance industry does not allow insurance companies or agents to discount insurance rates.

For example, if a person were to walk into a paint store and inquire about the price of a gallon of paint, he might not like the $35 price tag. He might even ask the customer service representative to discount the price, especially since he’ll be painting his entire house—inside and out—and will be buying a lot of paint from the store. In some stores, the customer service representative may have the authority to discount the price; in other stores, he may have to consult with a manager before doing so. In still other stores, the price will not be discounted.

When a consumer decides he doesn’t like the $3,000 proposed premium for his business life insurance policy and asks the producer to discount the price, it is not legal for the producer to do so. Offering a client an incentive to buy a policy is considered discrimination also considered rebating. Giving, paying, allowing, offering—directly or indirectly—any of the following, is illegal:

- A rebate, discount, abatement, credit, or premium reduction
- Special favor of advantage in policy dividends or other benefits
- Valuable consideration not stated in the policy

An example of giving an illegal rebate or discount would be for a producer to pay the first quarterly premium on a life insurance policy for the consumer as a way of “thanking” him for buying the $2,000,000 policy with a $3,000 premium. Most states consider the producer and the policyholder equally guilty in the preceding instance. In all cases, offering consumers “discounts” of any type is discriminatory and disrupts the rate structure; it is both illegal and unethical.

SHARING COMMISSIONS WITH AN UNLICENSED INDIVIDUAL

Insurance companies are not permitted, by law, to pay commissions to an individual or business entity unless the recipient of the commission payment is duly licensed. Individuals are not permitted, by law, to receive commission in exchange for the sale or servicing of an insurance policy, unless they are duly licensed.

An individual is also required by law to hold an insurance license in the line of insurance that was sold in order to receive commissions. For example, if Steve wishes to receive commission for the sale of an auto insurance policy, he must hold a property & casualty
insurance license issued by the state in which the auto insurance policy was sold and issued. Steve’s life insurance producer’s license does not entitle him to receive commissions paid on a property and casualty insurance policy, even if the license is issued in the same state.

Some consumers and non-insurance professionals mistakenly believe that it is customary for an insurance agent to share commissions with an unlicensed individual in the form of a finder’s fee or referral fee. For example, a realtor might refer a homebuyer to an insurance producer when they are in the process of buying a new home. The realtor may request a $10 referral fee for each consumer she refers to the producer. The realtor and producer may believe that because the agent isn’t sharing a percentage of his commissions, the transaction is not illegal. They are both mistaken and they are both guilty of violating the law if a referral fee is paid and received.

The payment of the finder’s fee or referral fee is a form of commission sharing. Another form of commission sharing is the offering of gifts to consumers in exchange for the purchase of policies or for referrals that may result in sales. For example, the finance manager at a car dealership regularly refers clients to an insurance producer. Whenever the producer sells an auto policy, he gives the finance manager a $10 gift card to a local coffee shop.

The practice of sharing commissions with an unlicensed individual, in any form, is both illegal and unethical. It should be noted that some state insurance codes stipulate a dollar threshold when defining a rebate, discount, abatement, credit, special favor, advantage, gift, or valuable consideration—such as $25 or $100.

**COMMINGLING OF FUNDS**

Insurance producers must always keep funds belonging to the consumer and/or the insurance company separate from those of the insurance producer and the insurance agency. Monies collected from clients on behalf of insurance companies are required to be held in a fiduciary capacity. No justification exists, legally or ethically, for an insurance producer to use client or company funds for any purpose.

As recently as the 1980s, some agent/company contracts permitted agents use of the premium dollars collected on agency-billed policies before it was due at the insurance company on the agent’s account current. The Account Current is the billing statement issued by insurance companies to its agents that lists the policies for which the agent is entirely responsible for collecting client policy premiums.

The insurance companies that allowed agents use of the money for a specified period, spelled out the privilege in the agent/company contract. Some of the provisions included:

- The agent was permitted to determine which new business policies would be billed directly by the insurance company and which would be billed by the agent; the agent marked his option on the insurance application.
• If the agent opted to bill a policy and include it on his Account Current, he was contractually permitted to use the premiums collected on agency billed policies for a set period of time.

• A typical arrangement would require payment of the net policy premiums (the policy term premium less the agent’s commissions) appearing on the Account Current by the first of the month that occurred two calendar months after the policies’ effective dates.
  o Example: The February Account Current would list policies with effective dates falling in the month of February; due and payable at the insurance company on May 1st.

As recently as twenty years ago, insurance company/agent contracts permitted agents use of the premium dollars collected by the agents for agency billed policies before it was due at the insurance company on the account current. Here is an example of how it worked with some insurance companies:

• The agent decided if a new business auto insurance policy would be billed directly by the insurance company or if he, the agent, would bill the client.

• If the agent decided to put the policy on agency bill, his contract with the insurance company allowed him the use of the premiums collected on agency billed contracts for a certain period of time. A typical arrangement would be that the net premiums (premiums paid by the client less the agent’s commissions) would be due at the insurance company on the Account Current statement for all policies by the first of the month that occurred two calendar months after the policies’ effective dates.
  o Example: the policy effective dates falling in the month of February would be listed on the Account Current statement that would be due for payment on May 1st.

What an ethical insurance agent did when he agency billed policies—even before state law required him to do so—was to deposit the policyholder’s premiums into a separate bank account for holding until they were due at the insurance company. Subtracting his commissions would have been done once the entire premium was paid.

For example, if the agent collected the entire policy premium of $100, he would deposit $80 into the escrow account and deposit his $20 commission into his operating (or personal) account. On the other hand, if the policyholder made two payments of $50 each, the first $50 payment would be deposited into the escrow account and the commission of $20 would be subtracted from the second payment of $50, after the $30 due the insurance company was deposited into the escrow account.

Unfortunately, some agents did not have the business sense to realize that if they deposited all premiums collected from agency-billed policies into their general account, and didn’t keep a separate accounting of the monies due the insurance companies on their Accounts Current, they might find themselves short of money once the Account Current became due. Many agents found that once they paid their operating expenses, which included payroll, insurance, rent, taxes, and utilities, they often didn’t have enough.
money to pay their Accounts Current.

A few other agents simply took advantage of “the float” (as the monies collected and not yet due) were called. Most states have established laws requiring the establishment of a separate bank account—a client trust account—for the express purpose of keeping the agent’s money separate from that of the client and the insurance company. In fact, the insurance departments of many states actually audit insurance agents and agencies to confirm the existence of client trust accounts and to verify that they are being properly utilized.

Another item of note is that when an insurance company issues a return premium on an insurance policy that is included on an Account Current (i.e. agency billed), the return premium must also be deposited into the trust account. This refund does not belong to the agent; it belongs to the policyholder, as does the return commission.

If an agent does not utilize a trust account, and instead deposits his clients’ premium dollars into the same bank account as his agency’s operating account or his personal bank account, he is considered guilty of commingling funds—and breaching the fiduciary duty owed to both the client and insurance company. If he uses any client’s premium dollars—earned, unearned, or refunds—to pay any of his own expenses (business or personal), he is also often considered guilty of theft. Failing to utilize a trust account, or to utilize one properly, is both illegal and unethical.

UNFAIR CLAIMS SETTLEMENT PRACTICES

The National Association of Insurance Commissioners (NAIC) developed the Unfair Claims Settlement Practices Model Act, which has been adopted by most states. Using the NAIC model, each state has its own Act and particulars of state legislation address unfair claim settlement practices in that state. For example, in Massachusetts, the courts award double or triple damages if an insurance company is judged to have violated state unfair claims settlement practices with respect to insurance claims as outlined in two separate sections of Massachusetts General Law. In California, legislation protects seniors and requires severe penalties for anyone committing senior abuse—especially with respect to insurance practices and insurance claims practices. A recent case in that state awarded the client triple damages for the unethical acts of two insurance securities brokers.

In most states, a practice is considered to be an unfair claims settlement practice if it occurs with such frequency it can be considered a regular business practice. Some states, however, consider even a single instance of a violation to be illegal. The following are typical offenses considered to be unfair claims settlement practices in most states:

1. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue,
2. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies,
3. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies,

4. Refusing to pay claims without conducting a reasonable investigation based upon all available information,

5. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed,

6. Neglecting to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear,

7. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds,

8. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application,

9. Attempting to settle claims on the basis of an application which was altered without notice to or knowledge or consent of the insured,

10. Making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; policy coverage,

11. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration,

12. Delaying the investigation or payment of claims by requiring an insured, claimant, or physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information,

13. Failing to promptly settle claims, if liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance, or

14. Failing to provide promptly a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

Insurance policies are contracts. The terms of the policy contract specify when coverage is provided and when it is not provided. State law specifies the boundaries insurance companies, producers, and adjusters must respect when settling claims. Of course, the actions of insurance companies, producers, and adjusters may be interpreted differently by different people. Item #2. above will be used in an example.

In a particular state, insurance code cites it is considered an unfair claims settlement practice for a person (aka anyone) to “fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies with such frequency as to indicate a general business practice.” Therefore, if Sharon was driving a vehicle and Rachel rear-ended her, Sharon might want to submit her claim to Rachel’s insurance company because Rachel would be considered legally responsible for the
collision. Sharon faxes a loss notice to ABC insurance Company, the insurer providing coverage on Rachel’s vehicle. ABC never responds to Sharon. Is this an unfair claims settlement practice? Is ABC’s lack of response illegal? Is its lack of response unethical?

A few things need to be researched before being able to answer these questions accurately:

1. Did Sharon actually fax his loss notice to ABC Insurance Company? Did she have the right fax number?
2. Was the fax received by ABC?
3. If the fax was received by ABC, it needs to be determined if ABC ignored Sharon’s fax or if it misplaced it.
4. How long has it been since ABC received the fax?
5. Did Sharon give ABC a reasonable amount of time to respond?
6. Did Sharon give ABC her contact information?
7. What if ABC did respond but Sharon didn’t receive its response?
8. What if Sharon’s contact information wasn’t legible and ABC’s response was directed to a wrong address or phone number?
9. What if ABC did receive Sharon’s fax and it’s sitting on a claim representative’s desk because she’s on vacation?
10. What if the fax is buried beneath a pile of work and the assigned claim representative hasn’t gotten to it yet?
11. What if the assigned claim representative simply doesn’t want to handle the claim and shreds the fax?

Are any of the preceding situations going to be described as practices that are committed with “such frequency as to indicate a general business practice?” If so, then ABC is violating the law—in this particular state and in those states that adopted the NAIC model act with this factor included. If the situation is an isolated incident, it is unlikely to be considered illegal—unless it occurs in one of those states that considers a single act to qualify as a violation.

Using the previous scenario, except instead of faxing her loss notice to the insurance company, Sharon calls her own insurance agent to report the claim and never receives a response from her insurance company. All the same questions listed above must be asked of both the agent and company before we can decide if the agent, or the insurance company, is acting in bad faith and committing any unfair claims settlement practice.

Did the agent forget to notify the insurance company—i.e. she forgot to document the telephone conversation or she printed a loss notice and forgot to fax it, etc.? Did the agent submit the loss notice--by either fax, e-mail, or other electronic means--and simply overlook following up? Did the insurance company receive the information from the agent and do any of the things cited in the previous example? Or did the agent deliberately not report the loss to the insurance company because she didn’t want it to affect her loss ratio?

Again, it must be determined if the actions of the agent or insurance company are being
committed with “such frequency as to indicate a general business practice” to be considered illegal. What if this is the first time the agent decided not to submit a loss? What if it’s December and she’s hoping to postpone submission of the claim until January, when it won’t apply to her current year’s loss ratio? Are the agent’s actions illegal according to state law? Probably not. Are they unethical? You bet they are—in addition to being a breach of the contract between the insurance agency and the insurance company.

One thing to keep in mind with respect to unfair claims settlement practices and bad faith claims is that there exists a tremendous body of legal precedent in this area. Each state’s laws and previous court cases have a lot to do with the final determination of an agent’s (or adjuster’s or insurance company’s) culpability when accused of an unfair trade practice or acting in bad faith—of any kind.

PRACTICES INVOLVING THE AUTO BUSINESS

Most states have enacted legislation regulating the business transactions occurring between insurance companies and automobile body repair shops, glass vendors, and rental car agencies. Before such legislation was enacted, insurance companies had a tendency to include specific businesses on their lists of referral vendors. Policyholders and third-party claimants were directed to obtain services from only those vendors appearing on the pertinent lists. Financial gain was the motive for this practice, on the parts of insurance companies and vendors. Vendors were able to secure a steady stream of referral business and insurance companies were able to limit their claims expenses.

These practices, however, were considered to be both unfair and unethical by consumers, vendors not on the preferred lists, and the states. In many states, insurance companies must, by law, inform their policyholders and third-party claimants that they may obtain motor vehicle repairs, glass repairs, and/or covered rental car services from the vendors of their choice. State law may specify rates the insurance companies must pay the vendors—regardless of whether or not they appear on the insurance company’s preferred vendor lists. State law also specifies the procedure insurance companies must follow when a vendor asks to be added to the insurance companies’ vendor lists. The decision to add, or not add, a vendor to its preferred list can no longer be made solely based upon the insurance companies’ discretion.

A typical example involves rental car services. Beth is driving her car and is rear-ended by Brendon. She submits her claim for damages to Brendon’s insurance company and obtains authorization from them to rent a car for three days and bill the charges to them. The insurance company tells her that she must rent the car from 123 Rental Company, because it’s their only approved vendor in the town in which she lives. In states where legislation has been enacted, this practice is illegal. The insurance company must tell Beth that she may rent a car from whatever rental car agency she prefers. The insurance company may tell Beth that 123 Rental Company is its preferred rental car company and they can process her claim more quickly if she utilizes them because they’ll pay 123 directly rather than requiring Beth to pay the vendor of her choice and then submitting a bill for reimbursement.
MILITARY SALES PRACTICES

The U.S. government offers service members life insurance as part of their benefits package. Each member is eligible for low-cost Servicemembers’ Group Life Insurance (SGLI), which can provide up to $400,000 of term life insurance coverage. It should be noted that SGLI does not contain an exclusion for death resulting from an act of war, which some policies offered by life insurance companies do contain.

According to a 2009 Report to Congressional Requesters by the U.S. Government Accountability Office (GAO), the following is a summary of the predatory and dishonest practices that were taking place nationwide in 2005: “In the 2006 Military Personnel Financial Services Protection Act (the Act), Congress found that certain life insurance products were improperly marketed as investment products and provided minimal death benefits in exchange for excessive premiums that were front-loaded in the first few years, making the products inappropriate for most service members. The Act provided for state insurance regulators, the National Association of Insurance Commissioners (NAIC), and the Department of Defense (DOD) to address concerns over unsuitable insurance products and inappropriate sales practices directed at servicemembers.

The report went on to say that sales of life insurance coupling life insurance with side savings account were “problematic,” especially for junior servicemembers. The sales of these products contained unfavorable features that “included a high-cost life insurance product that provided nominal supplemental coverage and aside fund that had an unfavorable interest-crediting method and high withdrawal penalties for the policyholder.” According to information Congress received from state regulatory authorities, these policies had an unusually high lapse ratio for non-payment of the policy premium. In addition to the previously cited issues, the Department of Defense identified that many of the sales of these policies involved agents who used prohibited means of gaining access to the military installations for the solicitation of insurance and other types of products and services.

In 2007, the NAIC adopted model regulation governing military sales practices in conjunction with the Department of Defense that comply with the federal Military Personnel Financial Services Protection Act, P.L. No.109-290 (2006). The purpose of the Act and Model Regulation is to provide uniform standards among the states to protect active duty service members of all branches of the U.S. Armed Forces from the dishonest and predatory practices of insurance producers. The majority of states either have adopted the Model Regulation or are in process.

Model Regulation applies to the sale and solicitation of life and annuity products but does not apply, typically, to property and casualty insurance products. The NAIC also established the Military Sales Online Reporting System (MCORS) to carry out the Act’s stipulation that a national system be created to collect data about anyone against whom disciplinary action has been taken with respect to the sale or solicitation of any life insurance product on a U.S. military installation. As of 2009, the Department of Defense was not using the MCORS system because it was not yet designed to accept external queries. According to the NAIC, it was expected that all 50 states, the District of
Columbia, and Puerto Rico would have adopted Model Regulation.

The Model Regulation states that particular acts and practices are false, misleading, deceptive, or unfair. According to Model Regulation, the following acts or practices committed by an insurance company or producer are considered false, misleading, deceptive, or unfair when committed on a military installation or in military controlled housing:

- Soliciting the purchase of any life insurance product “door-to-door” or without first establishing a specific appointment for each meeting with the prospective purchaser;
- Soliciting service members in a group or “mass” audience or in a “captive” audience where attendance is not voluntary;
- Making appointments with or soliciting service members during their normally scheduled duty hours;
- Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation;
- Soliciting the sale of insurance without first obtaining permission from an office designated by the installation commander;
- Posting unauthorized bulletins, notices or advertisements; and
- Failing to present DD Form 2885, Personal Commercial Solicitation Evaluation, to persons solicited or encouraging persons solicited not to complete or submit a DD Form 2885.

Several state regulators and the Department of Defense have taken regulatory action against insurance companies and agents for conducting prohibited sales practices on military installations. Texas, Georgia, Florida, North Carolina, and Illinois, all took action and were involved in pending litigation as of April 2009. According to the GAO report, “Despite new regulations and actions taken by DOD and state regulators, inappropriate sales practices and some sales of unsuitable life insurance products appear to continue.” The DOD, NAIC, and state regulators continue to work to increase the effectiveness of the programs in place and to implement new programs for the protection of servicemembers of the U.S. Armed Forces.

**PRETEXT INTERVIEWS (AKA BAIT AND SWITCH)**

Bait and switch tactics are a form of false or misleading advertising and are illegal in the United States and in each of the fifty states. Bait advertising involves the offer to sell a product, or one of its features, that the advertiser does not truly want to sell. When the consumer is distracted by the “bait,” the advertiser attempts to sell something else, to obtain leads to other people, or to obtain information not pertinent to the “bait.” In the insurance industry, unethical producers often use bait and switch tactics in the form of a pretext interview to obtain information under false pretenses.

The growing popularity of estate planning and living trusts has generated scams called “Living Trust Mills.” These scams often target seniors, who are attracted to free
seminars about estate planning, living trusts, and other similar topics. Some producers provide themselves with official sounding titles, such as “Trust Expert,” “Trust Advisor,” “Senior Estate Planner,” and “Paralegal” and present free seminars under the pretext of helping establish or update living estates. The true purpose of these producers is to acquire the financial information of seniors they might otherwise not be able to obtain—in the form of a pretext interview. Some states, including California, have enacted legislation that prevents an individual from using a senior designation unless it meets specific regulatory requirements.

**ILLEGAL PRACTICE OF LAW**

Oftentimes, a consumer will ask a producer for advice that borders outside the producer’s area of expertise, such as with accounting and legal matters. It is illegal in most states for a producer to offer any type of legal advice without being licensed to practice law. If the producer is questioned about any topic related to insurance that deals specifically with estate planning, elder care planning, and/or tax planning he should be referred to the appropriate professional for consultation and advice.

**UNFAIR TRADE PRACTICES SUMMARY**

Most state legislation related to unfair trade practices reflect actual practices that were originally accepted within the insurance industry. The practices evolved into acts that became deceitful, fraudulent, or harmful to consumers and the citizenry—and the state—decided they were unacceptable.

The previously cited unfair trade practices are used as representative of the major illegal practices recognized by most states and are in no way to be considered the only unfair trade practices in any of the states. They may, however, be utilized when evaluating situations involving consumers where the producer is not sure how to behave. Sometimes, it appears that a single act or behavior is acceptable because it benefits the client and it “doesn’t hurt anyone else.” In order to confirm the legality of an act or practice, a producer should always refer to the rules and regulations of the insurance company, his agent/company contract, and the laws of the state(s) in which he is doing business.

**TRADE PRACTICES AND SENIORS**

Because of a number of factors, the senior segment of the population in this country is at more risk, in a variety of ways, than any other segment. Seniors are more susceptible to high-pressure sales tactics and scams, especially those that prey on a senior’s fears associated with longevity and the condition of their health. Because medical science is advancing at such a rapid rate, people are living longer, which presents the very real possibility that many seniors will outlive the retirement income they’ve set aside—if they don’t spend it all on medical and health care costs.
Everyone assumes some risk when purchasing an annuity; seniors assume a much higher risk. Ethical producers take pains to explain all available options, and elicit as much information as possible, when dealing with senior clients in order to gauge appropriately the level of risk they can safely assume.

Choosing and executing a successful retirement plan doesn’t happen overnight. An individual’s retirement goals should begin to take shape at around age forty—and sometimes at a younger age. Considerations when setting retirement goals in the earliest phase of retirement planning include:

- What is the desired retirement age?
- Will a spouse or other individual be a party to the retirement plan?
- What is the desired retirement lifestyle?
- Where will the funding for retirement come from?
- What retirement funding options are available?
- How will assets be allocated both before and after retirement?
- What are the tax advantages available throughout the process AND in retirement?
- What financial, legal, and insurance professionals will assist with the process?

As the individual approaches retirement, he should not only continue to focus on his goals but also to revise them. A job change, children moving out of the home, acquisition of property, divorce, and other life-altering events often dramatically affect a person’s retirement goals and the ability to carry them out. Existing investments, pension and profit-sharing plans, inheritances, and taxes all manage to influence the process, as well.

Once a consumer has officially retired, he should carry on with his plans and revisions, with an eye to his very special needs now that he is no longer earning income and must support himself with the retirement funds he has established. Did he accurately predict his retirement expenses and cost of living? Is he living the lifestyle he intended five (or twenty) years ago? Do his spouse and/or other family members depend upon the retirement income he’s provided for himself? Will required minimum distributions come into play at age 70 ½ and, if so, how will they affect the plan?

An insurance producer must be familiar with all phases of retirement planning, and all the concerns a client might have, in order to properly advise and recommend products, features, benefits, and available options—especially when dealing with seniors, who have much less time to act than other consumers do.

**FINANCIAL CONCERNS**

Once a person reaches the age of 60 or 65, he has far more concerns than younger people realize. Perhaps he doesn’t have to get up and head to the office each morning, but the worry about bringing home the bacon doesn’t disappear just because he no longer sits behind a desk from 9 to 5. Sure, he can hop in the RV and tour the mid-west in the summer, or spend every morning at the fishing hole, but these pursuits cost money—and he’s no longer earning any.
**SOCIAL SECURITY**

The majority of people depend upon their Social Security benefits in retirement; however, most don’t understand when benefits start or the most beneficial way to take advantage of them. For example, every consumer knows he can opt to begin receiving Social Security retirement benefits at age 62, but few realize they’ll receive a permanent reduction in their monthly benefit in an amount between 25% and 30%! Poor planning may result in taking a huge bite out of someone’s retirement income.

If an individual begins working after receiving Social Security benefits, his benefit amount may change and he may actually have some of his benefits withheld if he has excess earnings. Once the individual reaches full retirement age, the SSA will recalculate the benefit amount to give the individual credit for any months in which he didn’t receive benefits because of earnings. Here is a chart that shows the age at which a person receives full Social Security retirement benefits:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Full Retirement Age</th>
<th>Year of Birth</th>
<th>Full Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1937 or earlier</td>
<td>65</td>
<td>1955</td>
<td>66 and 2 months</td>
</tr>
<tr>
<td>1938</td>
<td>65 and 2 months</td>
<td>1956</td>
<td>66 and 4 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 and 4 months</td>
<td>1957</td>
<td>66 and 6 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 and 6 months</td>
<td>1958</td>
<td>66 and 8 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 and 8 months</td>
<td>1950</td>
<td>66 and 10 months</td>
</tr>
<tr>
<td>1942</td>
<td>65 and 10 months</td>
<td>1960 and later</td>
<td>67</td>
</tr>
<tr>
<td>1943-1954</td>
<td>66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If a person delays receiving Social Security benefits past his full retirement age, his benefits will be increased by a certain percentage, depending upon his date of birth. The benefit increase no longer applies when a person reaches age 70, even if he continues to delay taking benefits.

Here is a chart that shows the increase percentages for delayed retirement:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Yearly Increase</th>
<th>Monthly Rate of Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1933-1934</td>
<td>5.5%</td>
<td>11/24 of 1%</td>
</tr>
<tr>
<td>1935-1936</td>
<td>6%</td>
<td>½ of 1%</td>
</tr>
<tr>
<td>1937-1938</td>
<td>6.5%</td>
<td>13/24 of 1%</td>
</tr>
<tr>
<td>1939-1940</td>
<td>7%</td>
<td>7/12 of 1%</td>
</tr>
<tr>
<td>1941-1942</td>
<td>7.5%</td>
<td>5/8 of 1%</td>
</tr>
<tr>
<td>1943 and later</td>
<td>8%</td>
<td>2/3 of 1%</td>
</tr>
</tbody>
</table>

NOTE: If a person delays retirement, he should still sign up for Medicare at age 65. Delaying this process may generate higher costs or affect eligibility. Having benefits reduced by receiving them a few years early doesn’t seem like a significant thing to some people; neither does forfeiting an increase in benefits by not working a year longer than planned. However, most people reconsider their position after looking at actual figures. Let’s consider two scenarios:

**Scenario #1:** Eleanor opts to begin receiving her Social Security retirement benefits at age 62 instead of at age 66 (she was born in 1947). If her monthly benefit would have been $1,000 at her full retirement age of 66, her benefit reduction is about 30%. This
translates into a monthly benefit of $700 instead of $1,000. Beginning now, when she starts to receive benefits, she’ll receive $3,600 less per year. If Eleanor lives to be 82 years old, she’ll have forfeited $72,000 in Social Security retirement income.

**Scenario #2:** Eleanor opts to work one extra year past her full retirement age to take advantage of the increased benefit percentage. If her monthly benefit would have been $1,000 at age 66, she’ll receive an additional 8% per year if she begins receiving benefits at age 67. This means she’ll receive $1,080 per month—or $960 more per year. If Eleanor lives to be 82 years old, she’ll have earned an extra $14,400 in Social Security retirement income.

**RETIREMENT PLAN DISTRIBUTIONS**

Many retirement plans, including qualified IRAs and 401(k)s require an individual to begin minimum distributions no later than April 1st of the year following the year in which they turn age 70 ½. The amount of the distribution is calculated based on life expectancy—the number of years over which it is expected withdrawals will be made. (The IRS provides three life expectancy tables: the Joint and Last Survivor Table, the Uniform Life Table, and the Single Life Expectancy Table.) These distributions are subject to taxation as ordinary income for the qualified portion of the assets and the account’s earnings; the portion of distributions that are a return of pre-taxed principal are not subject to income tax. If an individual fails to withdraw the required minimum distributions in a tax year, a penalty will be assessed that equals 50% of the amount of the required withdrawals.

**INVESTING RETIREMENT ASSETS**

Once a person has retired, his primary goal is keeping what he has. Yes, investing and growing assets is an attractive prospect, but most seniors don’t want to—and shouldn’t—risk their current assets and the safety of their principal for the possibility of accumulating more funds. Having said that, there are circumstances where seniors have enough liquidity to take some risk. It is up to the producer to help a senior determine precisely where he is with respect to liquidity and the potential for assuming risk and, then, to act accordingly.

**SURRENDER CHARGES**

In addition to any surrender charges contained in a particular annuity contract, it is very important for a producer to remind his client that premature surrender of, or withdrawal from, an annuity and other retirement plans—such as IRAs and 401(k)s—prior to age 59 ½ will generate a 10% federal penalty.

Even more important, is the aspect of surrender charges when a senior is considering the replacement of an existing policy or annuity. While the replacement contract might be attractive, it will likely involve a surrender term and penalties. It is possible to add benefits to the contract, such as critical illness and other crisis waivers to eliminate some penalties, but these options cost money—which reduces the beneficial effect of the replacement. The producer needs to keep the *substantial financial benefit* doctrine mind in all times when replacing an annuity contract.
INSURANCE CONCERNS

In the senior market, insurance concerns have a much more far-reaching effect than they did when the consumer was younger. Premiums are much higher for seniors if they’re purchasing brand new policies and, if they suffer from health issues, they may not be able to purchase new insurance coverage at all.

Many people are fortunate to have medical, disability, and life insurance included in their employee benefits. What happens when they retire? Do their benefits continue?

If the medical, disability, and life insurance benefits do not continue after the senior retires, the producer is often charged with the duty of helping the senior find alternative coverage. An individual is eligible for Medicare at age 65, but will that coverage be adequate for the senior’s needs? Can the senior afford a Medicare Supplement policy? The senior probably won’t need to continue his disability coverage, but what should he do if he decides to work part-time after retiring? Will he still need the life insurance? And what if he decides to retire before turning age 65?

Planning for long-term care should begin well before a person becomes a senior but, unfortunately, many people don’t consider long-term care coverage until after they develop a medical issue. They can’t purchase coverage, for the most part, once they’ve developed a serious medical condition they sometimes think, incorrectly, Medicaid will protect them.

ESTATE PLANNING

Regardless of the size of a consumer’s estate, the importance of having an estate plan in place cannot be overstated. An estate plan is comprised of several essentials: a will, a power of attorney, and a living will (or health care proxy or medical power of attorney). Sometimes a trust forms part of an estate plan.

When beginning an estate plan, it is important to consider all assets and what role they will play in the plan. Who is listed as beneficiary on the life insurance policies, retirement and pension plans, IRAs, etc.? Who will inherit the assets when the owner dies, including homes, businesses, and real estate? Who will be authorized to make medical decisions if the estate owner is unable to do so?

Once a person (or couple) answers these questions, the easiest way to assure that his (or their) wishes are carried out is to state these wishes in a will. Dying without a will, and allowing the state to determine how to distribute assets, can be costly for a person’s heirs and may ultimately result in the implementation of estate settlement contrary to what an individual actually desired.

The federal estate tax exemption is $3,500,000 in 2009. In 2010, it is scheduled to phase out. Unfortunately, unless Congress passes new laws, it will be reinstated in 2011—at a limit of $1,000,000! A person may leave an unlimited amount of assets to a surviving spouse without the spouse incurring a taxable event but, when the spouse dies, his/her taxable estate will be significantly increased, thereby generating a huge tax bite for
children (or the spouse’s heirs).

Life insurance and annuities may be effective tools in the estate planning process, especially when a client dies. Death benefits can cover costs that range from final expenses to the payment of taxes, thus allowing a surviving spouse or the client’s heirs from having to liquidate assets.

**SALES PRACTICES AND THE SENIOR MARKET**

When today’s seniors bought their first insurance policies, Whole Life insurance was popular—Universal Life hadn’t even been invented! The idea of flexible premium payments, cash value accounts with varying rates of interest, and buying an insurance policy that could invest in the stock market were unheard of. Insurance products have grown more complicated over the years and annuities are exceedingly complicated.

Many seniors are not equipped to understand all the changes that have been implemented in the tax treatment of insurance products or with the new features and benefits available. For this reason, it is especially important for a producer to be explicit in his explanation of contract provisions. Illustrating to the senior consumer all the consequences of a purchase, both positive and negative, and then documenting them for the client’s review is the best way to help a senior make the best buying decision.

**BUYER COMPETENCE**

The issue of legal capacity often arises in cases involving senior consumers. Legal capacity is the term used to define a person who is able to understand and appreciate the consequences of his actions. It determines his “buyer competence.”

A person who lacks legal capacity cannot, for example, enter into a contract, give a power of attorney, make a will, consent to medical treatment, or transfer property. Minors typically lack legal capacity, as do individuals who are mentally handicapped or under the influence of alcohol. The older we become, the more likely we are to develop a mental disease or disability such as Alzheimer’s disease or dementia, which diminishes both our legal and mental capacity.

If a producer sells an insurance policy to an individual who lacks legal or mental capacity, it could be argued that the sale is inappropriate--even if neither the producer nor the consumer were aware of the lack of capacity. Since basic contract law requires “competent parties” for a contract to be considered legal, it could further be argued that the contract is not valid and binding upon the incompetent individual.

Some seniors experience diminished capacity as they age; recognizing the signs of such a condition is often difficult, especially for a producer who doesn’t routinely have dealings with seniors. Producers who exert undue influence over seniors commit elder abuse. According to the National Committee for the Prevention of Elder Abuse, “undue influence,” is defined, in part, as: “…an individual who is stronger or more powerful making a weaker individual to do something that the weaker person would not have done otherwise. The stronger person uses various techniques or manipulations over time to
gain power and compliance.” Such techniques are both illegal and unethical.

The SEC recently reported that diminished mental capacity affects approximately 20 percent of seniors aged 85 and older. It is important that producers recognize the indicators a prospective insured might exhibit that illustrate the lack of short-term memory or judgment that is required to knowingly purchase an annuity.

Diminished mental capacity does not mean an individual does not have legal capacity; it does indicate, however, that the individual does not function as well as s/he has functioned in the past. Since each person is unique and possesses varying degrees of decision-making capabilities at various stages in his life, it is a considerable challenge for a producer to recognize diminished mental capacity in a person he just met.

For a producer who is not formally trained in a mental health disciplines (and most are not), assessing diminished capacity is possible in some cases but, in general, beyond the expertise of a typical producer. A major issue involved in assessing diminished capacity pertains to short-term memory. Many individuals have occasional memory problems due to the natural aging process and take longer to make decisions. Loss of memory, and/or the onset of diminished mental capacity, is usually a gradual process that accelerates over time. It is entirely possible for a senior consumer to make an insurance-related decision today, when appearing cognitively adept, and to be considered cognitively impaired two or three years in the future—after a complaint of elder abuse has been filed.

Below is a list of several indicators of diminished mental capacity of which producers should be aware. Not all of these indicators will be apparent in the context of a typical meeting with a senior. Additionally, some of these indicators require prior knowledge of the senior in order to determine if deterioration has taken place in a particular aspect of the senior’s behavior over time.

- **Memory loss**: The senior is repeating questions, forgetting details, forgetting appointments, misplacing items or losing track of time
- **Disorientation**: The senior is confused about time, place, or simple concepts OR the senior appears to be disoriented with surroundings or social settings
- **Difficulty performing simple tasks**: The senior lacks the ability to remember the order of performance of the steps necessary to complete a simple task such as tying one’s shoes.
- **Difficulty speaking**: The senior use words that do not fit the context of their use
- **Difficulty understanding consequences**: The senior appears unable to appreciate the consequences of decisions.
- **Difficulty with decision-making**: The senior makes decisions that are inconsistent with his or her current long-term goals or commitments.
- **Attitude**: The senior seems overly optimistic.
- **Difficulty following simple directions**: The senior has difficulty with directions, particularly when they include multiple steps that must be performed in sequence
- **Deterioration of handwriting and signature**: The senior appears unable to accurately write the letters of the alphabet or the letters are written backwards
- **Drastic mood swings**: The senior may exhibit a swift change in mood within a
short period of time with no obvious reason for the mood change

• **Difficulty with finances:** The senior does not remember or understand recently completed financial transactions.

• **Lack of attention to personal hygiene:** The senior appears uncharacteristically unkempt

• **Confusion as to date and time:** The senior may be confused as to the season, the current month, the day of the week, or the time of the day.

The Alzheimer’s Association publishes a list of explanations for some of the indications of Alzheimer’s Disease. While this information relates to the recognition of Alzheimer’s, it also provides a brief description of normal behaviors that can be of value to a producer when attempting to recognize signs of short-term memory loss and/or lack of judgment in senior consumers:

• **Memory loss that affects job skills.** It is normal for a person to occasionally forget an item at the grocery store, a deadline, or a colleague's name; frequent forgetfulness or unexplained confusion may signal that something is wrong.

• **Difficulty performing familiar tasks.** Busy people get distracted from time to time. For example, a person might leave something on the stove too long or forget to serve the vegetables at dinner. People with Alzheimer's disease might prepare a meal and not only forget to serve it but also forget they made it.

• **Problems with language.** Everyone has trouble finding the right word on occasion; a person with Alzheimer's disease may forget simple words or substitute inappropriate words, making his or her sentences difficult to understand.

• **Disorientation about time and place.** It's normal to momentarily forget the day of the week or what you need from the store. People with Alzheimer's disease can become lost on their own street--not knowing where they are, how they got there, or how to get back home.

• **Poor or decreased judgment.** Choosing not to bring a sweater or coat along on a chilly night is a common occurrence. A person with Alzheimer's, however, may dress inappropriately in more noticeable ways, such as wearing a bathrobe to the store or wearing several blouses on a hot day.

• **Problems with abstract thinking.** Balancing a checkbook can be challenging for many people, but for someone with Alzheimer's disease, recognizing numbers or performing basic calculation may be impossible.

• **Misplacing things.** Everyone temporarily misplaces a wallet or keys. A person with Alzheimer's disease may put these and other items in inappropriate places, such as an iron in the freezer or a wristwatch in the sugar bowl, and then not recall how the item got there.

• **Changes in mood or behavior.** Everyone experiences a broad range of emotions, such behavior is part of being human. People with Alzheimer's disease tend to exhibit more rapid mood swings for no apparent reason.

• **Changes in personality.** People's personalities may change somewhat as they age. However, the personality of a person with Alzheimer's can change dramatically, either suddenly or over a period of time. It is not uncommon for a person suffering from Alzheimer's to have his normally easygoing temperament become angry, suspicious, or fearful.
• **Loss of initiative.** It's normal to tire of housework, business activities, or social obligations, but most people either retain or regain their interest. The person with Alzheimer's disease may remain uninterested and uninvolved in many or all of his usual pursuits.

One method of preventing the future claim of an ethics or suitability violation involving a senior is for a producer to invite a trusted family member or other individual to be present when meeting with a senior for the purpose of discussing insurance or annuities. Privacy issues may have an impact on this practice and producers should make certain compliance with all privacy laws and regulations are in place. Another concern for the producer is the possibility that the trusted family member is, himself, the perpetrator of elder abuse.

Examples of a family member exploiting a position of influence over a senior to gain access to the senior’s assets, funds, or property (the definition of elder abuse) include:

- Cashing a senior’s checks without authorization or permission
- Forging a senior’s signature
- Misusing or stealing a senior’s money or possessions
- Coercing or deceiving a senior into signing a document, such as a will or a contract
- Improper use of conservatorship, guardianship, or power of attorney

Possible signs of elder abuse being committed by a family member include:

- The senior’s sudden reluctance to discuss financial matters
- Sudden, unusual, or unexplained withdrawals from, or other changes in, a senior’s bank accounts, insurance policies, or other investments
- Abrupt changes in a senior’s will, trust, or power of attorney
- The senior’s increasing lack of contact with, and interest in, the outside world
- Admission or suggestion that a financial or material exploitation is taking place
- The senior’s concern or confusion about missing funds in his/her account
- Fear of placement in a nursing home if money is not given to a caretaker
- Appearance of insufficient care or neglect, despite having money and a means of support

The Financial Industry Regulatory Authority (FINRA), the Securities and Exchange Commission (SEC), and the majority of the states are increasingly concerned about elder abuse and unethical sales practices targeting seniors. An ethical producer will report all instances of suspected senior abuse to the appropriate authorities and will also refrain from working with a senior if the producer even suspects the senior is a victim of diminished legal or mental capacity.
CHAPTER 4 REVIEW QUESTIONS

1. Ethical behavior is characterized by all the following values EXCEPT _____.
   [a] Goodness
   [b] Morals
   [c] Scruples
   [d] Wealth

2. Meta-ethics focuses on how to define _____.
   [a] What is morally right and morally wrong
   [b] What makes a man happy
   [c] The justification of using force
   [d] Moral emotions

3. If a person knowingly makes a false statement on an application for the purpose of deceiving, he has made a _____.
   [a] Representation
   [b] Misrepresentation
   [c] Guarantee
   [d] Warranty

4. When a producer misrepresents policy terms, conditions, or benefits to induce a customer to buy a policy, he has committed the act of _____.
   [a] Rebating
   [b] Twisting
   [c] Commingling
   [d] Discrimination

5. Scams targeting seniors, who are attracted to seminars about estate planning and other similar topics, are called _____.
   [a] Living Trust Mills
   [b] Estate Planning
   [c] Military Sales Practices
   [d] Commingling of Funds
Chapter 5

MANAGING PROPERTY & CASUALTY RISKS

In today’s marketplace, insurance agents are faced with many of the same issues they’ve been contending with for years. New issues, however, continue to crop up and sometimes make working in the insurance industry feel like a ride on a roller coaster.

The insurance market in this country tends to grow and decline in cycles, just like every other industry. The different cycles are referred to as “soft” and “hard” markets. These markets demonstrate what drives insurance industry business practices for a set period of time. How an insurance company responds to, and acts during, a soft or hard market will have a direct effect on its results when the market turns around.

The type of cycle is a gauge of the industry’s basic stability and whether it will experience overall growth or decline. A soft market is characterized by low premiums, reducing profits, high capital, and a lot of competition. The hard market follows on the heels of a soft market, usually because of some type of wide-ranging catastrophe, such as a hurricane or other disaster. Underwriting practices tighten and, as a result, premiums increase—along with profits. Competition usually eases in a hard market.

The property & casualty segment of the insurance industry has been struggling with a number of frustrating issues in recent years, not the least of which is the continuation of a soft market that was predicted to harden in the third quarter of 2009—which it did not do. Typically, the property and casualty market remains soft for an extended period of time only when investment earnings persuade insurance companies to ease off in their underwriting practices. Investment earnings in early 2009 were not what anyone would call bountiful, yet still, the market remained soft. Predictions about what will happen in the future vary, depending upon who is making the prediction. Most industry professionals seem to agree that a hard market is coming, but that it will be slow in coming.

A soft market typically benefits the property and casualty consumer, because insurance is easy to obtain and prices are low, especially for consumers who might otherwise have a difficult time obtaining coverage because of loss history or credit score. The soft market may also benefit insurance companies and agents, but only if the carriers don’t ease off too much on their underwriting guidelines. It is absolutely essential for insurance companies to maintain the proper balance between their increasing premium volume and growing expenses. Sometimes, the market can harden before an insurance company sees it coming (who can predict natural disasters?) and winds up overextending itself,
propelling itself and its policyholders into financial difficulty.

So, how does the soft market affect insurance agents and the ways in which they interact with potential and existing clients? First of all, the soft market may entice consumers to leave their current agent or company to follow the dollar sign. After all, in a soft market, consumers are experiencing payroll cuts and layoffs, reductions in employee benefits, and the same financial woes that face businesses: loss of profits/income. Consumers can find some very attractive pricing in a soft market. What they don’t always understand is that the lower premiums they find often equate to reduced coverage. During a soft market, many consumers are lulled into a sense of security and tend to take risks by eliminating coverages. The second thing affecting agents and companies in a soft market is relationship. When financial times are difficult, a higher number of customers tend to jump ship: agents seek other companies to represent and consumers seek less expensive pricing. As anyone who has been in the insurance business a long time knows, the markets always cycle and, in the end, everything evens out. Not everyone has the patience, or financial endurance, to hang in for the long run, however.

According an article by Phil Gusman that appeared in National Underwriter in January 2010, Ernst & Young indicated that both personal and commercial lines accounts have experienced reduced exposures and rising combined ratios in recent years and that combined ratios in commercial lines accounts were over 100 in 2008. The only segment of the property and casualty industry that has been experiencing rising rates, according to a number of industry organizations, is coastal property. According to the Insurance Information Institute, the P & C industry posted nearly a 5% return on average surplus during the first three-quarters of 2009, which is much better performance than its negative rate of return during the first quarter.

One other thing to take note of is that although no major disasters occurred in the U.S. in 2009, it appears that direct losses increased slightly. This is another harbinger of the hard market, which many believe won’t take hold until 2011.

Regardless of the type of market an agent find himself in, he needs to be aware of why the property and casualty marketplace is functioning as it is, why it’s not the way it used to be, and why it’s going to change again. If an agent understands the cycles, can explain them to the consumer, and can advise the consumer how to best adjust himself within the marketplace, everyone winds up winning.

Knowledge is key when managing property and casualty risks. The more an agent knows—about the consumer, about his carriers, about the products available, about the economy, about the geographical portion of the country in which the agent and his customers live, about the contentious issues taking place—the better an agent will be able to conduct his insurance business affairs.

As discussed earlier in this material, agents must comply with regulations, exhibit due diligence at all times, and disclose various kinds of information to any number of parties. Discussion will now focus on how to implement those practices in the property &
casualty segment of the insurance industry with respect to issues that are of current concern to agents, insurance companies, and consumers.

SPECIALIST OR GENERAL PRACTITIONER?

If a person were to visit property and casualty agencies across the country, he’d find a flavor of agent to match every flavor of ice cream that’s ever been invented. Depending upon the locality, the client-base, and the insurance concentration of the people working within the agency, insurance is marketed, sold, and serviced in innumerable ways.

However, the basics of property and casualty insurance remain the same: Personal Lines and Commercial Lines.

Some agencies concentrate in one line, others spend equal time in both lines. Larger agencies tend to hire producers and CSRs who work exclusively with either personal or commercial products and smaller agencies tend to hire producers and CSRs who are fluent in both lines. It is even possible to find agents who devote their time to a single insurance product, such as Workers’ Compensation or Directors & Officers Liability.

Regardless of an agent’s decision concerning the concentration of his professional efforts, the most important thing for him to remember is that he must know what he’s doing. If an agent is going to specialize, and hold himself out as a specialist, he had darn well better have special knowledge in his field. As we’ve seen in previous chapters, and as we’ll see in the chapter devoted to avoiding E & O traps, agents who specialize are held to a higher standard of care in all their professional endeavors: with consumers, with company personnel, and with fellow members of their staff. An agent can tell a consumer he’s the best agent to do business with because of special expertise in his field but if he doesn’t deliver on his promise, he’s likely to find himself facing a lawsuit.

Some consumers prefer to do business with specialists and others prefer to do business with general practitioners. The agent who works in both personal and commercial lines of insurance may find himself building stronger, more long-lasting client relationships than the specialist. The specialist may initially have the stronger bond, but the natural tendency of the client to want to expand that relationship based on the trust and confidence that’s been built is quite often frustrated when the specialist is either unable or unwilling to step outside his area of specialty.

Example #1: The agent, Ted, owns his an agency that specializes in workers’ compensation insurance. He knows it like the back of his hand, has been immersed in it for twenty years, and can talk experience mods and retrospective rate plans in his sleep. His client, Bob Smith, who owns ABC Manufacturing, has watched his workers’ compensation premiums plummet over the years because of the work he’s done with Ted, including utilizing his Loss Control and Risk Management services—services the previous workers’ compensation agent didn’t provide. ABC Manufacturing’s commercial package and umbrella policies are coming up for renewal and Bob wants Ted
to provide him with quotes. Ted carefully explains that, although he is licensed to sell those other types of policies, he is not familiar with them because he has chosen to specialize in workers’ compensation insurance. Ted suggests to Bob that if he’s unhappy with the agent handling those other policies, he should do some shopping. Well, when Bob follows Ted’s advice, he learns he could be receiving an account discount on all three policies if they were written with the same insurance company. In addition, while not all agents offer loss control and risk management services, many do—as do the insurance companies.

In the previous example, maybe the relationship Ted and Bob have built is so strong that another agent is unable to persuade Bob to give him the workers’ compensation business. Or, maybe Ted has done such a good job implementing loss control and risk management practices at ABC Manufacturing, another agent or company couldn’t compete in that area. However, what if, at some point down the line, Bob and Ted experience a blip in their relationship? What if one of ABC Manufacturing’s employees suffers a workplace injury despite all the loss control and risk management measures in place? What if Bob’s relationship with the agent who writes the commercial package and umbrella policies grows stronger than Bob’s relationship with Ted grows?

Now, if Ted worked at a large agency instead of as a solo practitioner, he probably would have introduced Bob to another producer at the agency. Dilemma solved, right? Maybe not. What if the other producer doesn’t do a good job? What if Bob doesn’t care for the other producer and their personalities don’t mesh?

Example #2: The agent, Betty, has owned her own insurance agency for twenty years and handles all lines of insurance. She knows her customers as well as she knows her family. She knows her insurance stuff, too. Betty’s client, Edie, has insured her home and autos with Betty for years. Now that she’s divorced, Edie has decided to use some of the money she obtained in her divorce settlement to open a hair and nail salon. She asks Betty to write the insurance and Betty says she’ll be happy to do so. She and Edie complete applications necessary to secure quotes from several companies and Betty eventually writes coverage that, while a little more expensive than Edie expected, provides her with all the coverage she needs. Edie feels good that she has Betty looking out for her best interests.

After receiving her policy in the mail from Betty, Edie reads it and has some questions. When she stops by the insurance office to ask Betty her questions, Betty jots them down and says she’ll get back to her later that day. She provides Edie with the answers during a phone call later on, as promised, but Edie wonders why Betty didn’t know the answers right off the top of her head—as she’s always done with Edie’s auto and homeowner insurance questions. Edie begins to wonder if, perhaps, Betty doesn’t really know that much about insurance for hairdressers because she handles so many other kinds of insurance. Edie stops in at the biggest insurance agency in town and talks to an agent who specializes in business insurance. That agent reviews Edie’s policy and proceeds to answer Edie’s questions immediately, confirming that Betty provided her with the correct answers. The agent also says that he could probably have provided the same coverage at
a lower price because his larger agency represents far more insurance companies than Betty’s little agency does.

Will Edie continue to do business with Betty after the other agent confirmed her level of knowledge? Will Edie realize that she doesn’t mind Betty not having the right answer immediately so long as she does provide the right answer? Will her long-time relationship with Betty matter more to Edie than the alleged savings the agent specializing in business insurance promised? Or will Edie feel more secure placing her business insurance with a fellow who “knows the answers off the top of his head,” someone who specializes in business insurance and who can also save her money?

The previous examples are hypothetical situations. However, they mirror real-life situations that occur every day. As well as agents know their clients, sometimes they don’t know all they need to know. Moreover, even in the presence of a rock-solid relationship, other concerns may weigh more heavily when it comes time to buy, renew, or replace insurance policies. Agents should understand the benefits and drawbacks to both specialization and general practice and manage their business affairs around them.

**AUTO INSURANCE**

**UNINSURED MOTORIST COVERAGE**

One of the most contentious issues concerning auto insurance these days is Uninsured and Underinsured Motorist coverage. As of January 2010, 22 states required consumers to purchase Uninsured Motorist Coverage when buying an auto insurance policy. Of the states that do not mandate the purchase of UM coverage, many require policyholders to purchase policies without it only after they’ve rejected it in writing. Approximately one-third of all states either allow or mandate the stacking of Uninsured Motorist coverage limits after an accident.

In states where the stacking of Uninsured Motorist coverage is required or permitted, premium charges for coverage are usually higher. Why? Because policyholders may submit claims under all policies carrying limits for the coverage instead of just one policy.

For example, if Dan owns two vehicles, each is insured on a separate policy, and each policy carries Uninsured Motorist coverage at limits of 50/100, he may collect up to the limits of both policies if he has a covered Uninsured Motorist loss. (Some states also allow the stacking of Underinsured Motorist Coverage and Medical Payments Coverage. Other coverages, such as Bodily Injury Liability and Property Damage Liability are not permitted to be stacked.)

A significant number of court cases have been won by policyholders suing their agents and/or insurance companies because the policyholder claimed inadequate limits of Uninsured Motorist Coverage were sold to them. Consumers view the value of coverage
differently before and after a loss. While a $100 annual premium charge for increased UM limits might seem high to a consumer before the loss, after the loss—when she’s looking at having to pay for thousands of dollars of medical bills out of her own pocket—that $100 may not seem so high.

While documenting the offer and/or rejection of coverage is important regardless of the line of business and type of policy, it is especially important with respect to Uninsured Motorist coverage. Because the coverage is complex and not easily understood by consumers, and because many states have strict requirements about offering limits equal to the bodily injury liability limits and obtaining signed rejection forms or waivers, an agent must pay close attention to the requirements of the state in which he is writing coverage. The obligations of due diligence and disclosure are evaluated very closely when a UM suit or claim is filed because an agent is alleged to have failed in his professional duties when offering or selling this coverage.

**Court case as reported by a national E & O carrier:** The named insured had previously insured her vehicle with two insurers, purchasing the same limits each time a policy was issued: Bodily Injury Liability with limits of 50/100 and Uninsured and Underinsured Motorist limits of 12/25. She signed the UM/UIM waiver given to her by her new (third) agent, indicating that she wanted and accepted the lower limits for the UM/UIM coverages. After involvement in an accident caused by an uninsured driver, and finding that her insurance company would pay only 12/25 limits for UM, she sued the new agent, claiming he negligently sold her the lower limits and never offered her the same limits as her Bodily Injury limits of 50/100. (Her injuries exceeded $12,000.)

The agent testified that when she called to request coverage after having received a quote from him about six months prior, he mailed the UM/UIM waiver to the named insured, along with a new business application. He further testified that when the named insured requested both the quote and the issuance of her policy, she insisted she wanted the same coverages and limits that appeared on her previous policies. The agent had retained in his files a copy of the most recently issued policy declarations page in his files.

The E & O carrier argued that the named insured, by signing the application and waiver form, accepted and requested the limits of 12/25. The Court, however, found that the named insured had never been given quotes showing higher limits with applicable premiums and that the agent had never offered her higher limits. The Court decided that the agent, by placing an “X” on the waiver form and mailing it to the named insured, had made the decision concerning UM limits. Judgment was entered against the agent.

**BUSINESS AUTO**

The business auto policy has a wider scope of eligibility for the types of vehicles it insure than the personal auto policy does. Virtually any type of vehicle can be insured, so long as its use is not excluded per an insurance company’s underwriting guidelines.

The business auto policy also allows the applicant a choice when choosing which of their vehicles will receive certain types of coverage. **Symbols** are assigned based on the
applicant’s choices:

- Symbol 1 -- Any auto
- Symbol 2 -- Owned autos only
- Symbol 3 -- Owned private passenger autos only
- Symbol 4 -- Owned autos other than private passenger autos only
- Symbol 5 -- Owned autos subject to No-Fault benefits
- Symbol 6 -- Owned autos subject to a compulsory uninsured motorist law only
- Symbol 7 -- Specifically described (listed) autos only
- Symbol 8 -- Hired autos only
- Symbol 9 -- Non-owned autos only

Symbols are entered on the Declarations Page of a business auto policy next to the type of coverages. Absence of a symbol indicates that no autos are covered.

**SYMBOL ISSUES**

**Symbol 1** – Coverages with this symbol next to them on the policy declarations page apply to any auto. Most insurance companies use this symbol only for liability coverages. If Symbol 1 were chosen for liability coverages (Bodily Injury and Property Damage), then any vehicle – including owned, non-owned, hired, and borrowed – used in the business of the insured will have coverage.

For example, if an employee of the insured allows his teenage daughter to drive the company car, then it will be covered by the policy. If the same employee asks his daughter’s boyfriend to run a business errand for him, then the daughter’s boyfriend’s car will be covered by the policy.

**Symbol 2** – Coverages with this symbol next to them on the policy declarations page apply to any auto the insured owns, including vehicles acquired after inception of the policy and vehicles not listed on the policy. As with Symbol 1, most insurance companies use this symbol only for liability coverages. If an agent has a client who buys vehicles frequently, Symbol 2 is a good idea because owned vehicles do not need to be described on the policy to be covered.

**Symbol 7** – Coverages with this symbol next to them on the policy declarations page apply to vehicles that are described on the policy. Collision, Comprehensive, and Specified Perils coverages generally are assigned Symbol 7. Keep in mind that if a client has Symbol 7 next to Collision and Comprehensive, these coverages do not automatically go into effect when the insured purchases the vehicle. Some insurance companies, and some policies, will automatically provide coverage for Symbol 7 – but they are the exception.

For example, if the client has a Symbol 1 for Liability and a Symbol 7 for Collision, a newly acquired vehicle will automatically be covered for Liability but will NOT be automatically covered for Collision (unless policy language specifically states otherwise); Collision coverage will go into effect when coverage is bound and the vehicle is considered to be “described” on the policy.
Symbol 8 – If an insured rents vehicles or equipment covered by the business auto policy for business use, this coverage is essential. Unlike the personal auto policy, coverage does not automatically extend from the business auto policy for rented vehicles unless this symbol appears on the policy declarations page.

Symbol 9 – If employees of the insured business, or anyone – including the business owners or partners – use their personal vehicles to conduct business affairs of the insured, this coverage is essential. Unlike the personal auto policy, coverage does not automatically extend from the business auto policy for non-owned vehicles unless this symbol appears on the policy declarations page.

VEHICLE USE

It is imperative to determine accurately the use of every vehicle insured, not only for purposes of charging the appropriate rate but to be sure that the insured’s policy will provide necessary coverage in the event of a loss. An agent should never assume he knows the use of a vehicle and should always ask specific questions about its use.

Describe a typical day in the life of this particular vehicle – how is it used, who drives it, and where does it go? This, or something very similar, is an excellent way to determine the use of a vehicle insured on a business auto policy. Most businesses do not have all covered vehicles available for an insurance agent’s inspection and this is one of the most thorough ways to get information without actually seeing the vehicles to be insured.

Business auto policies rate vehicles with one of three types of use:

1. **Service Use:** Permitted service use on a business auto policy includes transporting the insured’s employees/personnel; transporting the insured’s tools, equipment, and incidental supplies to or from a job location. Service use applies to vehicles that are primarily parked at job locations during the day or to transport employees/personnel between job locations.
2. **Retail Use:** Permitted retail use on a business auto policy includes picking up, or delivering property to, individual households.
3. **Commercial Use:** Permitted commercial use on a business auto policy includes transporting property other than as described in Service or Retail use.

RADIUS OF OPERATIONS

Business vehicles can be used locally, as in commuting between the business and the homes of employees or just in-town. They can also be used to travel long distances, such as between business locations in different states or to make deliveries. The distances travelled are an important aspect of rating on a business auto policy.

Agents should be sure to ask the typical number of miles, one way, that each insured vehicle drives in a day. Local use is generally 50 miles or less. Depending upon the company, the radius of operations for Intermediate and Long Distance may vary, with 200+ being Long Distance. As the radius of operations increases, so does the premium because the daily exposure to losses increases with the miles driven.
For rating purposes, some insurance companies use the greatest distance a vehicle will travel on any given day; other insurance companies want to know the greatest distance a vehicle will travel on average. Because these two different underwriting approaches have a direct impact on premium and, perhaps, coverage, an agent should be sure he knows which underwriting methodology each of his carriers utilizes.

It is essential to determine properly the use and radius of operations of all vehicles insured. Be sure that this information is obtained not only at policy issue but also at each change and policy renewal. Failure, on the part of the insured, to report a change in vehicle use or radius of operations may be grounds for cancellation of the policy or denial of a claim.

**RENTING VEHICLES**

Each car rental company has its own contractual agreements that contain their own language. While the language does vary somewhat, the following items should be noted as typical of most rental agreements:

- The person signing the agreement is totally responsible for damage to the rental vehicle and any damage or injuries arising from the use of the rental vehicle
- The value for which the person signing the agreement is responsible equals the replacement value of the rental vehicle
- If the person signing the agreement has personal auto insurance extending coverage to the rental vehicle, it will be provided on a primary basis
- Any insurance purchased by the rental car company to protect the rental car equals the minimum limits required of the financial responsibility laws in the state in which the vehicle is rented
- The person signing the vehicle may waive some or all of the contractual requirements of the agreement with respect to damage of the vehicle; these waivers are called Loss Damage Waivers or Collision Damage Waivers

So, an agent may wonder, what does all that mean? This is what it means:

1. The person signing the agreement is contractually committing himself to be personally responsible for the rental vehicle and any ensuing injury or damage—even if he has insurance and even if that insurance doesn’t pay for all injuries and damages.
2. The person signing the agreement is contractually agreeing to be responsible for the replacement value of the rental vehicle although, in most cases, the Collision and Comprehensive coverages offered by personal auto policies provide these coverages on an Actual Cash Value basis.
3. The person signing the agreement is contractually agreeing that his personal auto policy will pay on a primary basis—meaning before any other policies pay, including those owned by the car rental agency. Since the personal auto policy specifically states that it will pay all claims for non-owned autos on an excess basis, a huge conflict exists. The person signing the rental agreement does not automatically bind his auto insurance carrier to this provision and is personally assuming responsibility under the contract.
4. If the owned auto coverage purchased by the car rental agency truly does equal the minimums required by the state, then physical damage coverages have not been purchased. If the person signing the agreement does not have physical damage coverage on his policy, then NO physical damage coverage exists on any policy and the person signing the agreement is personally assuming responsibility for damage to the rental vehicle.

5. Car rental agreements, like any other contracts, contain clauses indicating what is not permitted. Some of the typical “exclusions” in a car rental agreement—and that constitute breach of contract—include:
   a. Allowing someone who is not listed on the contract to drive the vehicle. The reason doesn’t matter—even an emergency.
   b. Misstating the name or age of a driver (most agreements require drivers to be at least 21 years old or 25 years old)
   c. Using the vehicle in any prohibited fashion:
      i. Driving on unpaved roads
      ii. Driver doesn’t have a valid driver’s license
      iii. Driving in Canada, Mexico, or outside the stated geographic limitations stated in the agreement
      iv. Using the vehicle to tow anything
      v. Unacceptable driving history
      vi. Using the vehicle in the course of committing a crime
      vii. Using the vehicle while under the influence of alcohol or drugs
      viii. Driving the vehicle while it is an unsafe or unroadworthy condition
      ix. Driving the vehicle in any race, speed contest, or rally
      x. Subletting the vehicle to another person
      xi. Driving the vehicle for the purpose of transporting people or cargo for a fee
      xii. To carry an animal or pet

For example, if a person were driving a rental car on a private road that was unpaved, and damage resulted to the car (or damages and/or injuries were caused to another person), the person who rented the car would be considered to have breached the contract. He would be responsible for the damages and it is likely that his personal auto policy would not provide coverage.

The vast majority of people renting cars (including insurance agents!) do not read the agreements before signing them. They assume that if they sign a contract, their auto policy will assume any liability they’ve accepted. This is not necessarily the case. Some states have enacted particular legislation concerning rental cars and insurance, others have rulings in court cases that have set precedents for such matters. An insurance agent should familiarize himself with such laws and rulings.

The Loss or Collision Damage Waivers are not insurance! In the 1980s, the NAIC instituted litigation in eight states because several national rental car companies were claiming to offer “insurance.” In exchange for $X per day, the individual renting the auto could purchase the car rental agency’s “insurance” and not have to worry about either
Problem was: the car rental agencies a) weren’t selling insurance, and b) it was illegal for them to call themselves agents and to solicit or “sell” insurance without being duly licensed. What the car rental agencies were doing was collecting the $X per day fee for “insurance” and escrowing it. When one of their vehicles was involved in an accident, the car rental agency used the funds in the escrow account to pay for the damage to the vehicle and any other damages and injuries that stemmed from the accident OR to be applied to their policy deductible.

After the litigation, rental car agencies changed the language of their contracts. If an agent were to read the contract, he would find an “Insurance Provision” and the contractual waiver provision called a Loss Damage Waiver or a Collision Damage Waiver. These contractual provisions waive some or all of the responsibilities stated in the agreement. The following paragraphs cite language stated in different waiver provisions of different rental car companies.

**Collision Damage Waiver:** ABC Company provides you, the renter and authorized drivers with a way to minimize or eliminate your responsibility for loss or damage to the rental vehicle through the purchase of Collision Damage Waiver (CDW). **CDW is NOT insurance.** It is a waiver of ABC Company's right to collect from the renter or authorized driver for the loss or damage to the rental vehicle. ABC company offers three levels of CDW to meet the needs of its customers. #1 - waives the renter's and authorized driver(s) responsibility for loss or damage to the rental vehicle up to the full value of the vehicle including administrative and loss of use fees. #2 - waives up to the first $500 of loss or damage to the rental vehicle, the renter or authorized driver(s) pays for any loss or damage in excess of $500 up to the full value of the vehicle. This option is for renters who want to minimize their responsibility as well as renters who may carry a $500 deductible on their personal insurance policies. #3 - waives up to the first $3,000 of loss or damage to the rental vehicle, the renter or authorized driver(s) pays for any loss or damage in excess of $3,000 up to the full value of the vehicle. This option is for renters who want to minimize their responsibility as well as renters who may carry a $3,000 deductible on their personal insurance policies. CDW does not cover unauthorized drivers and is void if the Renter or Authorized Driver(s) engage in any of the Prohibited Uses and Violations as described in the Terms and Conditions. See the Terms and Conditions for additional Exclusions.

**Loss Damage Waiver:** If accepted for a daily fee, your responsibility for any damage to the vehicle is waived, provided the rental agreement is not violated. If declined, you will be fully responsible for all damage to the vehicle, regardless of fault.

**Loss Damage Waiver:** Renters may purchase loss damage waiver (LDW) that reduces the financial liability for loss or damage to the car as long as they comply with the terms of the rental agreement.

So, depending upon the Loss or Collision Damage Waiver, the provision may waive all liability resulting from the rental of the vehicle or it may simply waive the first $X of damage resulting from the use of the rental vehicle. Clearly, it is in the best interests of
the renter to purchase the most comprehensive waiver. Some rental car companies do sell insurance these days. Yes, they employ licensed insurance agents and sell additional bodily injury and property damage liability insurance, accident insurance, and physical damage insurance.

What’s an agent to do when his client calls from the rental car agency four states over and says, “I’m here renting a car and I want to know if I need to buy their insurance?”

1. Ask the client to provide a copy of the rental agreement. After all, a professional insurance agent shouldn’t give advice about a client’s contractual responsibility to purchase insurance coverage if he hasn’t read the contract’s insurance requirements—right?

2. If when the client claims he can’t provide a copy of the contract, the agent should explain that most rental agreements contain provisions that conflict with the personal and business auto policies. In the absence of being able to read the contract, the agent should advise the client to purchase the broadest Loss or Collision Damage Waiver and any additional insurance offered by the car rental firm.

Many consumers do not want to pay the extra $11, $15, or $19 per day for the Loss or Collision Damage Waivers. They may be able to “save” $100 or more dollars by not purchasing the waiver. On the other hand, if a loss occurs that involves contradictory language between the rental agreement and the insurance policy OR if the client breaches the rental contract, he may wind up having to pay far more than that $100. Keep in mind that most insurance companies do not consider Down Time or Loss of Income to be part of the Property Damage definition or coverages provided under either personal or business auto policies. If the client is involved in a loss that generates Down Time or Loss of Income, he will most likely become personally liable for those amounts.

Another consequence of not purchasing the Loss or Collision Damage Waivers is the fact that most rental car agreements indicate that the car renter is responsible for a number of other fees and charges in the event of a loss where the insurance requirements have been waived. The portion of the agreement invariably states that the car rental firm may establish such charges and fees, which include:

• Administrative fees
• Fees to investigate
• Fees to complete paperwork
• Anything else the firm cares to include

In summary, while renting a car may be a quick, easy, streamlined process—insurance claims that result when driving a rental car may involve serious consequences that neither the consumer nor the agent were aware of if the rental contract was not read prior to the rental.
HOMEOWNER INSURANCE

The homeowner insurance policy provides both property and liability insurance coverage for individuals who reside in homes they own. The intent of the homeowner policy has always been to provide property coverage for personal belongings of the insured and personal liability coverage for personal activities of the insured. Two major issues arise repeatedly to jeopardize coverage on the homeowner policy for people, businesses, and situations that many consumers assume are covered.

1. Who is insured, or covered, by the policy
2. What “business” coverage is provided by the policy

WHO IS AN INSURED

Depending upon the policy language, the definition of “insured” may vary slightly between policies and insurance companies. Most homeowner policies currently define an “insured” as someone who is a “Named Insured,” a resident relative of the “Named Insured,” and anyone under the age of 21 and in the care of any “insured.” Policies also typically consider a person or persons with proper custody of the “insured’s” animals and covered watercraft to be an “insured.”

That’s all well and good, an agent or consumer might be thinking. But what do those terms mean?

• “Named Insured” is the person or persons listed on the policy’s declarations page. The “Named Insured” should be the names listed on the deed to the home that’s insured. For example, if Doug and Ann own the home, Doug and Ann should be listed on the policy as named insureds.

• A resident relative is someone who lives in the same household with Doug and Ann (resident) and who is related by blood, marriage, or adoption to either Doug or Ann (relative).

• People qualifying for being “in the care” of any insured might be foster children, wards, and foreign exchange students. Remember, they have to be under age 21.

The most common problem arising from these definitions are consumers and agents who mistakenly believe that all residents are considered insureds. Roommates and cohabitants of the insured do not meet the definition of “insured” unless they are also related. For example, if a college student purchases a tenant homeowner policy, his three roommates do not have coverage on his policy—unless they are related. Now, if the college student’s brother is one of the roommates, he has coverage. Not because he’s a roommate, but because he’s a resident relative. Another example involves a woman who purchases a homeowner policy for her newly purchased home. Six months later, her boyfriend moves in with her. They both assume he’s covered by the policy. He’s not. Although he is a resident, he’s not a relative.

Some insurance companies offer endorsements to provide coverage for non-resident relatives. Some insurance companies will allow the non-resident relative (as in the case of a domestic partner) to be listed as a “Named Insured.” However, the unendorsed
policy does not include either property or liability coverage for individuals who do not meet the definition of “insured.”

**BUSINESS EXPOSURES**

Historically, the homeowner policy has provided limited property coverage for business personal property and no coverage for business liability. Some homeowner with incidental on-premises business exposures, such as professional offices and school or studio occupancies, have been able to obtain limited premises liability coverage by endorsement on homeowner policies. Insurance Services Office (ISO) introduced an in-home business endorsement in the 1990s in response to the growing number of homeowners who operated businesses from their homes, although not every company subscribing to ISO uses it.

According to numbers published by the U.S. Department of Labor, Bureau of Labor Statistics, these are the most recent figures (2004) collected concerning self-employed individuals and home-based businesses:

- **Concerning the self-employed**
  - 6.9 million self-employed individuals worked at home in non-agricultural businesses
  - Nearly half worked in management, professional, and related occupations
  - 66.5% of the self-employed individuals working at home in non-agricultural businesses worked at a home-based business
  - 48.7% worked 8 or more hours per week from home
  - 22.3% worked 35 or more hours per week from home

- **Concerning individuals working from home**
  - 20.7 million people *usually* did some work from home as part of their primary job
  - These people reported working from home at least once per week
  - These people accounted for 15% of the non-agricultural employment in May 2004 (which remained unchanged from May 2001)
  - Nearly 30% of individuals working from home worked in a managerial, professional, or related capacity
  - About 20% of people working in sales regularly work from home
  - Only 3% of people working in production, transportation, and material-moving operations worked from home
  - Of the 13.7 million people receiving compensation in the form of wages or salary, roughly 25% had a formal arrangement with their employer to be paid for the work they performed at home
  - On average, those with a formal pay arrangement to work at home spent about 19 hours per week working at home

According to International Data Corporation (IDC), a global provider of market intelligence and advisory services, there were 13.8 million income generating home-based businesses in the U.S. in 2005. Of those, 9.7 million were the primary source of income for the family.
In view of the fact that the U.S. population was roughly 292,000,000 in 2004, the numbers show that 9.5% of the population either was self-employed and worked from home or worked from home on a regular, weekly basis as part of their primary job as an employee for someone else. Research and statistics indicate those numbers have risen. In light of these statistics, consumers, insurance companies, and producers require clear understandings of how homeowner policy coverages affect those individuals who either conduct business from home or operate a home-based business. The unendorsed homeowner policy provides very little property coverage for business property and NO business liability coverage. Even when “business” endorsements are added to the homeowner policy, significant gaps in coverage are always going to exist.

Most homeowner insurance applications contain a question or section addressing business use on the premises, even if they don’t outright ask Are any business activities being conducted on or from the residence premises? Depending upon how the section reads, and how the producer asks his question, some vagueness or uncertainty may exist in the mind of the consumer concerning the topic. A stay-at-home mom might consider the dolls she makes and sells in her spare time a “hobby.” A man who earns $80,000 a year as a manufacturing plant manager might consider the lawnmower and small engine repairs he does for friends and co-workers a way to blow off steam after a 60-hour week. Either person could earn several thousand dollars a year and not believe s/he is conducting a business, especially if s/he hasn’t filed for a business certificate and aren’t claiming the income on her/his tax return! Another scenario that might occur is the consumer not responding factually when asked a direct question about a home-based business, especially if he believes what he does at home is one of those “hobbies” that generates income not appearing on a tax return.

In the vast majority of situations involving home-based businesses or individuals who work from home, however, either the agent didn’t address the subject or the consumer began his business activities after the homeowner policy was issued and the topic was long forgotten and never again addressed. When that happens, the agent has a good chance of seeing an E & O claim in his future. Homeowner policies usually state that they provide, as a special limit under personal property coverage, a maximum limit for business personal property. The 2000 edition of the ISO homeowner forms provide $2,500 of coverage on-premises and $500 off-premises. The limit on other homeowner forms ranges from $200 to $5,000; some may not include different limits for property on and off-premises.

Here’s a claims-scenario example. Grace owns an accounting business and she operates it in her home. Her business personal property is valued as follows:

- $5,000 computers and equipment
- $2,000 furniture
- $1,000 telephone system
- $1,000 office supplies and miscellaneous property

While the value of Grace’s business personal property is $9,000, if her house burns to the ground, the most she can collect from her homeowner insurance policy is the stated
special limit for business personal property—whatever it may be ($2,500 or $200 or $5,000).

What happens when Grace marries Max, a plumbing contractor, and he and all his stuff move in with her? She handles his books and business matters, so he doesn’t need his own office furniture/equipment. However, he does own $17,000 of plumbing tools and equipment stored in the garage and the back of his pickup truck. Will Max receive his own special limit of coverage because he has his own, separate business? NO! The special limit on business personal property applies to **all** business personal property.

Some insurance companies allow the special limit to be increased; the maximum amount is usually $10,000. Even if Grace and Max purchased the endorsement, they’re still out of luck—and $7,000 short in the event of a loss. (Not considering the deductible!)

In addition, unendorsed homeowner policies specifically exclude building coverage on Other Structures from which business is being conducted or that are being rented. What this means is that if Grace’s accounting office is located in her remodeled, detached garage, she has no building coverage when the garage burns to the ground. She **can** add building coverage by endorsement and pay an additional premium—but she and her agent need to know the business is being conducted from the Other Structure in the first place. Ditto if Grace is renting the apartment over the garage to her friend’s college-age daughter: no coverage on the unendorsed homeowner policy when the garage burns to the ground.

As ugly as the business personal property limit-scenario may seem, the business liability exclusion offers the greatest potential for problems with a home-based business. Four activities are **not** considered “business” activities for liability purposes:

1. Providing care for a relative in exchange for money  
2. Mutual exchange of care, as in a babysitting exchange  
3. Volunteer activities for which the insured isn’t paid or for which the insured only receives expense reimbursement  
4. Other activities (i.e. yard sales, snow shoveling, grass-cutting) for which no insured receives more than a total of $2,000 in the year before the policy began

Grace’s accounting business activities and Max’s plumbing business activities definitely do not qualify as any of the four activities listed above. Which means that when one of Grace’s clients stops by to drop off his shoebox full of tax-return documents, trips over the hose in the front yard, breaks a hip, and sues her—the homeowner policy doesn’t provide coverage. In addition, when Max, who’s heading out to his truck after fixing a leak in the bathroom sink at a customer’s house, accidentally knocks over a valuable *objet d’art*, the homeowner policy doesn’t provide coverage when the customer presents max with the $25,000 bill.

These are not the only types of home-based businesses that present coverage problems when the consumer mistakenly believes his homeowner policy is protecting him. A few other examples include:
• The Mary Kay representative who doesn’t have coverage when her customer develops a rash from the make-up she bought
• The “gardener” who sells vegetables at a roadside stand during the late summer and early fall when a customer suffers an allergic reaction to a pesticide used on the tomatoes
• The fellow who repairs lawnmowers in his garage on weekends when his neighbor is accidentally injured when a metal scrap is propelled into his eye during a repair
• The woman who “babysits” for the neighbor’s three kids and earns $200 a week doing so, after the neighbor sues because the “babysitter” spanked her child
• The retired couple who “helps out” their working neighbors by walking dogs during the day—to the tune of $10 per walk—when one of the dogs decides to gnaw on the ankle of a pedestrian during a walk

The scenarios and possibilities for calamity are endless. In order to protect his clients, and himself, a producer needs to exhibit a tremendous amount of care when writing homeowner policies. Although agent-inspections of client homes don’t guarantee the detection of business activities, they do provide the producer with a method of obtaining insight into the consumer’s lifestyle and an opportunity to ask questions. They also allow the producer to view the property and other structures. The existence of a barn might lead to questions about the horses in the pasture: are they the consumer’s horses or does the consumer rent the pasture and barn to someone else? The existence of a large workshop might lead to questions about precisely what kind of “work” is taking place in the workshop. The more information a producer obtains about the lifestyle and activities of his homeowner clients, the better prepared he will be to advise them and recommend proper coverages.

FLOOD INSURANCE

The peril of flood is excluded on virtually every property policy issued in the United States. Unfortunately, although many insurance producers explain this fact to consumers, few producers and consumers understand the precise definition of “flood” or how the definition, and exclusion, is interpreted when a loss occurs.

The National Flood Insurance Program (NFIP), which administers all flood insurance written in this country and is controlled by the Federal Emergency Management Agency (FEMA), defines flood as being a general and temporary condition during which the surface of normally dry land is partially or completely inundated. Language may vary slightly between insurance companies but is very similar. The following conditions are also considered flood: surface water, waves, tides, tidal waves, overflow of a body of water, spray from any of the preceding, mudslide, and mudflow. It doesn’t matter if the wind drives water—the condition is still considered flood. The peril of flood IS covered on a flood insurance policy and IS NOT covered on the vast majority other property policies.

The two biggest challenges faced by producers and insurance companies concerning the
issues of flood occur after coastal hurricanes and inland flooding caused by periods of unremitting heavy rains. Many consumers believe that a) they are not in a flood zone if their property is not adjacent to the ocean or a large body of water such as a river or lake, and b) their homeowner policies will provide coverage for any type of water damage resulting from rain or wind-drive rain, such as that generated by a hurricane or heavy rainstorm. Many consumers also claim they were never advised about the flood exclusion or that separate flood insurance is available.

The most frequently occurring natural disaster is flood. According for the CDC, flood represents 40% of all natural disasters worldwide. Floods regularly occur in each of the fifty states and everyone lives in a flood zone, even if it isn’t rated as having a high, medium, or low-risk of flooding. The NFIP reports that nearly one-quarter of all floods occur outside high-risk flood areas. Their Preferred Risk policy is specially designed for property in such areas and the premiums are relatively inexpensive.

In recent years, several national E & O carriers have reported that E & O claims against producers concerning flood have risen sharply. Why? Four reasons account for the majority of the claims:

1. The producer didn’t offer flood insurance coverage to the consumer (or he didn’t document that he offered it)
2. The producer didn’t write a flood insurance policy correctly
3. The producer didn’t offer excess flood insurance (or he didn’t document that he offered it)
4. The producer didn’t properly explain and document either the “flood” exclusion on a property policy OR how a flood policy works

As addressed previously in this material, if a producer fails to inform a consumer about the availability of coverage—or fails to explain coverage properly—it will be considered that the producer violated his duty to exhibit due diligence and/or to disclose. Some producers are unfamiliar with flood insurance, the flood policy, and how a flood policy coordinates (or doesn’t) with a property policy because they seldom, if ever, write flood coverage. As a result, many states and/or insurance companies now require producers to complete a certain number of hours of continuing education if they sell flood insurance—through either the NFIP or any of the Write Your Own programs.

The flood policy is not complicated: it’s a one-peril policy. The language is easy to read (when compared to other policies), as is the manual. A few areas of note, however, seem to be the traditional causes of producer mishaps when writing flood insurance coverage or explaining it, as evidenced by the rising number of E & O claims.

The first area of note concerns eligibility. Eligibility for flood insurance is based on whether the consumer lives in a participating community—not whether he lives in a flood zone. If the community participates, coverage is available based on the degree of participation—the regular and emergency programs. The type of policy, standard or preferred, is written based on the consumer’s flood zone—and every location has a flood zone.
The second notable area involves the maximum coverage limits that are available. The regular and emergency programs offer different minimum and maximum limits of coverage, which are clearly outlined in the flood manual. Unfortunately, some producers believe flood insurance is not available for buildings valued in excess of the maximum limits shown in the flood manual, and that is what they tell their clients. This belief, and advice, is incorrect. For example, the NFIP and Write Your Own companies will only write up to $250,000 of building coverage for a residential dwelling. If a consumer owns a home that is worth $500,000, flood insurance IS available in the excess market—which many producers and consumers don’t know…until after a loss.

Another area of concern involves coverage for personal property and/or any type of coverage for real or personal property below the surface of the ground. Strict limits, definitions, and requirements apply and sometimes producers have a mistaken understanding of what constitutes a “basement” or when, how, and at what limits personal property coverage can be obtained.

The 30-day waiting period before flood insurance applies is also somewhat of a mystery to some producers and most consumers. If flood insurance coverage is required by a mortgagee because a home is being purchased or refinanced, the waiting period may be waived. A number of other, lesser-known, occasions waive the waiting period, as well. However, when a client decides to purchase flood insurance all on his own, or because a neighbor experienced a flood and he’s worried the same will happen to him, a waiting period of 30 days applies. A producer wants to make sure he explains that 30-day waiting period, and documents his explanation, as well.

As more and more natural disasters occur, and as the NFIP becomes increasingly burdened (it was actually scheduled to expire at the end of March 2010 if Congress didn’t intervene), it becomes more incumbent upon insurance producers to not only know and understand this important coverage, but to make sure their clients and other consumers are properly informed about availability and how coverage applies and coordinates with other property coverages.

PLACING INSURANCE WITH NON-ADMITTED INSURERS

Most retail insurance agencies represent insurance companies that are admitted, or authorized, to do business in their home states and the states in which they hold licenses and regularly do business. When a producer finds himself unable to find an admitted carrier willing to write insurance for a consumer or his business, the producer may seek to write coverage with a non-admitted or non-authorized carrier.

Surplus Lines Agents and Brokers are the only producers licensed to sell insurance on behalf of non-admitted insurers. For producers wishing to write as many classes of business as possible, including those not written by their in-house, admitted insurance companies, establishing relationships with Surplus Lines Agents or Brokers is a way to:

1. Establish stronger relationships with clients by being able to assist them with the
placement of as much of their insurance as possible

2. Earn more income

Each state has specific laws that address the differences between ordinary producer licenses and surplus lines licenses. Because of the different requirements of law, a producer with a property and casualty license should be well versed about how the relationship between himself and a surplus lines agent/broker should be handled. Otherwise, he may find himself inadvertently binding coverage when he isn’t permitted to do so or securing coverage with terms that are quite different from what he intended to obtain—and what the consumer wanted.

Some of the differences between retail agencies and surplus lines brokerages include:

- Surplus lines agents/brokers are subject to sections of insurance code that apply specifically to surplus lines insurers, producers, and insurance
- Surplus lines agents/brokers are the only parties involved in the insurance transactions who are permitted to bind coverage—the retail agent or producing agent cannot bond coverage on behalf of a non-admitted carrier
- Surplus lines brokerages pay commissions that are usually less than those paid by admitted carriers with whom a producer is contracted or has an employer/employee relationship; the surplus lines brokerage, essentially, shares his commission with the producing agent/agency
- Surplus lines brokerages are more often representing admitted carriers than they did in the past
- Surplus lines brokerages are NOT responsible for explaining policy coverages, terms, endorsements, conditions, etc. to the consumer – that is the producer’s responsibility
- Quite often, the proposals and quotations prepared by surplus lines brokerages state that the terms offered may NOT be the same as those requested
- Surplus lines brokerages most often provide the insurance company’s A.M. Best rating on their quotes and proposals; if they do not, be sure to obtain that information (some state laws require them to provide insurance company financial information)
- Surplus lines brokerages often allow the producing agent to subtract his commission from the premium submitted with the new business application

When writing insurance with a non-admitted carrier, the producer should know that certain taxes and fees will be required in addition to the policy premium. These taxes and fees vary from state to state, as do the procedures for reporting and recordkeeping. In some cases, the taxes and fees are fully earned and this fact should be disclosed to the consumer, along with the reason for the additional taxes and fees.

A very important element of the transaction between a consumer and a non-admitted carrier is the fact that non-admitted carriers DO NOT participate in state guaranty funds. If a non-admitted carrier becomes insolvent, the policyholder cannot fall back on the state guaranty fund in the event of a claim. Because most agent E & O policies contain an exclusion for insurer insolvency, a wise producer provides a disclosure to clients who
purchase policies from non-admitted carriers. A wiser producer obtains the client’s signature!

Another area that requires special attention is the review of policy forms and endorsements. While some non-admitted carriers use Insurance Services Office (ISO) forms, many do not. And even those companies that do use ISO forms often utilize company-specific forms and endorsements, as well. The typical proposal received from a surplus lines agent/broker contains a list of forms and endorsements that will apply to the quoted coverage if a policy is written. Producers should review the list and, if they note a form, endorsement, or exclusion they are not familiar with, should ask the surplus lines agent/broker to send a copy of the form—which most firms are accustomed to doing. Remember: the producing agent is responsible for reviewing/comparing coverages and policy forms, and explaining them to the consumer. The consumer is the writing agent’s client; the writing agent is the surplus lines agent’s client.

In most cases, non-admitted carriers require a minimum earned premium of 25%. What this means is that regardless of when the policy is cancelled, the insurer will retain 25% of the annual premium. For example, if the annual premium is $1,200 and the policyholder wishes to cancel the policy two weeks after the effective date, the insurer will retain 25% of the $1,200—or $300. If the policy cancellation terms are short-rate, the insurer will retain the short-rate penalty, as well. Some types of policies, such as special event policies, require a fully earned premium, meaning the entire policy premium must be paid in advance and no refund will be issued, even if the policy is cancelled before the end of its term.

Most General Liability policies written by a non-admitted carrier contain a Classification Limitation endorsement. This endorsement spells out that the policy premium is based on the operations and rate classifications listed in the policy. If the insured conduct activities outside the operations or rate classifications listed on the policy, claims resulting from those activities will not be honored. This endorsement is especially pertinent to contractors who may perform work in a number of areas, such as carpentry, plumbing, electrical, roofing, excavation, etc. Each of the separate rate classifications needs to be listed on the policy; the insurance company wants to be sure it’s collecting the appropriate premium for the exposure.

An example of a situation where a policyholder, or an agent, can get into trouble concerning the classification endorsement involves a fellow whose general liability policy was issued by a non-admitted carrier for his business that installed windows. Lance told his agent, Barbara, that he acted as a sub-contractor for a particular general contractor. All he did, Lance claimed, was install windows in new homes. Barbara asked him if he performed any carpentry, any framing, any roofing, any remodeling, and any interior finish work. Lance insisted that all he did was windows. When Barbara asked Lance to sign a form confirming that fact, he was happy to do so. When Barbara delivered the policy to Lance, her cover letter indicated he needed to advise her if he expanded his operations beyond installing windows.
Several months after the policy was delivered, Lance reported a liability claim to Barbara. One of his customers, a fellow who owned a business building, complained that the windows Lance had installed leaked and caused damage to his building. The insurance company adjuster called Lance to interview him about the claim and Lance asked the adjuster if he’d mind visiting him at a job site. The adjuster was happy to accommodate Lance and, when he arrived at the job site, found Lance pouring concrete for a foundation of an addition he was building for one of his customers.

Was there a problem? Absolutely! Lance’s policy did not provide coverage for concrete work OR remodeling. Had a loss occurred, it wouldn’t have paid. The adjuster took Lance’s claim statement and didn’t mention the concrete work until the claim interview was over. He then asked Lance if he did a lot of concrete work. Lance told the adjuster he did whatever kind of work came along, his wife had just had a baby, and he needed to bring money home however he could. The adjuster reported the information to the insurance company, which issued an endorsement for concrete work. The base rate for the concrete work was less than that for the window installation—but the additional concrete work Lance contracted for increased his overall sales. Which increased his premium. When Lance received his policy change endorsement and invoice, he also received a letter from Barbara explaining the reason for the change, along with a copy of the form he’d signed indicating that he only installed windows and that if he expanded his operations, he’d notify her.

What would have happened if Barbara hadn’t obtained that signed form? Might Lance have sued her? Might he have forgotten his promise to notify her if he expanded his operations? In the end, Barbara was happy Lance didn’t submit a claim concerning his concrete operations. Although she likely would have prevailed if Lance claimed he hadn’t known about the classification limitation endorsement, the matter would have introduced unnecessary stress into her life.

While writing insurance with non-admitted carriers can be beneficial to a producer’s clients and bottom line, it requires extra time and attention to detail. Some producers do not write surplus lines business for those very reasons. For those who do, it is very important to understand how surplus lines brokerages operate, why they operate the way they do, and to conform to required business practices when working with them.

EMPLOYMENT PRACTICES LIABILITY INSURANCE (EPLI)

Employment Practices Liability Insurance claims are increasing. The U.S. Equal Opportunity Commission (EEOC) published statistics in early 2010 indicating the following numbers of total charges for workplace violations during the give prior years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Charges</th>
</tr>
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<tr>
<td>2005</td>
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</tr>
<tr>
<td>2006</td>
<td>75,768</td>
</tr>
<tr>
<td>2007</td>
<td>82,792</td>
</tr>
<tr>
<td>2008</td>
<td>95,402</td>
</tr>
<tr>
<td>2009</td>
<td>93,277</td>
</tr>
</tbody>
</table>

Why are people suing their employers? According to the EEOC, contributing factors
include employees’ increasing awareness of their rights under law, easier accessibility to the EEOC, changes to the practices that eliminated a number of steps necessary to file a charge, and the economy. The EEOC reports that in 2009, monetary relief recovered on behalf of victims (through lawsuits, mediation, and enforcement) totaled more than $376 million.

Standalone EPL policies have been available for large employers since the 1980s because it was universally believed that larger employers were more susceptible to lawsuits than smaller employers were. While that may have historically been the case, things are changing. According the vice-president of employment practices liability for a large national insurer, smaller employers have been increasingly experiencing discrimination charges (age, gender, race, disability, etc.). Because the economy is forcing many business to cut back on staff, employment laws are evolving and becoming more sophisticated, and the workforce is simultaneously aging and becoming more diverse, employers are more at risk now than they’ve ever been.

His company’s statistics show that as unemployment rates rise, so do the number of EPLI claims against small businesses. As the numbers of individuals who are protected by law grow, so do the claims. Finally, as the media brings attention to workplace discrimination, people become more aware of their rights and how to enforce them—and attempt to do just that.

Note the following statistics about EPL insurance obtained from two national insurers and a report published in Rough Notes magazine in its July 2009 issue:

- 1.2% of the small commercial businesses surveyed have EPLI coverage
- 30.7% of the middle market businesses surveyed have EPLI coverage
- The average award in employment practices cases is in excess of $200,000
- Defense costs range, on average, from $100,000 per case with a single plaintiff to several million dollars per case if a class action claim is involved
- 2 out of 3 small business owners are worried that past or present employees may file charges against them
- More than 50% of EPLI claims are brought against smaller companies, yet fewer than 2% of small companies have purchased coverage
- 60% of small business owners surveyed believed that the average cost to settle and defend an EPLI claim was less than $20,000; in actuality, 81% of EPLI claims are settled for an average of $22,500 to $40,500—even if the suit is groundless
- Nearly half of the small companies surveyed were unaware affordable coverage was available for EPL
- An employer is more apt to experience an EPL claim than a General Liability or Property loss
- Nearly 75% of the lawsuits filed against corporations involve allegations of misconduct in the workplace

If a business purchased EPL Insurance, it would either obtain a standalone policy or add an endorsement to its Directors & Officers (D & O) policy. (Some businessowner policies include a $25,000 or $50,000 limit of coverage by endorsement.) Coverage is
written on a claims-made basis and is provided only for claims the insured knew about, or should have known about, and that the insured reports promptly during the policy period. Most policies include retroactive dates and some include coverage for full prior acts. Some policies do provide defense coverage outside the policy limits, but most provide coverage for both indemnity and defense in a single policy aggregate limit. Deductibles and/or retention limits apply for the purpose of avoiding nuisance claims. Defense provisions vary and should be thoroughly investigated and explained.

Coverage is provided for claims made by employees, past employees, and potential employees for torts that arise in the workplace; for example, offenses such as discrimination (disability, age, gender, race, etc.), wrongful termination, sexual harassment, retaliation, failure to grant tenure, wrongful denial of training, breach of employment contract, wrongful discipline, hostile workplace, failure to supervise, and other allegations concerning job-related issues. Many people working in small businesses are under the mistaken impression EPL coverage is designed only for claims and suits filed by current employees.

Examples of typical claims are:

- An employee takes offense after hearing a joke told in the lunchroom and files a discrimination claim
- The methods a supervisor used when firing an employee are at issue and the employee files a wrongful termination claim
- Charges of discrimination are filed by a person who wasn’t hired after interviewing for a position

The typical definition of insured includes the entity shown on the policy declarations page (individual, corporation, partnership, LLC, etc.) and its stockholders, employees, directors, officers, heirs, executors, administrators, and legal representatives. Standard exclusions include perils that are covered by general liability, workers’ compensation, and personal injury policies, as well as intentional behaviors such as criminal conduct and assault & battery. Other exclusions that might be found include failure to provide benefits, punitive damages, fines, penalties, and violations of federal and state laws, like OSHA, RICO, the WARN Act, and those pertaining to pollution laws and securities violations.

One insurance company states their most reported claim issue is wrongful termination, followed closely by discrimination, harassment, humiliation, and retaliation. Another item of note is the fact that EPL claims can be filed under federal law (also known as Title VII), state law, and local and county ordinances—all at the same time.

Like D & O policies, EPL insurance policies require the insured to give the insurance company prompt notice in the event of a claim or a situation from which a claim might arise. This requirement does not allow the insured to wait until a claim for damages has been actually filed. The requirement means that as soon as the insured thinks there might be a possibility of a claim, he needs to report it. Some policies contain a “strict” notice provision requiring the insured to provide
[written] notice within a certain time period, such as 60 days. A number of EPL carriers have denied coverage because of late notice, specifically in circumstances where the insured received a notice from the EEOC that a claim had been filed but did not submit notice to the EPL carrier as required. In many cases, the policyholders reported their claims upon receiving demand for damages or being sued, which occurred long after receiving notice from the EEOC and the expiration of the notice requirements in their policies.

Many employers do not report the claim when they receive the EEOC notice because the notice is just that, it’s a notice or an allegation—it’s not a guarantee that a charge will be filed or a claim will be made. Unfortunately, the courts have made it clear that their interpretation of when notice should be made coincides with the insured’s first awareness that a potential claim might exist. Producers should be aware of the provision requiring notice and should, in turn, discuss it in detail with the client—along with consequences for failing to provide notice as required.

**EPLI Claims Scenario:** An employer hired a woman who had been employed three years when she became pregnant and informed her supervisor she would be taking maternity leave. Around the same time, the firm lost a few of its major accounts and found itself in the position of having to downsize. Because the pregnant woman had worked on one of the lost accounts, she was one of the employees terminated. Her termination took place a month before her maternity leave began. She subsequently filed a suit alleging discrimination (pregnancy), wrongful termination, and sought damages for distress and lost wages. During the course of the trial, testimony indicated that the worker’s supervisor had informed the worker that the company had a previous bad experience with a pregnant employee. Because of the supervisor’s statement concerning the previous “bad experience” and the short period of time between the employee’s termination and the beginning of her maternity leave, the jury found for the employee. Damages were awarded for $500,000 in addition to an order that the employer pay the employee’s attorney fees of $175,000.

As indicated earlier in this section, the vast majority of small business owners do not know coverage is available or that it is affordable. Firms that do not have Human Resources professionals on staff, or who do not outsource their HR duties, are far more likely to commit an offense that will give rise to a loss.

If a producer fails to offer EPLI to a company inquiring about, or renewing, business coverage, he runs the risk of being slapped with an E & O suit. Remember due diligence and the duty to disclose? This seemingly “minor” coverage can pack a significant wallop if overlooked when discussing a consumer’s insurance account—regardless of the size of the business.

**WORKERS’ COMPENSATION INSURANCE**

The subject of workers’ compensation requires weeks to address properly all the details.
and nuances of coverage and how they affect consumers and producers. In today’s marketplace, however, two particular issues crop up with regularity and they are the subject of attention in this chapter.

AUDITS

Although the concept of the audit provision of a workers’ compensation policy—and, for that matter, general liability policies—is fairly simple, many policyholders claim not to understand it. In all fairness to consumers, some agents don’t explain the audit provision—either because they, themselves, are unaware of it or because they assume the policyholder does understand it.

Essentially, workers’ compensation premiums are not firm or guaranteed. They are estimated. This is one of the first things a producer should explain to a consumer when discussing coverage. Workers’ compensation policy premiums are based on the payroll the employer pays his employees. If a consumer is purchasing a workers’ compensation policy today, and the premium is based on the payroll the employer will pay during the next year, how can the premium be firm? Does the employer know precisely what his payroll will be? Can he guarantee that none of his employees will quit? Or that none of them will have pay raises? Or that none of them will work overtime? Of course not.

When an employer provides an insurance producer with his annual payroll, it is an estimate. Therefore, the premium charged is also an estimate. When the policy anniversary nears, the insurance company mails the employer a payroll report, which requires the employer to provide the actual payroll paid to employees during the policy period. Some employers complete the reports themselves; many have their bookkeepers or accountants prepare the forms. In most cases, insurance companies require supporting tax documents, such as the employer’s form 941.

Upon receipt of the payroll report, the insurance company compares not only the actual payroll on the report to the estimated payroll contained on the policy; it also compares the employee classifications of the employees on the form with those on the policy. For example, if the employer is an insurance agency, its policy will likely shows employee rate classifications for both salespersons and clerks. Different premiums are charged for the different classifications. If the payroll report shows that no clerks were employed during the last half of the policy year, the employee rate classification and payroll for clerks would be reduced appropriately during the preparation of the audit. The insurance company would issue a refund, assuming the payroll for salespersons wasn’t higher than estimated. On the other hand, if the payroll report indicated that the actual payroll for both salespersons and clerks was higher than originally estimated, the insurance company would bill the employer for the additional premium.

What can make the audit concept complex to some employers is the fact that in states where workers’ compensation is mandatory, an employer may find himself providing coverage for payroll he hadn’t anticipated. This is especially true in the cases of general contractors who hire sub-contractors. If a sub-contractor has his own workers’ compensation insurance in place, and provides the general contractor with proof of
coverage in the form of a certificate of insurance, the general contractor does not have to include the money he pays to the sub-contractor as payroll on his payroll report. But, if the sub-contractor does not have workers’ compensation in place OR cannot provide proof of coverage, the individual performing the workers’ compensation audit will include the payments the general contractor made to the sub-contractor in the actual payroll figures.

If the general contractor had estimated his payroll at $100,000 because he didn’t plan to hire any uninsured sub-contractors, and he subsequently hires uninsured sub-contractors and pays them $30,000 during the policy year, his audit will require an audit premium equal to roughly 30% of his estimated policy premium AND his renewal premium will be increased by 30%. Oftentimes, consumers, especially those who have never purchased workers’ compensation insurance before, are shocked by this process—even when the producer explained the process.

In recent years, more and more agent E & O claims are arising from producers’ failure to disclose the audit provision of workers’ compensation policies.

**OTHER STATES COVERAGE**

Workers’ compensation statutes vary by state but most insurance companies and states use the policy adopted by the National Council on Compensation Insurance (NCCI). On the policy, item 3.A. of the Information Page shows the Workers’ Compensation and occupational disease law of each state or territory providing coverage under the policy. It does not include any federal Workers’ Compensation law or provisions of any law that provides non-occupational disability benefits. Neither does it include any of the monopolistic states. A monopolistic state is one that prohibits coverage from being issued or purchased by an entity other than that state, such as Ohio, North Dakota, Washington, and Wyoming.

The policy covers all of the Insured’s workplaces listed in Items 1. and 4. of the Information page, and pays benefits for the states shown in item 3.A. unless the insured has other insurance or is self-insured for such workplaces. It is important for a producer to understand that coverages are provided based upon the benefits provided by the state in which an employee works, and is injured, NOT based on the employee’s state of residency. If Rhode Island is shown in Item 3.A. of the policy and a worker is injured in Connecticut, where he is temporarily working, the policy will pay Rhode Island benefits. However, if Connecticut mandates that the worker is entitled to Connecticut benefits, the insurance company will have to pay them, even if they’re more than Rhode Island benefits.

If an employer has employees working in states other than those shown in Item 3.A., coverage can be obtained by inserting proper wording in Item 3.C. of the policy. Suggested wording is: *Coverage is provided in any state not listed in Item 3.A. above or the monopolistic fund states.*

Producers get themselves into trouble when they are not familiar with the requirements of
listing other states on the policy OR when they do not ask the employer about operations in other states or workers who travel to other states to work.

CERTIFICATES OF INSURANCE

A certificate of insurance (certificate) is a snapshot of the insurance coverages that are in place a particular date. Unlike a binder, a certificate is neither a guarantee of coverage nor a temporary policy. Certificates are used as proof of insurance.

For example, a sub-contractor may need to show a general contractor that he has workers’ compensation and general liability insurance in place. The sub-contract asks his agent to issue a certificate of insurance to the general contractor. The certificate will show the policy numbers, the policy dates, and the limits of coverage. Other examples might involve a landlord requiring a certificate from his tenant to show that the tenant has both liability insurance and plate glass coverage in place or the lessor of telephone equipment might require a certificate to show that the lessee has insured the leased telephone equipment on his property insurance policy.

Certificates of insurance are only used in commercial lines. Personal lines uses a form called an Evidence of Insurance in a similar fashion. Some insurance companies manuscript their own certificates, many use the industry standard ACORD forms. Producers should always check with their carriers to determine which the preferred form is. Producers should also check with their MGAs or Surplus Lines Brokerages before issuing certificates; some wholesalers do not permit retail agents to complete certificates of insurance.

After preparing a certificate, in addition to sending an original to the party requesting the certificate, copies should always be provided to the insured and the insurance company. Many insurance company underwriters will indicate they don’t want certificates mailed to them unless an additional insured is also included on the form. Producers should mail copies anyway; the company can always dispose of the form if they don’t want it. Most agent/company contracts require the agent to send copies of all certificates. In situations where a loss occurs and the insurance company doesn’t have a copy of the certificate on file and decide to deny coverage, the producer needs to show that he sent a copy to the company to avoid an E & O claim.

In today’s marketplace, litigation is a common word—and occurrence. It behooves an agent to confirm all requests for certificates with the named insured. It is not uncommon for vendors, contractors, and other business partners of an insured to call the producer and request a certificate. But what if the request isn’t legitimate?

Actual scenario: The producer worked at a large commercial lines agency and received a call from John Doe, who worked at ABC Construction. He needed a general liability certificate for the producer’s client XYZ Hardware. The producer obtained the name and address of ABC from John Doe, issued the certificate, mailed the original to ABC, and
copies to the insured and the insurance company. When Mike, the owner of XYZ Hardware, received his copy of the certificate, he called the producer in a fit of rage. ABC Construction—a firm Mike never heard of—had the same post office box as the attorney of an individual who just had Mike and his company served with a lawsuit. “John Doe” was really the plaintiff’s lawyer, who’d requested the certificate of insurance to obtain XYZ Hardware’s policy limits. Mike proceeded to sue the producer and the agency for breach of duty and laundry list of other offenses.

Lesson: A producer may collect information from a caller requesting a certificate of insurance but he shouldn’t actually issue and mail, e-mail, or fax the certificate until he has received the authorization of the insured to do so. It’s also a good thing for the producer to obtain from a business client the exact names of the people working at the company who are authorized to provide information.

Another pitfall when handling certificates is the issue of additional insured requests. A party requesting a general liability certificate may ask for specific verbiage on a certificate, usually when also asking to be named as additional insured on the GL policy. The only verbiage that appears on a certificate should be policy language; verbiage that is not policy language does not bind the insurance company and is not valid. Although the piece of paper may say precisely what the party requesting the certificate wants it to say, the piece of paper doesn’t legally bind the insurance company—especially when a producer prepared the certificate in violation of insurance company rules and regulations.

If a producer receives a request for special verbiage on a certificate, the verbiage should be submitted to, reviewed by, and approved by an underwriter before the producer actually enters it on the certificate. Unfortunately, additional insured verbiage is sometimes not approved by an underwriter, which can upset a client when a business deal or relationship depends upon issuance of the certificate as requested. In addition, a premium is sometimes charged for certain types of additional insured endorsements, further upsetting the client.

Since the premium charges for additional insured endorsements are fully earned, and can be as high as $100-150 per endorsement, it’s always a good idea to run additional insured requests past an underwriter before issue. **Certificates of insurance listing additional insureds should always be sent to the insurance company**—along with an endorsement request. Adding an additional insured to a policy changes it and only the insurance company can change a policy. Additional insureds have rights under the policy and share the limits of liability with the named insured. Serious consequences can result when a certificate is issued with additional insured language and the insurance company never receives notice. In such cases, insurance companies refuse coverage on behalf of the “additional insured” because the policy was never endorsed to include their name. Which means the producer’s E & O policy pays the claim—unless a provision excludes coverage. In that case, the producer, himself, is responsible.

Another area giving rise to lawsuits pertains to the section on the ACORD certificate that states “Description of Operations/Locations/Vehicles/Exclusions Added by
Endorsement/Special Provisions.” Suits have been filed by certificate holders because an exclusionary endorsement on the insured’s policy does not provide coverage to the certificate holder in a particular instance and the certificate holder’s policy also precludes coverage. In order to find insurance protection, the certificate holder sues the agent who issued the certificate, accusing him of a number of things, including negligent misrepresentation of the policy. Manually reading a commercial lines policy, or several of them, and listing all the exclusionary endorsements, is a prolonged process and not one every producer wants to perform. Which introduces a serious dilemma to the producer. Perhaps insurance companies will opt to use their own certificate forms or will permit agents to strike the language on the ACORD form. Either way, as certificate holders become more knowledgeable and exacting in their requests for certificates of insurance, the producer’s job of acting in the best interests of his clients becomes more difficult.

Before issuing a certificate, the producer should also determine the exact purpose of the certificate and what policies should appear on it. If a landlord requests proof of liability coverage, it’s not in the best interests of the client to include the business auto, workers’ compensation, and umbrella policies and limits on the certificate. The landlord doesn’t need to have that information.

A final issue concerns the aggregate limits shown on the certificate. What does a producer do when he knows a policy aggregate is impaired by paid claims? For example, the client is an appliance store and is relocating to a larger space. Earlier in the policy year, a customer tripped and fell in the icy parking lot and received a claim payment of $300,000. The policy limits are $1,000,000/$2,000,000. The new landlord requests a certificate showing liability limits of $1,000,000/$2,000,000. Technically, since the $300,000 claim payment was made, only $1,700,000 is available on the policy for the balance of the policy year. Does the producer list the available limit on the certificate ($1,700,000) or does he list what appears on the policy declarations page ($2,000,000)?

Opinion on this matter is divided, depending upon whom a person talks to. If an agent finds himself in this situation, he should check with the insurance carrier of the client, his own E & O carrier, and perhaps even the named insured. Lawsuits have been filed by certificate holders because, after receiving certificates showing the limits of coverage they requested, future claims were not paid to the limits expected because policy aggregate limits had been impaired and the certificate they received did not indicate that fact.

What used to be a routine process that involved little time and effort has now become one of the leading causes of agent E & O claims. In summary, when issuing certificates of insurance, a producer should:

- Obtain authorization from the named insured before issuing
- List only the specific policies pertinent to the request
- Request underwriting approval of all special verbiage and additional insureds before issuing
- Request approval to issue from all MGAs and Surplus Lines Brokerages
- Verify with the insurance company and E & O carrier the correct procedure for
completing certificates on policies where the limit has been impaired by paid claims
• Send copies to the certificate holder, the insured, and the insurance company

CLAIMS-MADE LIABILITY POLICIES

Because most liability policies are written on an Occurrence form, many people become very confused about liability policies written on a Claims-Made form. The major difference between the two forms is what triggers payment by the company. In an occurrence policy, payment is triggered when a covered event takes place during the policy period. In a Claims-Made form, payment is triggered when a loss occurs after the retroactive date and the loss report of a covered event is made during the policy period.

A covered event can also be called a wrongful act or be referred to as an act, error, omission, or the rendering of, or failing to render, professional services. Each policy defines a covered event and it is essential for the agent and insured to be aware of the precise definition contained in the policy.

Until the 1970s, nearly all liability policies, including professional liability policies, were written on an Occurrence form. On an Occurrence form, the event triggering coverage was also the event that triggered the insurance company’s obligation to indemnify the insured. In a professional liability policy, the covered event was the insured’s professional “mistake,” such as an act, error, or omission—as defined in the policy. So long as the event occurred during the policy term, and was subject to all the other policy terms and conditions, the insurance company was contractually obligated to indemnify the insured.

In the 1970s, insurance companies writing professional liability policies experienced a significant increase in the number of claims that were reported late. Of these claims, a considerable number involved an increased average cost because of the effect of inflation on the late-reported claims. The insurance industry found itself being unable to accurately price professional liability policies because the majority of claims were not reported during the policy year of the Occurrence form. Some insurance companies stopped writing coverage on the Occurrence form and others raised rates so high that few professionals could afford them.

As a result of the inherent issues with professional liability policies written on an Occurrence form, insurance companies began writing professional liability on a Claims-Made form. Although the Claims-Made form was not new to the industry, it had previously been used only for specific events or projects. It has evolved quite a bit since the 1970s and this discussion centers on current versions of the form.

In many instances, the Claims-Made form poses more problems to an insured than the Occurrence form, because of reporting requirements, the retroactive date, and complications if the policy is ever replaced. It is also provides one big advantage: if an
insured keeps a Claims-Made policy over a long period of time, and increases his limits as time goes by, he will be covered at the higher limits in the event of a covered loss.

For example, two different clients purchased liability policies on January 1, 1990 with limits of $300,000; one was written on an Occurrence form and the other was written on a Claims-Made form. Each client increased his limits at renewal in 2000 to $1,000,000 and the policies are currently in place at those limits. A loss occurred on February 1, 1998 and the claimant didn’t notify either client of his injury until he filed suit in 2001. Each client reported the loss to his respective insurer immediately. Judgment was entered against each of the clients in 2004 for $500,000 and the clients’ insurers paid their claims. The following chart shows how each client’s policy responded to the claims:

<table>
<thead>
<tr>
<th>Policy Limits at issue</th>
<th>Occurrence Policy</th>
<th>Claims-Made Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Limits at the time of loss (2/1/98)</td>
<td>$300,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Policy term of policy paying the claim</td>
<td>1/1/1998-1999</td>
<td>1/1/2001-2002</td>
</tr>
<tr>
<td>Policy limits of policy paying the claim</td>
<td>$300,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Amount of claim payment</td>
<td>$300,000</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

**RETROACTIVE DATE**

One of the most important aspects of a Claims-Made policy is the retroactive date. Because claims-made policies provide coverage for losses that are reported during the policy period, the date of the loss can be any time in the past. Insurance companies use the Retroactive Date as an underwriting tool to limit or expand the time frame for which they will honor losses. Coverage is NOT provided for losses that occurred before the Retroactive Date; coverage is only provided for losses that occur on or after the Retroactive Date.

Three types of Retroactive Dates exist:

1. **Same as Inception Date**: The Retroactive Date and policy inception date are the same. This type of Retroactive Date is used when the previous policy form was an Occurrence Form or if the insurance company does not wish to assume responsibility for losses that occurred prior to the issuance of the policy, such as an applicant who did not have a CGL in place before issuance of the current policy.

2. **Specific Earlier Date**: The Retroactive Date is earlier than the policy inception date. This type of Retroactive Date is common at the renewal of claims-made policies. It provides continuous coverage and assumes responsibilities for losses that occurred during the policy periods of previous claims-made policies.

3. **No Retroactive Date**: If no Retroactive Date appears on the Declarations page, the insurance company will provide coverage for any claim made during the policy period, regardless of when it occurred. If an Occurrence Form policy was in place on the date of the loss, however, the Occurrence Form policy would be primary and the Claims-Made policy would be excess.
Some policies do not state a retroactive date but do provide coverage for any events or acts that occurred before the policy’s effective date, no matter how long before the effective date. The policy is said to provide Full Prior Acts Coverage. Oftentimes, a policy is considered to have Prior Acts Coverage when the retroactive date precedes the policy’s effective date. For example, the policy’s effective date is June 1, 2010 and the policy’s retroactive date is January 1, 2008. The prior acts coverage covers the period from January 1, 2008 through the policy’s effective date of June 1, 2010.

REPORTING PROVISION

Virtually all Claims-Made forms include a provision that spells out the insured’s obligations with respect to reporting and providing notice of losses and claims. Because insurance companies need to know about losses and the potential for claims as early as possible in order to price policies correctly and establish adequate loss reserves, this is a very important provision—to both the insurance company and the insured. If the insured fails to meet the requirements of the reporting provision, he quite often finds himself without coverage.

Claims-Made policies typically contain the following reporting, or “notice,” requirements:
1. The specific details of the act, error, omission, etc. that caused an incident
2. The injury or damage that may be an outcome, or that is already an outcome, from the incident, and
3. The manner in which the insured first received notice, or became aware of, the incident

In addition to the above requirements, the insured must also report the loss during the policy period, or within the time frame of any extended reporting period applying to the policy—including an additional 30 or 60 days that may be provided by endorsement. It is also very important for an agent to inform his client that the terms claim and incident are not synonymous. An incident may or may not give rise to a claim. An incident is simply an occurrence—something happened. Quite often, an incident occurs and damages may not be realized for quite some time. It isn’t until the damages are realized that the claim is made.

For example, if a CPA has a professional liability policy in place, he may make a professional error when completing a client’s tax return. It may not be known until several years later that the error occurred. Once the error is discovered, it may take more time before it is determined that the CPA’s error will result in his client owning the IRS back taxes and penalties. When the client informs the CPA that the IRS discovered an error on the tax return, the CPA becomes aware of an incident. He should report it to his agent and/or professional liability carrier. When the client informs the CPA that the IRS is billing him for $10,000, the CPA now has received notice of a claim and needs to report that to his agent and/or professional liability carrier.

The courts have ruled that a claim is a demand for money or services. Unfortunately, Claims-Made liability forms tend to include their own definitions of claim. The
following are some different policy definitions of “claim” contained in various Claims-Made forms:

- A written demand
- Written demand received by the insured
- A written demand for monetary damages or non-monetary relief
- A formal civil, criminal, administrative or regulatory investigation, against an **Insured Person**, including any appeal
- A civil or criminal adjudicatory proceeding or arbitration
- A formal administrative or regulatory adjudicatory proceeding
- (1) a demand for money or services; or (2) a **suit**
- A demand received by any **Insured** for money or services including the service of suit or institution of arbitration proceedings. “Claim” shall also mean a threat or initiation of a suit seeking injunctive relief…”

The previous list vividly illustrates that both the agent and the insured need to know precisely how the insurance company defines “claim.”

**CHOOSING A CLAIMS-MADE FORM**

Not all Claims-Made forms are the same. Without reviewing an exhaustive list of all the many differences among Claims-Made forms, here are the top three things for an agent to look at when comparing forms in an effort to obtain the “best” coverage form for a client.

- Try finding a “Claims-Made” form rather than a “Claims-Made and Reported” form. Finding one may not be easy, but the effort should be made (and documented).
- When using a “Claims-Made and Reported” form, try to find one that includes a provision providing an additional 30 or 60 unrestricted additional days after policy expiration during which the insured may report a claim first made. (This is called an extended reporting period.) If using this form, find one that doesn’t require “receipt by the insured” in the definition of “claim.”
- When prior coverage was in force for the client, use a form that does not use the policy effective date as the prior and pending litigation date or continuity date. Or use a form that excludes only “known litigation…prior to inception.”

**SWITCHING OR REPLACING FORMS/COVERAGE**

On occasion, a client may find himself needing to switch a policy from an Occurrence form to Claims-Made form, or vice versa, OR changing carriers—which means changing the type of Claims-Made form. Switching from an Occurrence form to a Claims-Made form seldom results in a coverage gap, especially if the Claims-Made form includes full prior acts (i.e. a retroactive date that includes the time period during which the Occurrence form was in place). Switching from a Claims-Made form to an Occurrence form always leaves a gap and switching from one version of a Claims-Made form to another often has the same result.

For example, the insured purchased a policy with a Claims-Made form and replaced it at
renewal with an Occurrence form, believing himself to have “better” coverage. View the following chart for specifics:

<table>
<thead>
<tr>
<th>Retroactive Date</th>
<th>Occurrence policy</th>
<th>Claims-Made policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss Reported 7/29/2010</td>
<td>No coverage in place</td>
<td></td>
</tr>
</tbody>
</table>

The Claims-Made form policy provides coverage for losses occurring after the retroactive date and reported during the policy term (i.e. before expiration and during any 30 or 60-day automatic extended reporting period). The Occurrence form policy provides coverage for losses occurring during the policy period, no matter when they are reported. In the above example, the loss report satisfies the conditions of neither policy.

The only way to provide coverage for such an instance is to add a Supplemental Extended Reporting Form (SERP) or “tail” endorsement to the Claims-Made form before writing the Occurrence form policy. A SERP, in basic terms, provides a specific amount of time after expiration of the policy, and any automatic extended reporting period, to report any claim occurring after the retroactive date and. In essence, it extends the expiration date for purposes of claims reporting. It doesn’t change the requirement that the event triggering coverage occurred during the policy period and/or after the retroactive date. SERPs can typically be purchased for periods of time ranging from 1 – 5 years. Some policies allow longer periods.

RISK MANAGEMENT BASICS

The rationale behind risk management is to protect the consumer and his assets through a program that involves identifying and analyzing his exposures to loss, controlling those exposures, financing the losses with either personal funding or external funding, and implementing procedures to monitor the entire process. The best way for an agent to help a consumer develop an efficient, affordable insurance program is to assist him with the basics of risk management.

Commercial lines insurers offer their clients loss control and risk management services but personal lines insurers tend to leave the process of risk management to producers. A producer can build strong, long-term relationships with his clients and carriers, while also enhancing his professional success, if he understands the basics of risk management and shares them with consumers.

The risk management process involves five basic steps:
1. Identifying the risk
2. Analyzing the risk
3. Controlling the risk
4. Financing the risk
5. Administering the risk

Clearly, identifying the risk is the most important step because the unknown cannot be analyzed, controlled, financed, or administered. But what IS a risk? The definition of risk is the likelihood or uncertainty of a loss occurring. There are two types of risk:

1. **Pure risk** is a situation that presents the opportunity for loss and not gain. Pure risks can be insured. Driving an automobile is an example of a pure risk.
2. **Speculative risk** is a situation that presents the opportunity for loss OR gain; speculative risks cannot be insured. Placing a bet on the outcome of a card game is an example of a speculative risk.

Exposures are situations that might lead to a loss. Property ownership is an exposure: when an individual or business owns property, he/she runs the risk of losing the property in a fire, losing it to a thief, or having it suffer other types of damage. The activities of an individual or business present the exposure of liability: a person or business may become legally liable for causing injury or damage when driving a car, speaking in public, signing a contract, or building a house. The third type of exposure is for loss of income or loss of use; if a building burns, its owner may lose income if business can no longer be conducted from it and may incur additional expenses when having to relocate to a new location while repairs are being made. Human exposure rounds out the types of situations that might lead to a loss. An individual may become disabled, die, or be sued.

When a producer meets with a consumer to identify his risks, the four exposures should be explored. The producer should ask the consumer a number of questions, including *What is the worst thing that could ever happen to you?* As in: What is the worst catastrophe that could occur with respect to the property the consumer owns? (He wouldn’t have a home to live in but would still have to pay the mortgage.) And as a result of his activities? (He hunts a lot and may accidentally shoot another hunter.) And as a result of loss of income/loss of use? (If he loses his job, he can’t pay his bills and he’ll go bankrupt.) And because of his very existence? (He contracts a serious illness and leaves his family behind with no means of financial and emotional support.)

In addition to asking questions, a producer can provide the consumer with a risk management survey or checklist, which are often provided by insurance companies. He can also perform a physical inspection of the consumer’s home, business, or other property. If the consumer has a web site (either personal or business), or is a party to contracts (leases, by-laws, hold harmless agreements, car rental agreements, insurance policies, etc.), the producer should review those items, as well, to identify risks and exposures.

Once the consumer’s risks have been identified, they should be analyzed. The potential for loss should be measured against the actual exposure to loss. For example, if a consumer owns a home that is worth $200,000, owes $180,000 to a mortgagee, and has liquid assets of $1,000--his potential for loss is great. What is the potential for loss? Fire, flood, earthquake, windstorm, hail, vandalism… When comparing all the things that might happen to the home to cause the consumer to suffer a loss, and measuring the
value of that loss ($200,000), the risk is significant. On the other hand, if the consumer owns a leather briefcase that is worth $100 and has liquid assets of $1,000—his potential for loss is not great. What could happen to the briefcase? He might leave it behind in a business meeting, but it’s not a likely target for theft or other loss. In addition, it’s only worth $100; he has the ability to replace it without significant financial impact.

The next thing to analyze is the likelihood of a loss occurring, how often it might occur, and how severe it might be. If a home were perched on the bank of a river, the likelihood of a flood occurring—over and over, is high. Moreover, the severity of the loss would be significant if the home were flooded. But if the home were located 10 miles from town on an unpaved road, the likelihood of a theft occurring is low. If someone did manage to get out to the house to steal the consumer’s belongings, the consumer’s three pet Rottweilers would be likely to send the thief back to town.

During the analyzing phase, a few things should be kept in mind:
- The exposures that will occur most frequently, or that will be most severe, should be addressed before other exposures
- Severity is the result of frequency
- It’s not wise for the consumer to risk a lot for a little
- It’s not wise for the consumer to risk what he can’t afford to lose

A consumer has a number of options when faced with risk. His options are the methods he uses to control the risk.
- Avoidance – The consumer can refrain from participating in particular activities, or choose not to own particular property, that might result in a loss. For example, if the consumer is concerned with auto accidents, he can refrain from driving or not purchase an automobile. Avoidance is not always realistic.
- Reduction – The consumer can take steps to reduce any loss that may occur. For example, he can wear a seat belt when he drives a car or he can install a smoke detector in his home.
- Retention – The consumer can accept that a loss may result from participating in a particular activity, or purchasing property, but decide to assume responsibility for that loss himself. A policy deductible is a form of retention because an individual assumes responsibility for a portion of the loss along with the insurance company.
- Transfer – The consumer can take steps to transfer the financial consequences of loss to another party. For example, legal contracts transfer risk; hold harmless agreements and insurance policies are two common ways to transfer risk via contract.

Transferring risk is the purpose of insurance: paying a relatively small premium to reduce or eliminate a financial loss, or the consequences of a financial loss. When a consumer pays a premium to an insurance company, that is his form of financing the risk. If a consumer has a savings account with $5,000 in it, that savings account may be a form of financing risk—especially if the client chooses high deductibles on his auto and homeowner policies. Another way to finance risk is to do so via a contract, such as a hold harmless agreement.
Finally, administering risk involves two processes: implementing procedures to keep track of what’s going on and then monitoring what happens. If a consumer maintains a list of all his assets, along with their values, he’ll be able to measure his exposure to loss more easily. When he realizes his daughter is nearing the age to be driving, he may want to re-evaluate his assets and potential for loss based on the increased likelihood of a car accident occurring in his household once she begins driving.

The examples used here involve individuals and families, but the same principles are used when managing commercial risks. With businesses, however, more attention to detail is required in the risk management process because more people are involved (i.e. the insured, its employees, stockholders, customers), more activities are taking place, and the potential for loss is often much more significant.

The producer who introduces the concept of risk management to his clients not only helps them better protect themselves and their assets, he also helps them reduce their insurance costs. Trust and confidence is built, along with knowledge and security.
CHAPTER 5 REVIEW QUESTIONS

1. A soft market is characterized by all of the following EXCEPT _____.
   [a] Low premiums
   [b] Reducing profits
   [c] Tightened underwriting
   [d] Excess competition

2. One of the most contentious issues concerning auto insurance is _____.
   [a] Uninsured Motorist Coverage
   [b] Home-Based Businesses
   [c] EPLI Coverage
   [d] LTC Coverage

3. All of the following are examples of EPLI claims EXCEPT _____.
   [a] An employee takes offense after hearing a joke told in the lunchroom and files
      a discrimination claim
   [b] The methods a supervisor used when firing an employee are at issue and the
      employee files a wrongful termination claim
   [c] An employee is injured when a fellow employee hits him (this is a workers’
      compensation claim)
   [d] Charges of discrimination are filed by a person who wasn’t hired after
      interviewing for a position

4. _____ is the most frequently occurring natural disaster in the world.
   [a] Flood (per the CDC)
   [b] Earthquake
   [c] Mudslide
   [d] Hurricane

5. A certificate of insurance is _____.
   [a] A guarantee of coverage (this is a binder or a policy)
   [b] A temporary policy (this is a binder)
   [c] A snapshot of coverage
   [d] A policy endorsement (this is a particular form of coverage)
MANAGING LIFE & HEALTH RISKS

Not only is the insurance industry in a state of flux these days, so is the country. The economy is scuffling along and the financial disasters such as those involving General Motors, Lehman Brothers, AIG, and Fannie Mae have a tremendous impact on a significant number of Americans. President Obama’s plans for healthcare reform are one of many issues of tremendous concern to consumers, along with unemployment, rising prices, the stability of the stock exchange, and sluggish home sales.

What, one might wonder, do all these things have to do with life and health insurance? Just about everything, that’s what.

When consumers find themselves out of jobs or facing wage cuts, when their investments and retirement plans are in jeopardy, and when the government is operating on shaky ground, people get nervous. They hear things. They wonder whom they can and can’t trust. One of the hardest things to do during a crisis is maintain a positive outlook and remain steady. Yet that’s the best thing an insurance producer can do during this state of nationwide volatility.

Producers need to focus even more diligently on the issues at hand—legislation, the financial stability of insurance companies and other big businesses, and anything of major concern to the consumer. Knowledge is power. Producers who remain calm during the country’s economic crisis and keep abreast of the changing times will weather the storm with far more ease than those who bury their heads in the sand or behave reactively instead of proactively.

In this chapter, the focus is on segments of the life and health insurance marketplace that seem to be experiencing more disruption and turmoil than other areas. It cannot be stressed enough that times are definitely changing and producers must keep pace with the changes in order to be effective and successful.

HEALTH INSURANCE

In March of 2010, President Obama signed into law HR 3692, the “Affordable Health Care for America Act.” Because of much contention about the contents of HR 3692, the House passed a reconciliation bill--HR4872, the “Affordable Health Care for America Act.” As of this writing, some of the provisions of HR 3692 will become effective in September 2010 and others at later dates, such as 2014 and 2016.
Depending upon whom a person listens to, the president’s version of health care reform is either going to save this country or it’s going to cause the sky to fall in. Regardless of a person’s opinion about health care reform, it’s hard to argue that the landscape of health insurance is in the process of great change.

Because the future of health insurance is uncertain, the focus in this section is a few of the basics about health insurance works—as it works in March 2010.

HISTORY

Health insurance first made its appearance in the United States in the 1800s, in the form of accident insurance. The benefits provided were only for injuries resulting from travel on the railroad or by steamboat. Health insurance policies covering “sickness” debuted in the last decade of the 1800s.

Beginning in the early 1900s, health insurance policies became more comprehensive as their popularity increased. The first group health insurance policies were introduced in the 1920s. A number of large life insurance companies began marketing and selling health insurance policies in the 1930s and non-profit organizations, like Blue Cross and Blue Shield, formed to sell health insurance, as well.

When the depression caused the emergence of strong labor unions, group health insurance plans began expanding coverages and benefits because so many Americans were uninsured. The government created programs to assist consumers who were unemployed or ineligible for coverage. Disability benefits were incorporated into Social Security in the 1950s and Congress created the Medicare and Medicaid programs in the mid 1960s. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 was enacted to protect employees and their families in the event of job loss, death, divorce, and other life-changing events. COBRA allows employees to continue their group health insurance for a specific period of time after they leave or lose their job—under certain circumstances—if they pay the insurance premiums themselves.

STATISTICS - 2007

According to the U.S. Census Bureau, Housing and Household Economic Statistics Division, 84% of the American population was covered by some form of health insurance during calendar year 2007. These figures include both private and government programs. Of those covered, fewer than 30% had either Medicare, Medicaid, or Military health care benefits.

TYPES OF HEALTH INSURANCE COVERAGE PLANS

MAJOR MEDICAL

Major Medical plans require the insured to pay for part of covered expenses in the form of a deductible (i.e. first $1,000 of coverage charges). After the deductible is met, the insured is responsible for a percentage of the costs paid for covered charges up to a
certain threshold. For example, 20% of covered charges after the deductible and up to $10,000. This coinsurance clause would limit the insured’s out-of-pocket expenses, after the deductible, to $2,000. Major Medical is also known as “traditional” health insurance because the insured may choose any health care provider or hospital without experiencing a reduction in benefits.

**HEALTH MAINTENANCE ORGANIZATION (HMO)**

HMOs require the insured to choose a primary care physician within the organization who is then responsible for making referrals to other providers and hospitals within the HMO. Benefits are not paid for healthcare obtained outside the HMO organization. This type of plan focuses on preventive care and limits choices. It is less expensive, as a rule, than Major Medical plans and is considered “Managed Care.”

**PREFERRED PROVIDER ORGANIZATION (PPO)**

PPOs contain elements of both Major Medical plans and HMOs. They require an insured to seek health care providers and facilities within a network. The insured may choose care either in or outside of the network but benefits are reduced for out of network care. Deductibles and co-insurance percentages are also increased for care obtained outside of the network. Most PPOs do not limit benefits for emergency care, even out of network. PPOs do not allow total freedom of choice without a reduction in benefits.

**POINT OF SERVICE (POS)**

POS plans combines elements of HMOs and PPOs. They require the insured to choose a primary physician, who must refer the insured to other providers for all care. The provider can be in or outside the network but benefits can be declined for treatment obtained without a prior referral. POS plans are considered “Managed Care” but permit more freedom than an HMO and may not be limited to a network.

**CHOOSING THE PLAN**

What’s a person to do? Should he buy a Major Medical, HMO, PPO, or POS plan? Briefly, here are the advantages and drawbacks of the four types of health insurance plans currently available:

- **Major Medical** – although the insured pays a deductible and co-insurance, he has complete freedom in choosing health care providers and hospitals
- **Health Maintenance Organization (HMO)** – although the cost is usually less expensive than other plans, benefits are only paid if services are afforded by health care providers and facilities of the HMO
- **Preferred Provider Organization (PPO)** – benefits are paid at a higher rate for in-network health care providers and facilities than out-of-network providers and facilities
- **Point of Service (POS)** – insured chooses an approved primary physician and benefits are afforded so long as all care is provided by health care providers and facilities referred by the primary physician

*One thing a producer should remember when advising a consumer who is deciding...*
what type of health insurance plan to purchase is: Choosing deductibles and options the express purpose of lowering the premium will be reflected as increased out-of-pocket costs at claim time!

HEALTH SAVINGS ACCOUNTS (HSA)

A Health Savings Account (HSA) is a tax-exempt trust or custodial account created for the purpose of saving and paying for qualified medical expenses in connection with a high-deductible health plan. Authorized by Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, an HSA is established for the benefit of an individual (including his family), and is portable. HSAs can be offered in conjunction with group and individual policies; they can also be obtained directly from other administrators such as banks.

The minimum annual deductible allowed on the plan of insurance to qualify for an HSA (as of 2010) is:
- $1,150 for individual coverage
- $2,300 for family coverage

The annual out-of-pocket expenses cannot exceed:
- $5,800 for individual coverage
- $11,600 for family coverage

Money deposited into the HSA is deposited pre-tax used to pay for qualified medical expenses.

<table>
<thead>
<tr>
<th>EXAMPLES OF QUALIFIED MEDICAL EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Ambulance</td>
</tr>
<tr>
<td>Prescription birth control</td>
</tr>
<tr>
<td>Breast reconstruction surgery</td>
</tr>
<tr>
<td>Contact lenses and cleaning solutions;</td>
</tr>
<tr>
<td>Eyeglasses</td>
</tr>
<tr>
<td>Dental treatment and braces</td>
</tr>
<tr>
<td>Lodging away from home for prescribed</td>
</tr>
<tr>
<td>outpatient care</td>
</tr>
<tr>
<td>Hospital services and lab fees</td>
</tr>
<tr>
<td>Hearing aids</td>
</tr>
<tr>
<td>Nursing home</td>
</tr>
<tr>
<td>Organ transplant (donor &amp; recipient)</td>
</tr>
<tr>
<td>Osteopath</td>
</tr>
<tr>
<td>Prescription medications</td>
</tr>
<tr>
<td>Sterilization</td>
</tr>
<tr>
<td>Therapy</td>
</tr>
<tr>
<td>Wheelchair</td>
</tr>
</tbody>
</table>
EXAMPLES OF NON-QUALIFIED MEDICAL EXPENSES

<table>
<thead>
<tr>
<th>Athletic or health club membership</th>
<th>Auto insurance premiums allocable to medical coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bottled water</td>
<td>Cosmetic surgery (unless for deformity)</td>
</tr>
<tr>
<td>Cosmetics</td>
<td>Hygiene products</td>
</tr>
<tr>
<td>Diaper service</td>
<td>Domestic help</td>
</tr>
<tr>
<td>Electrolysis or hair removal</td>
<td>Funeral, cremation, or burial expense</td>
</tr>
<tr>
<td>Hair transplant</td>
<td>Maternity clothes</td>
</tr>
<tr>
<td>Nutritional supplements</td>
<td>Insurance premiums</td>
</tr>
</tbody>
</table>

The U.S. Department of the Treasury has a wealth of information about HSAs online at: http://www.ustreas.gov/offices/public-affairs/hsa/

LIFETIME MAXIMUMS

The future of lifetime maximums may be short-lived in light of recent health care reform. However, until current legislation requires changes, individuals and employers choose the lifetime maximum benefit provided by their health insurance plan. The higher the lifetime maximum, the higher the benefit and, consequently, the higher the plan cost. Although increasing the lifetime maximum does generate a premium increase, it is generally not very expensive. It is in the best interests of all parties involved for the producer to offer and quote the highest lifetime maximum available and to have the applicant sign-off if purchasing a lower amount.

Few plans currently offer unlimited benefits. Some plans offer annual maximums for certain types of benefits—such as outpatient services or treatment for alcohol or drug dependency, or for all benefits, in addition to lifetime maximums. While these annual maximums offer some premium relief, the insured may be sorely disappointed in the event a serious illness or accident generates expenses that exceed the annual maximum. If a consumer opts for a plan that includes annual maximums for any types of services, the producer should document the reason for the consumer’s choice (i.e. premium savings).

DEDUCTIBLES, CO-INSURANCE, AND PAYMENTS THE INSURED MUST MAKE

When considering the type of health insurance plan and its benefits, a consumer should be keenly aware of the amount of money he can afford to pay out of his own pocket during a calendar year for uninsured medical expenses. These expenses will include:

- Premiums
- Deductibles – individual and family
- Emergency services and treatments with their own special deductible either in addition to or outside of the policy’s annual deductible
- Amount of money available to pay for emergency services and accidents,
- Amount of money available to replace lost income in the event the applicant is disabled because of an accident/injury and unable to work,
• Amount of money available to pay for dental and vision treatment not otherwise covered

Deductibles and other limits are a cost-control measure built into group and individual health insurance policies. The more the policyholder pays for covered charges before the insurance company begins paying, the lower the policy premium.

**DEDUCTIBLES – INDIVIDUAL AND FAMILY**

Different plans of insurance offer different types of deductibles. Most apply on a calendar year basis. The applicant (either the employer on a group plan or the individual on an individual plan) chooses the deductible. In group insurance, the individual employees do NOT choose their own deductibles.

An **Individual Deductible** is the amount of money paid by the policyholder on an annual basis, **per covered individual**, before the insurance company begins paying for covered charges. If the plan covers a man, his wife, and three children, each of the five family members has his own annual deductible. If the individual deductible is $1,000, the insured must pay the first $1,000 of covered charges, per covered person, per year. For example, if Dad sprains his ankle and incurs $800 of covered medical expenses, the policyholder pays the $800 and it is applied toward his $1,000 individual deductible. If Mom is hospitalized later in the year and incurs $4,000 of medical expenses, the policyholder pays $1,000 toward Mom’s deductible and the balance of the covered charges is paid based on the plan. If one of the children breaks a leg and incurs $2,500 of medical expenses, the policyholder pays $1,000 toward the child’s deductible and the balance of the covered charges is paid based on the plan.

A **Family Deductible** is the amount of money paid by the policyholder on an annual basis, **for the entire family**, before the insurance company begins paying for covered charges. The family deductible supersedes the individual deductible. If the plan covers a man, his wife, and three children, and the individual deductible is $1,000, once the total paid by the policyholder on behalf of all family members reaches the family deductible, the insurance company begins paying for covered charges—even if the individual deductible of one or more family members has not been met.

Using the example in the previous paragraph, if the individual deductible is $1,000, the family deductible might be $2,500. The individual deductibles would be made until the family deductible is met—then they would be considered satisfied for the calendar year. Here’s how it works:

• Dad’s deductible payment of $800 is applied to the family deductible, leaving $1,700 to be met
• Mom’s deductible payment of $1,000 is applied to the family deductible, leaving $700 to be met
• When the child breaks his leg, only $700 of his individual deductible needs to be met because that’s the amount remaining to satisfy the family deductible
• From this point on, no individual family member has a deductible for the remainder of the calendar year because the family deductible has been satisfied
At this point, the insurance company begins paying covered charges at the chosen co-insurance percentage rate.

**CO-INSURANCE**

Most health insurance plans offer several co-insurance percentage options, depending upon the deductibles and out-of-pocket limits chosen. These payments begin after the individual and/or family deductibles have been met and continue until the out-of-pocket limit has been met. They are:

- **100%** - the company pays 100% of covered charges after the deductible is met
- **80/20** – the company pays 80% of covered charges and the insured pays 20% of the covered charges, up to out-of-pocket limit, after the deductible is met
- **70/30** - the company pays 70% of covered charges and the insured pays 30% of the covered charges, up to out-of-pocket limit, after the deductible is met
- **50/50** - the company pays 50% of covered charges and the insured pays 50% of the covered charges, up to out-of-pocket limit, after the deductible is met

Once the policyholder’s payments at his co-insurance percentage reach the out-of-pocket limit, the insurance company begins paying covered charges at 100%—up to the lifetime maximum—and any annual maximums or special limits that might apply. The higher the benefit payment percentage paid by the insurance company, the more costly the premium.

If a plan makes payment at 100% for covered charges after the deductible is met, the deductible is usually high--$3,500 or higher. The lower the benefit payment percentage by the insurance company, the longer it will take for the policyholder to meet the out-of-pocket limit.

**OUT OF POCKET LIMIT**

The out of pocket limit, unfortunately, is NOT the maximum amount of money the policyholder pays out of his own pocket for uninsured medical expenses per year. The out of pocket limit represents the coinsurance payments of the policyholder before the insurance company begins paying 100% of covered charges. For example, if a policyholder had a $2,000 out of pocket limit and a 20% coinsurance requirement, the total amount of covered charges incurred would be $10,000 before the policyholder paid his $2,000. (I.e. 10,000 X 20% = 2,000)

Most health insurance plans, both individual and group, do NOT include the deductible in the out-of-pocket limit; the out of pocket limit must be met IN ADDITION to the deductible. Other charges (i.e. an emergency room fee if the patient is not admitted to the hospital and separate health condition-specific deductibles) are NOT included in the deductible or out-of-pocket limit; they are also paid in addition. A producer should be sure to help the consumer calculate ALL exposures when choosing these limits. For example, if the deductible were $1,000, the out of pocket limit were $3,500, and an emergency room fee were $75, a policyholder might have to pay $4,575 out of pocket in a calendar year. (Assuming no other limits and deductibles applied.)
SUMMARY CONCERNING DEDUCTIBLES, CO-INSURANCE, AND PAYMENTS
THE INSURED MUST MAKE

It is very important for a producer to disclose ALL benefits that require the policyholder to make cash payments because the sum total of these cash payments will increase the policyholder’s annual uninsured medical expenses. It is especially imperative to provide this information to policyholders who will be contributing to an HSA because they will be able to be reimbursed for those payments with pre-tax money. If a consumer’s HSA contribution calculations are off, he may wind up paying for uninsured expenses with after-tax dollars—something that is not to his benefit.

HEALTH INSURANCE POLICY EXCLUSIONS

Each policy lists its own exclusions, just as it does its own benefits. Although exclusions can vary from company to company, and policy-to-policy, here is a list of the more commonly found health insurance policy exclusions—all of which are subject to state mandates and legislation:

- Pre-existing conditions – which is currently under review per HR4872
- Illness or injury caused by war, commission of a felony, attempted suicide, and influence of an illegal substance
- Routine vision, foot, hearing, or dental care (unless dental coverage has been purchased)
- Cosmetic services, including surgery and medication
- Charges by a healthcare provider who is an immediate family member (i.e. spouse, child, sibling, parent, etc.)
- Charges reimbursed by Medicare, workers’ compensation insurance, or auto insurance
- TMJ or CMJ
- Infertility
- Genetic testing, counseling, or services
- Sex changes
- Over-the-counter medications
- Contraceptives
- Drugs not approved by the FDA or purchased outside the United States
- Treatment for smoking cessation, obesity, hair loss, sexual dysfunction or function, or cognitive enhancement
- Experimental drugs, treatment, or services
- Practitioner-assisted suicide
- Chiropractic services (some plans provide limited benefits or benefits if these services are prescribed by a physician)
- Pregnancy—although some states mandate coverage for all subscribers, others exclude coverage if it isn’t specifically purchased

DENTAL AND VISION COVERAGES

Most group plans offer Dental coverage; only some offer Vision coverage and some individual plans offer dental coverage. Dental benefits are usually offered at two
levels—one basic and one more comprehensive—and are provided according to a schedule. Most dental plans include a waiting period before coverage applies, typically 6 or 12 months.

A separate deductible may apply for treatment, based upon the schedule or payment is only made at a certain percentage of the charges. An outline of coverage is provided for each available plan and includes its own conditions, limits, and exclusions that are separate from those applying to the other portions of the policy.

Some insurance companies only offer group Dental coverage if the employer has a minimum number of employees or if a minimum percentage of employees enroll. Vision benefits, like Dental benefits, are provided according to a schedule. Separate deductibles apply, as do outlines of coverage, limits, and exclusions. Most individual health insurance plans do not offer Vision coverage.

**SHORT TERM HEALTH INSURANCE & ACCIDENT INSURANCE**

Health insurance is [currently] available for periods of time up to one year for individuals who are between jobs, who have a waiting period before coverage begins at a new job, and similar circumstances. While the benefits provided on a short-term health insurance policy are not usually as comprehensive as those offered on an individual or group basis, they may protect a consumer against catastrophic medical expenses.

Accident insurance is available to consumers as stand-alone policies or as riders to other types of policies: for student athletes, travel accidents, and accidents of all types.

**COBRA**

The Consolidated Omnibus Budget Reconciliation Act was enacted by Congress to provide continuation of group health benefits for employees that would otherwise be terminated. COBRA amended the Employee Retirement Income Security Act, the Internal Revenue Code, and the Public Health Service Act. The major provisions of COBRA provide the rights to temporary continuation of health coverage at group rates to certain former employees, retirees, spouses, and dependent children.

For example, if an employee is laid off or terminated, his group health benefits usually terminated immediately. To protect the employee and his family, COBRA provides for the continuation of group benefits for 18 months. An employee is usually eligible for COBRA benefits so long as he hasn’t been terminated for “gross misconduct.” Employees are also available for coverage if their number of hours has been reduced and they no longer qualify for group health insurance as a result.

Eligibility for COBRA requires certain qualification elements: the group health plan has to meet certain terms, the individual seeking coverage must be a “qualified beneficiary,” and the event triggering benefits must be a “qualified event.” The terms for meeting COBRA qualification, or eligibility, are:

- Plan Coverage – Eligible plans include group plans for employers with 20 or more
employees on more than 50% of the working days in the previous calendar year; employees are defined as workers who are full-time, part-time, self-employed, agents, independent contractors, and directors—so long as they were eligible to participate in group coverage

- **Beneficiary Coverage** – An eligible beneficiary is anyone covered by a group plan on the day before a qualifying event; an eligible beneficiary includes an employee, the employee’s spouse and dependent children, and in some cases, a retired employee, and a retired employee’s spouse and dependent children

- **Qualifying Events** – These events determine eligibility because, without COBRA protection, the individuals would lose health coverage. The type of event determines who the eligible beneficiaries are.
  a. For Employees:
     i. Voluntary or involuntary termination of employment for reasons other than “gross misconduct”
     ii. Reduction in the number of hours of employment
  b. For Spouses:
     i. Termination of the covered employee’s employment for any reason other than “gross misconduct”
     ii. Reduction in the number of hours worked by the covered employee
     iii. Covered employee becomes entitled to Medicare
     iv. Covered employee becomes divorced or legally separated
     v. Covered employee dies
  c. For Dependent Children:
     i. The same as for spouses, above, and
     ii. Loss of “dependent child” status under the group plan’s rules

COBRA contains special notice requirements for employers, qualified beneficiaries, and plan administrators in the even a qualifying event occurs. The three major notice requirements are:

- The 30-day notice employers must give plan administrators when an employee dies, is terminated, receives reduced hours of employment, or becomes entitled to Medicare
- The 14-day notice plan administrators must provide, in-person or by first-class mail, to employees or family members upon receiving notice of a qualifying event
- The notice an employee must give the plan administrator within 60 days of becoming divorced, legally separated, or experiencing a dependent child’s status change

Qualified beneficiaries have 60 days’ time during which they may elect to continue group health coverage under COBRA. The 60-day period begins on the later of the date coverage was lost or the date the notice to elect COBRA coverage was sent. COBRA coverage is retroactive if the qualified beneficiary elects and pays for coverage within the required time frames for election and payment. A covered employee or the covered employee’s spouse may elect COBRA coverage for on behalf of any other qualifying beneficiary. Each qualifying beneficiary, however, may independently elect or decline coverage.
COBRA provides coverage on a temporary basis for either 18 months or 36 months.

<table>
<thead>
<tr>
<th>Coverage Term</th>
<th>Beneficiary</th>
<th>Qualifying Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 months</td>
<td>Employee, spouse, dependent child</td>
<td>Termination or reduced hours</td>
</tr>
<tr>
<td>36 months</td>
<td>Spouse, dependent child</td>
<td>Death of covered employee, divorce or legal separate, covered employee entitled to Medicare</td>
</tr>
<tr>
<td>36 months</td>
<td>Dependent child</td>
<td>Loss of dependent child status</td>
</tr>
</tbody>
</table>

When electing to choose COBRA benefits, the beneficiaries are entitled to *exactly the same* that was provided under the group health plan. Employers and plan administrators are required, by the Act, to provide notices and explanations of the beneficiaries’ rights with respect to the election of coverage. Both COBRA and ERISA require employers to provide Summary Plan Descriptions within 90 days of an individual becoming a participant in a group health plan.

COBRA does allow employers to provide coverage for longer periods than those shown above. One other requirement contained in COBRA pertains to group health plan options that permit beneficiaries to convert group coverage to individual plans. If a group plan contains such an option or provision and it is available under COBRA, it must be offered to the beneficiary.

The cost of coverage may not exceed 102% of the premium being charged to similar individuals on the plan who have not experienced a qualifying event. The cost will reflect the entire premium billed by the insurance company and usually reflects both the portion paid by the employer AND the employee—100% of the insurance cost. The 2% permitted reflects administrative costs for administering COBRA.

Premiums due may be increased if the plan experiences a rate increase but, usually, the premiums must be fixed in advance of each 12-month policy cycle. Beneficiaries must be permitted to pay premiums on a monthly basis, if that’s the payment plan they prefer. The initial premium payment must be made within 45 days of the date the qualifying beneficiary elects COBRA benefits and must be for the period of time from the date of the qualifying event to the date coverage is elected. Premiums due for each successive period are due on the date stated in the plan and must include a minimum grace period of 30 days. The plan is NOT required to send monthly premium notices after the initial invoicing.

COBRA does coordinate with other benefits and should not be confused with the benefits an employer must provide under the Family and Medical Leave Act (FMLA). Under FMLA, an employer must maintain group coverage for any employee on FMLA leave. FMLA leave does NOT constitute a qualifying event under COBRA. However, if an employer’s obligations to continue providing coverage under FMLA ends, such as when the employee notifies an employer of his intent not to return to work, then a COBRA qualifying event may take place.
The following organizations have jurisdiction over the continuation of group health coverage:

- Department of Labor (private sector health plans)
- Department of the Treasury/Internal Revenue Service (private sector health plans)
- U.S. Public Health Service/Department of Health and Human Services (public sector health plans)
- Pension and Welfare Benefits Administration (private sector health plans)

**HEALTH INSURANCE SUMMARY**

Between rising costs, inadequacies in the current health care system, the dwindling number of physicians, and litigation landscape in this country, few people will argue that something needs to be done about health insurance. For those producers selling health insurance in either the individual or group markets, it is clear their lives are bound to be shaken up quite a bit more before circumstances settle.

**DISABILITY INCOME INSURANCE**

One of the most important assets a person possesses is his ability to earn income. The younger the person is, the larger is his potential to earn income. Which, in a non-tangible way, means that a younger person has more assets than an older person does—even when the older person has far more material possessions.

For example, Donald is 55 years old. He owns a home worth $500,000, has $25,000 in the bank, has $250,000 invested in his retirement account, and has other assets valued at $250,000. He currently earns $80,000 a year at his job and plans to work until he’s 62 years old. Tim, on the other hand, is 25 years old. He owns nothing but his computer, an old pickup worth $1,800, a few clothes, and the $250 leather briefcase his parents bought him as a graduation gift. He’ll be starting his first job next week (as a pharmacist) and will be earning $50,000 a year. Who is worth more, Donald or Tim?

If we add up the value of Donald’s assets, and multiply his income by the seven years remaining until retirement, he’s worth $1,585,000. Of course, this doesn’t take into consideration the time value of money, interest earned on savings and retirements, and many other things.

If the value Tim’s assets are totaled—before his income earning capacity until he’s 62 years old, the figure is a whopping $3,000. Assuming Tim makes $50,000 a year for the next 37 years (until he’s 62)—and NEVER gets a raise, never acquires any more property or assets—he’s worth $1,853,000. Of course, the time value of money, interested earned, and other things haven’t been considered in Tim’s case, either.

If Donald becomes disabled tomorrow and can’t work, he’ll lose his income-earning potential for the next 7 years: $560,000. However, he does have assets of over $1,000,000 plus his health insurance at work. It Tim becomes disabled tomorrow and...
can’t work, he loses his income-earning potential forever. He doesn’t have health insurance to pay for his medical bills, as Donald does, because he hasn’t started working yet. In addition, he doesn’t have a retirement or other assets to liquidate to pay for his medical bills, a place to live, groceries, etc.

Many people purchase life insurance before they even consider purchasing disability insurance. Producers usually recommend life insurance before they recommend disability insurance. Which, in themselves, aren’t bad things. But think about this: Death only happens once per person; disability can happen over and over and over.

Disability income is a form of health insurance that replaces a person’s income when he is unable to work because of a covered accident or illness. Coverage can be written as a separate policy for an individual or on a group plan.

**ELIGIBILITY**

Medical underwriting for disability insurance is very similar to that for health insurance. The applicant’s occupation and business industry is an important factor in premium calculations. In addition, the insurance company requires documentation of the income the applicant is earning—from all sources. The total amount of disability insurance in place cannot exceed a certain percentage of the insured’s income. If it did, the insured would be profiting, which contradicts the theory of indemnity, which is to make a person whole. Typically, the maximum amount of disability income insurance available to an insured is 66.67% of his gross income. Insurance companies review W2s, 1099s, tax returns (for self-employed individuals), and other financial documents when underwriting applications for coverage.

**DEFINITION OF DISABILITY**

Each policy/plan has its own definition of disability. The definition of disability ranges from comprehensive to limited and can include the inability to perform the insured’s own occupation, the inability to perform any occupation for which the insured has been reasonably trained, or the inability to perform any occupation. The most desired definition of disability is the inability to perform one’s own occupation. This definition is usually reserved for occupations with a high earning capacity and degree of technical skill, such as physicians and white-collar professionals. The definition of disability becomes more restrictive as the income earning potential and degree of technical skill decrease.

Policy benefits are only paid if the insured suffers an accident or illness that causes disability—as defined in the policy.

**WAITING PERIOD**

Each policy requires a certain amount of time to elapse before benefits are paid. Waiting periods are lengths of time during which no payments are made, such as the first:

- 3 days of disability – typically seen on a short-term group policy
• 30, 60, 90, or 180 days of disability—typically seen on an individual policy
• 90 or 180 days of disability—typically seen on a long-term group policy

Once the waiting period has expired, benefit payments begin.

**BENEFIT PERIOD**

Benefits are provided for a specific period of time and can range from 6 months on a short-term disability policy to the insured’s lifetime on an individual disability income policy. Benefits are typically payable at 66% - 70% of the insured’s basic weekly wages or salary, up to the benefit amount purchased. Some plans coordinate benefits with other disability policies and Social Security disability payments.

Professionals, such as physicians and accountants, quite often purchase policies with benefit periods to age 65 or for their lifetimes. Policies for laborers and people working in more hazardous occupations than professionals are usually issued with shorter benefit periods, such as 15 or 24 months.

**GROUP DISABILITY COVERAGE**

Group plans may offer both short-term and long-term disability coverage or just one form of coverage. The employer chooses which types of coverage to offer. Short-term disability coverage typically provides a benefit payment for the first 26 weeks of disability. The waiting period can range from 0 days to 7 days. Long-term disability coverage is generally less costly than short-term disability coverage because it includes a waiting period of 90 or 180 days. The benefit period can be from 1 – 5 years or to the insured’s age 60 or 65. When sold together, short-term and long-term disability plans involve no overlap of coverage and provide continuous benefits beginning from the date of accident/sickness.

**EXAMPLES**

**EXAMPLE #1: CPA EARNING $200,000 PER YEAR**

The producer would prepare a proposal showing all available riders and endorsements, which would include a Cost of Living Rider, a Waiver of Premium Rider, Future Increase Rider (if the CPA is not yet 40), Social Security Rider, AD & D Rider, Automatic Benefits Increase Rider, Partial Disability Benefits Rider, Rehabilitation Benefit Rider, Lifetime Benefits Rider (if the benefit period is to Age 65), Impairment Rider, Non-Disabling Injury Rider, and perhaps a Return of Premium Rider.

The maximum monthly benefit available for this CPA would be roughly $9,000 - $10,000—from all sources. Although the proposal would be prepared for the maximum amount of coverage, the CPA would be able to choose whatever amount he felt comfortable with. He’d have to submit financial and wage documentation to the insurance company, which would be more comprehensive if he were self-employed than if he were an employee receiving W2 wages. He’d also undergo a physical exam to verify his underwriting eligibility and premium rate classification, based on underwriting
guidelines.

He’d probably choose a lifetime benefit period, or at least one to age 65, and a waiting period of 90 days. (Since he is financially stable, he could likely afford not earning income for three months. If he couldn’t he might choose a 30 or 60-day waiting period.) The definition of disability in his policy would likely be “own occupation,” meaning that if he suffered an accident or illness and could not perform the duties of a CPA, his policy would begin paying his monthly benefit (whatever monthly amount of coverage he purchased, based on other riders, other insurance, and in coordination with Social Security) after the first 90 days of his disability. Payments would continue for his benefit period (the balance of his lifetime, or to age 65, whichever benefit period he purchased). If, at any point, he were partially or residually disabled and he’d purchased riders pertaining to those issues, he’d receive payments—as appropriate.

EXAMPLE #2: SELF-EMPLOYED CARPENTER EARNING $40,000 PER YEAR

The producer would prepare a proposal with all the available riders, as in Example #1. The maximum monthly benefit available for this fellow would be roughly $2,200—from all sources. Although the proposal would be prepared for the maximum amount of coverage, the carpenter would be able to choose whatever amount he felt comfortable with. Because he’s self-employed, he’ll have to submit copies of tax returns and other financial and earnings documentation to the insurance company. He’d also undergo a physical exam to verify his underwriting eligibility and premium rate classification, based on underwriting guidelines.

Because, in his occupation, he’s far more likely to suffer an accident than the CPA is, the benefit periods offered by the insurance company will not include lifetime and probably will not include to Age 65. Depending upon the type of carpentry work he does, the maximum benefit period available to him will probably be 5 or 10 years. If the carpenter wants to reduce his premium, he might choose a shorter benefit period, such as 15 months or two years. Although the policy premium will be higher for a 30-day waiting period, he’ll likely choose the shorter waiting period if he chooses a shorter benefit period. Of course, choosing a 60 or 90-day waiting period for his rate classification would generate a significant premium decrease.

One thing the producer will want to pay attention to is providing the consumer with details about the consequences of choosing a shorter benefit period and documenting the consumer’s understanding. If a self-employed carpenter is injured and becomes permanently disabled, he will not be happy with a 15 or 24-month benefit period at claim time.

The definition of disability in his policy would likely NOT be “own occupation.” It will probably require the inability to perform any occupation for which he has been reasonably trained. If the carpenter suffered an accident or sickness and could not perform the duties of a carpenter, or those of another tradesman or in an occupation for which he has been reasonably trained, his policy will begin payments as stated in the previous example, after the waiting period has expired.
EXAMPLE #3: EMPLOYER CHOOSING GROUP DISABILITY BENEFITS
As in examples #1 and #2, the producer would provide a proposal showing all available plans and benefits. Group disability insurance typically does not offer the selection of riders that individual policies offer. In addition, an employer may choose to offer either short-term disability or long-term disability instead of offering both types of coverage.

Most group plans offer short and long-term plans that coordinate with each other. For example, if the short-term plan provides coverage for 26 weeks (i.e. 180 days), the long-term plan will usually have a 180-day waiting period. Short-term plans have waiting periods (i.e. 3 days) and others do not. Some short-term plans also provide coverage for fewer than 26 weeks (i.e. 13 weeks), thus leaving a gap in protection after the short-term coverage ends and before the long-term coverage begins. A producer should carefully explain all possible coverage options to the employer, along with the consequences of coordinating, or failing to coordinate, short and long-term plans.

DISABILITY INCOME SUMMARY
Addressing all the nuances of disability income insurance would take more than one course, let alone a short section in a course such as this. Although the information provided here is necessarily brief, it is not a reflection of the importance of this coverage. The most vital thing for producers to remember with respect to disability income insurance in the current marketplace is that many people—producers and consumers alike—overlook its value. The existence of disability income insurance in a consumer’s insurance portfolio may be the single difference between financial security and financial disaster.

LIFE INSURANCE
The basic concepts of life insurance are simple yet consumers are often confused because of the variety of products available and the extensive regulation surrounding it. The most advantageous aspect of a cash value life insurance policy is that its cash value grows tax-deferred. The most advantageous aspect of a life insurance policy that doesn’t provide a cash value is that it’s premium is very competitive.

But how does a consumer know what type of life insurance policy to buy or how much life insurance to buy?

Each consumer has his own unique financial situation and personal needs, as well as an individual perspective about where he plans to be, in a financial sense, at specified times in the future. Before a producer can make appropriate insurance recommendations, many details about the prospective client and his situation must be ascertained and evaluated. This process may encompass several meetings and the review of a number of insurance policies, annuity and investment contracts, and other documents.

Personal information about the consumer must be reviewed, including age, gender, marital status, the existence of dependents, and the life stages of any dependents. It is
also necessary to collect personal information about the prospective client’s spouse and dependents. Other personal information essential to producer’s evaluation include the consumer’s investment objectives, current financial state of affairs, and the existence of other types of policies.

Because of the sensitive nature of much of the information required to perform a thorough evaluation, a producer should always comply with state and federal regulations concerning the collection and security of non-public, private information. In order to earn and retain the trust of consumers, as well as to facilitate the process of collecting required information, producers should volunteer their familiarity with privacy regulations, make all required disclosures, and respect the consumers’ right to privacy.

**FINANCIAL STATUS OF THE CONSUMER**

The consumer’s current financial situation includes information related to his current annual income, assets, liquidity, future financial concerns, medical and long-term care concerns, anticipated age of retirement, financial support of family members, intended use of any proposed insurance, and sources of funding for it. No recommendations about the purchase of an insurance product should be made until this financial information is carefully reviewed and assessed.

It can’t be stressed enough that producers must collect all information pertaining to the consumer’s needs and objectives. Without possessing personal information about the consumer, it is nearly impossible to conduct an appropriate evaluation of his needs. At minimum, the producer should collect the following details about the consumer: name, address, date of birth, marital status, and number and type of dependents. In addition, similar information should be collected for all spouses and dependents of the consumer.

**PERSONAL INFORMATION**

The producer may want to inquire about other concerns to better gauge the consumer’s lifestyle, current and future needs for cash, and overall financial picture. They may include:

- With respect to dependents:
  - Do the dependents have special needs?
  - Will their dependency end at some point in the future?
  - What dependent expenses is the consumer responsible for?
- How often does the consumer travel? Where does she travel and what are the costs involved? Does she plan to continue travelling?
- Does the consumer have any hobbies or activities that require regular and/or significant cash outlays? Will they continue?
- Does the consumer participate in any regular/significant charitable giving? Will those donations continue?
- Does the consumer want to set aside money for education or retirement expenses?
- What kinds of debt does the consumer have, and in what amounts?
CURRENT ANNUAL INCOME
The consumer’s annual income and other sources of income are important elements of a producer’s evaluation. Some consumers simply do not possess the financial resources to fund their life insurance needs in a fashion they envision. The nature of the consumer’s annual income is also important to determine as well as the history of the income stream versus inflation. If the client is currently working and earning income, any predicted changes in future earnings should be taken into account. If the income tends to fluctuate, the nature and details of the fluctuation also need assessing and documentation. Another important element of the income stream is its ending point. For example, if the consumer sold a piece of real estate and owner-financed the sale, the fact that the payments will end in five years (because the term of the loan will end) is an important factor to consider.

ASSETS
Information should be collected about all the consumer’s assets, including investments. Some consumers possess many assets and because their value, on paper, is significant, a consumer may believe she is in a better position to fund a life insurance policy than he really is. Conversely, because a consumer may have may assets he may believe that his need for life insurance is less urgent than it really is.

FUTURE FINANCIAL CONCERNS
This category of information may involve discussion of many of the consumer’s goals and expectations: the purchase of a recreational vehicle or boat, the acquisition of real estate or motor vehicles, the funding of education for children or grandchildren, setting money aside for potential long-term care costs, cessation of employment, future termination of a current income stream, caring for a dependent (parent, child, or grandchild), wealth transfer, etc. The time horizon and amount of funding needed to satisfy each of these considerations will affect future needs for asset growth and liquidity.

MEDICAL CARE CONCERNS
The soaring costs of health care, and the potential inability of the consumer to afford future health care costs, is a concern for many consumers. Consumers aged 65 and older usually rely on Medicare Parts A and B to form the base of their primary health care delivery program. In addition, they should also consider Medicare Supplement coverage, as well as Medicare Part D to gain access to prescription drug coverage. In the case of a senior couple where one is not yet 65, the couple needs to have a strategy in place to obtain affordable health care for the younger spouse until Medicare eligibility is attained. The potential costs for custodial care should not be overlooked and are often addressed by the purchase of a Long-term Care policy. If a senior consumer needs long-term care services and does not have coverage, even the most sophisticated of financial plans can be devastated.

ANTICIPATED AGE OF RETIREMENT
The retirement date desired by the consumer will affect his retirement planning and life insurance needs. His anticipated retirement lifestyle and any debt structure, along with the financial ability to make premium payments, will help the consumer determine any cash value requirements, if purchasing permanent life insurance. The path to retirement
does not always contain a clear vision and, even when a consumer has firm plans for retirement, life often interferes with those plans. Illness, the death of a spouse, job layoffs, and downsizing are seldom anticipated. Some consumers choose to continue working after retirement or find themselves in the unfortunate position of needing to work part-time after retirement because they need the additional income. The possibility of such scenarios should also be considered and discussed when choosing an anticipated retirement date.

**FINANCIAL SUPPORT OF FAMILY MEMBERS**

If the consumer is currently supporting dependent family members, or anticipates the possibility of future support for family members that hasn’t already been calculated, the cost of providing support needs to be projected. Examples of this type of scenario include a child struggling to make ends meet as a single parent or the incapacity of a parent or spouse.

**PRODUCT SELECTION**

When selecting a life insurance product, a consumer should always have as much information available as possible. It is not in the best interests of anyone for the producer to “tell” the consumer what type of life insurance product to purchase, even when the consumer seems to be confused about precisely what life insurance is all about.

Term, whole life, and universal life products all have advantages and disadvantages and it behooves an agent to explain the particulars of each to a consumer considering the purchase of life insurance.

Illustrations and proposals should be prepared according to company, state, and federal regulations and all disclosures should be provided to the consumer. In addition to determining the consumer’s needs, a producer must establish and build trust—something that isn’t always easy to do when discussing the future death of the consumer or his loved one.

**ANNUITIES**

Annuities are intangible products that cannot be evaluated using the same methods utilized to assess tangible products. The value of an annuity is often difficult for a consumer to grasp—especially a senior consumer. The annuity contract is, by necessity, filled with legal terms, exceptions, and contingencies. The average consumer is not equipped to understand them, so he places his trust in the professional recommending and selling the product.

**SUITABILITY**

The consumer’s trust in his agent is usually well deserved; however, the opportunity for producers misleading or deceiving consumers exists. Suitability requirements were
established for the protection of consumers and, specifically, to prevent individuals from entering into contracts that are not appropriate for their particular situations and needs.

During the past several years, insurance regulators have been monitoring complaints from consumers concerning annuity sales. According to Kansas Insurance Commissioner, Sandy Praeger, who addressed the Senate Select Committee on Aging in September 2007, the total number of annuity complaints remains low when compared to other lines of insurance. The number of complaints is still significant, however, and indicates a troubling trend.

In the states that reported data on annuity sales to the National Association of Insurance Commissioners (NAIC), the period from 2004 through 2007 experienced a marked increase in the number of total complaints in the categories of suitability, agent handling, and misrepresentation. The total number of complaints reported in these categories rose from approximately 1400 in 2004 to more than 2300 in 2006. The proportion of these complaints attributed to suitability issues also increased each year—from just over 10% in 2005 to more than 18% in 2007. Each complaint is reviewed and investigated by the respective state Department of Insurance and, since 2004, more than 75% of the annuity complaints reported to the NAIC by state regulatory agencies have been resolved in favor of the consumer.

In light of the rising number of complaints about annuity sales, the NAIC adopted a white paper in 2006 that called for the development of suitability standards for non-registered annuity products similar to those that existed under the Securities and Exchange Commission (SEC) regulations for registered products. The white paper resulted in the creation of a working group under the NAIC Life Insurance and Annuities Committee; that group drafted a model regulation establishing suitability standards for all life insurance and annuity products.

The committee decided to focus first on the area identified as subject to the greatest abuse: the inappropriate sales of annuities to persons over the age of 65. The resulting Senior Protection in Annuity Transactions Model Regulation (Suitability Model) was adopted by the NAIC in 2003. This model is another tool regulators use to protect consumers from inappropriate sales practices.

Purchasing life and annuity products is often a complicated and confusing process for consumers of all ages, not just for seniors, and most regulators believed the protections of the Suitability Model should be extended to other segments of the population. The NAIC membership addressed this issue in 2006 by adopting revisions to the Suitability Model so that its requirements apply to all consumers, regardless of age. As of June 10, 2009, thirty-five states adopted the NAIC Suitability Model or similar suitability regulations.

The Suitability Model spells out duties of insurance companies and insurance producers with respect to recommending the purchase or exchange of an annuity that results in an insurance transaction (or a series of insurance transactions). The duties require the producer (or the insurance company if no producer is involved) to document his
reasonable grounds for believing the recommendation to the client is suitable based on facts obtained by the client, which will be detailed in the next chapter, and which include:

- Potential surrender term and surrender charges,
- Potential tax consequences and penalties if the consumer sells, exchanges, surrenders, or annuitizes the contract,
- Mortality and expense fees,
- Investment advisory fees,
- Potential charges for, and features of, riders,
- Limitations on interest returns,
- Insurance, and
- Investment components and market risk

If a state has adopted the Suitability Model, the requirements listed above are intended to supplement, not replace, the disclosure requirements. The Suitability Model also requires producers to possess adequate knowledge of annuity products before making recommendations to consumers and to comply with regulation concerning product-related training and continuing education. These requirements include familiarity with not only the annuity contracts themselves, but state law concerning suitability, disclosure, preparation and dissemination of illustrations and prospectuses, replacement, advertising, direct mailers, prohibited sales practices, special laws concerning seniors, comparison between the types of annuities, and policy cancellations and refunds.

Because of the complicated nature of annuities, some states require producers to complete a certain number of hours of continuing education on the subject of annuities before being able to sell them. In addition, it may require producers selling annuities to complete continuing education about annuities every license renewal period. A producer who is familiar with an insurance product is far more likely to make appropriate recommendations to the consumer than is a producer with little or no knowledge of the same product, hence the CE requirements.

Making an informed decision before purchasing or exchanging an annuity requires a consumer to understand, and the producer to explain, a great deal of technical information: the complexity of the various annuity contract provisions and features, the impact of state and federal taxation on annuity payouts, and the uncertainty of numerous factors affecting the consumer’s assets, needs, and longevity. As is the case with many insurance transactions, a client purchasing or exchanging an annuity will seldom recall each detail of the qualification process or the particulars of each conversation with the producer. It is essential for annuity producers to conduct every step of the suitability determination not only for the purpose of establishing “reasonable grounds,” but also to use the information for future evaluations of a client’s financial picture.

As products develop and acquire new uses, as federal and state tax laws change, and as our life expectancy stretches beyond previous prospects, the need for the producer’s attention to focus on all manner of detail and responsibility with respect to the sale of annuities continues to grow.
While all annuity contracts contain features and benefits that are advantageous, they also contain features and benefits that may not be advantageous to certain consumers in particular situations. The following questions are some of those a producer should ask himself—and the consumer—before recommending the purchase of an annuity:

- How much retirement income will the consumer need, in addition to an existing pension plan and social security benefits?
- Will the consumer need income for only himself or for himself and a spouse or other dependents?
- If the consumer invests in an annuity, will he have other cash available to pay for expenses?
- How long a period of time can the consumer afford to tie up his money in an annuity? How long does the surrender charge term last and will the annuity permit withdrawal from the annuity if the consumer should need to make withdrawals?
- Does the contract include survivor benefits?

One of the most common suitability complaints involves the overselling of annuities and leaving seniors without sufficient assets to meet their current financial needs. In other words, the producer convinces the senior to deposit too much of his assets into the annuity, thus leaving him without the funds to pay current and future expenses. As we all know, the larger the annuity premium deposit(s), the more commission is generated. Producers should make their recommendations to the consumer based on the needs and best interests of the consumer, NOT based on their desire to earn more commissions.

**SENIORS**

The federal government has enacted legislation for the protection of seniors and the NAIC has also developed model legislation for states to adopt. Numerous states have enacted legislation for the protection of seniors or are in the process of doing so.

California is one of the states with strict legislation concerning seniors and insurance practices concerning the sale of insurance, including annuities and long-term care insurance, to seniors. According to the California Department of Insurance, “Elder abuse is a growing problem that occurs daily in every community. Financial abuse can drain elderly people of all their life savings, leaving them vulnerable when there is a family emergency that requires health care or long-term care. Illnesses, such as dementia and Alzheimer’s, often make it difficult for a person to ask for help when confronted with financial problems. Agents can make substantial commissions on the sale of annuities. The majority of agents and brokers who sell insurance products obey the laws. However, many elderly individuals have been taken advantage of by insurance agents who have manipulated them into purchasing an unsuitable annuity or replacing existing or established annuities with a new one simply for the agent's financial gain.”

Some producers may not have personal relationships with seniors or may lack familiarity with many of the concerns and behaviors of seniors. As a result, they may overlook signs that indicate special care and attention is required. Other producers deliberately set about
either withholding information, or providing false information, with the intention of earning commissions on the sales of annuities that are not in the bests interests of seniors.

The growing popularity of estate planning and living trusts has generated scams called “Living Trust Mills.” These scams often target seniors, who are attracted to free seminars about estate planning, living trusts, and other similar topics. Some producers provide themselves with official sounding titles, such as “Trust Expert,” “Trust Advisor,” “Senior Estate Planner,” and “Paralegal” and present free seminars under the pretext of helping establish or update living estates. The true purpose of these producers is to acquire the financial information of seniors they might otherwise not be able to obtain.

According to the SEC, “The education, experience, and other requirements for receiving and maintaining a "senior" designation vary greatly. In some cases, a financial professional may need to study and pass several rigorous exams--after working in a designated field for several years --to receive a particular designation. In other cases, it may be relatively easy in terms of time and effort to receive a "senior" designation, even for an individual with no relevant experience.”

In 2005, the North American Securities Administrators Association (NASAA) began urging seniors to check carefully the credentials of people holding themselves out as “senior specialists.” Producers, registered representatives, and other people marketing investment products and services to seniors began calling themselves “senior specialists” to create a level of trust and confidence among seniors by indicating they have special training and expertise pertaining to people over age 55. Quite often, such “specialization” was simply a marketing and sales ploy used to take advantage of seniors. NASAA is the oldest international organization focusing on the protection of investors. The securities administrators of all 50 states are members, as are those of the District of Columbia, the U.S. Virgin Islands, Puerto Rico, Canada, and Mexico.

Patricia D. Struck, who was president of NASAA and also Wisconsin Securities Administrator at that time NASAA began warning seniors, announced, “These sales people and the alphabet soup of letters after their names can be confusing, and in some cases, may even be deceptive to seniors.” She indicated that while legitimate organizations do exist—and whose membership is required to complete painstakingly thorough study material, pass comprehensive examinations, and have extensive practical experience before receiving a senior designation—an increasing number of designations have been created for the purpose of scamming seniors. Struck reported that in 2005 alone, securities regulators instituted 26 cases against “senior specialists” in the eastern half of the U.S. Most of those cases involved individuals who were not properly licensed by state regulatory agencies.

The state of Massachusetts recently took action against a representative of a firm who stated during a senior seminar that he had earned a “Certified Senior Adviser” (CSA) designation and claimed to be specifically trained to manage and solve financial issues faced by seniors. He didn’t reveal that the designation entailed completion of a three-day course, or a home course, followed by a multiple-choice exam. Massachusetts regulators
reported that the seminar encouraged investors to invest in equity-indexed annuities because they were the best & method of participating in stock market gains without involving any risk. In fact, the equity-indexed annuities being recommended were very complicated contracts and their sales generated high commissions to the sales person. In addition, they contained long holding periods and stiff penalties for early withdrawals—two elements that quite often make them unsuitable for seniors. The state charged both the representative and his firm with misleading investors, especially seniors.

The Pennsylvania Securities Commission issued a cease and desist order in 2005 against the Association of Senior Counselors and an agent because of the sale of unregistered securities. The agent appeared at the home of a senior with marketing and sales material citing he had “credentials you can trust” and indicating that he had a CSA designation. An investigation into the charges indicated that the same agent had been charged in Connecticut the previous year for selling unregistered securities and failing to register as a securities agent of an issuer in connection with the alleged sale of promissory notes.

The issue of legal capacity often arises in cases involving senior consumers. Legal capacity is the term used to define a person who is able to understand and appreciate the consequences of his/her actions. A person who lacks legal capacity cannot, for example, enter into a contract, give a power of attorney, make a will, consent to medical treatment, or transfer property. Minors typically lack legal capacity, as do individuals who are mentally handicapped or under the influence of alcohol. The older we become, the more likely we are to develop a mental disease or disability such as Alzheimer’s disease or dementia, which diminishes both our legal and mental capacity.

If a producer sells an annuity to an individual who lacks legal or mental capacity, it could be argued that the sale is inappropriate—even if neither the producer nor the consumer were aware of the lack of capacity. Since basic contract law requires “competent parties” for a contract to be considered legal, it could further be argued that the contract is not valid and binding upon the incompetent individual.

Some seniors experience diminished capacity as they age; recognizing the signs of such a condition is often difficult, especially for a producer who doesn’t routinely have dealings with seniors. Producers who exert undue influence over seniors commit elder abuse. According to the National Committee for the Prevention of Elder Abuse, “undue influence,” is defined, in part, as: “…an individual who is stronger or more powerful making a weaker individual to do something that the weaker person would not have done otherwise. The stronger person uses various techniques or manipulations over time to gain power and compliance.” Such techniques are both illegal and unethical.

The SEC recently reported that diminished mental capacity affects approximately 20 percent of seniors aged 85 and older. It is important that producers recognize the indicators a prospective insured might exhibit that illustrate the lack of short-term memory, or judgment, that is required to knowingly purchase an annuity.

Diminished mental capacity does not mean an individual does not have legal capacity; it
does indicate, however, that the individual does not function as well as s/he has functioned in the past. Since each person is unique and possesses varying degrees of decision-making capabilities at various stages in his life, it is a considerable challenge for a producer to recognize diminished mental capacity in a person he just met.

For a producer who is not formally trained in a mental health disciplines (and most are not), assessing diminished capacity is possible in some cases but, in general, beyond the expertise of a typical producer. A major issue involved in assessing diminished capacity pertains to short-term memory. Many individuals have occasional memory problems due to the natural aging process and take longer to make decisions. Loss of memory, and/or the onset of diminished mental capacity, is usually a gradual process that accelerates over time. It is entirely possible for a senior consumer to make an insurance-related decision today, when appearing cognitively adept, and to be considered cognitively impaired two or three years in the future—after a complaint of elder abuse has been filed.

Below is a list of several indicators of diminished mental capacity of which producers should be aware. Not all of these indicators will be apparent in the context of a typical meeting with a senior. Additionally, some of these indicators require prior knowledge of the senior in order to determine if deterioration has taken place in a particular aspect of the senior’s behavior over time.

- **Memory loss:** The senior is repeating questions, forgetting details, forgetting appointments, misplacing items or losing track of time
- **Disorientation:** The senior is confused about time, place, or simple concepts OR the senior appears to be disoriented with surroundings or social settings
- **Difficulty performing simple tasks:** The senior lacks the ability to remember the order of performance of the steps necessary to complete a simple task such as tying one’s shoes.
- **Difficulty speaking:** The senior use words that do not fit the context of their use
- **Difficulty understanding consequences:** The senior appears unable to appreciate the consequences of decisions.
- **Difficulty with decision-making:** The senior makes decisions that are inconsistent with his or her current long-term goals or commitments.
- **Attitude:** The senior seems overly optimistic.
- **Difficulty following simple directions:** The senior has difficulty with directions, particularly when they include multiple steps that must be performed in sequence
- **Deterioration of handwriting and signature:** The senior appears unable to accurately write the letters of the alphabet or the letters are written backwards
- **Drastic mood swings:** The senior may exhibit a swift change in mood within a short period of time with no obvious reason for the mood change
- **Difficulty with finances:** The senior does not remember or understand recently completed financial transactions.
- **Lack of attention to personal hygiene:** The senior appears uncharacteristically unkempt
- **Confusion as to date and time:** The senior may be confused as to the season, the current month, the day of the week, or the time of the day.
One method of preventing the future claim of an ethics violation involving a senior is for a producer to invite a trusted family member or other individual to be present when meeting with a senior for the purpose of discussing insurance or annuities. Privacy issues may have an impact on this practice and producers should make certain compliance with all privacy laws and regulations are in place. Another concern for the producer is the possibility that the trusted family member is, himself, the perpetrator of elder abuse.

Examples of a family member exploiting a position of influence over a senior to gain access to the senior’s assets, funds, or property (the definition of elder abuse) include:

- Cashing a senior’s checks without authorization or permission
- Forging a senior’s signature
- Misusing or stealing a senior’s money or possessions
- Coercing or deceiving a senior into signing a document, such as a will or a contract
- Improper use of conservatorship, guardianship, or power of attorney

Possible signs of elder abuse being committed by a family member include:

- The senior’s sudden reluctance to discuss financial matters
- Sudden, unusual, or unexplained withdrawals from, or other changes in, a senior’s bank accounts, insurance policies, or other investments
- Abrupt changes in a senior’s will, trust, or power of attorney
- The senior’s increasing lack of contact with, and interest in, the outside world
- Admission or suggestion that a financial or material exploitation is taking place
- The senior’s concern or confusion about missing funds in his/her account
- Fear of placement in a nursing home if money is not given to a caretaker
- Appearance of insufficient care or neglect, despite having money and a means of support

The Financial Industry Regulatory Authority (FINRA), the Securities and Exchange Commission (SEC), and a number of states are increasingly concerned about elder abuse and unethical sales practices targeting seniors. An ethical producer will report all instances of suspected senior abuse to the appropriate authorities and will also refrain from working with a senior if the producer suspects the senior is a victim of diminished legal or mental capacity.

LONG-TERM CARE PARTNERSHIPS

The concept of long-term care partnerships dates back to 1987 when the Robert Wood Johnson funded a $14,000,000 demonstration project on the notion. The first state to establish a long-term care partnership was Connecticut (1992); it was followed by New York and Indiana in 1993 and California in 1994.

Partnerships for long-term care can be described as agreements between private insurance companies, state governments, and residents of the states where individuals purchase private long-term care policies and are rewarded (how they are rewarded varies from state to state) should they ever need Medicaid assistance with long-term care costs. The
insurance companies are required to structure their partnership long-term policies within
certain parameters, provide required consumer disclosures, and adhere to market conduct
standards.

The four states just mentioned are considered to be the pioneers of the long-term care
partnership concept. Many other states have implemented partnership programs since the
1990s. A 2005 General Accounting Office (GAO) report states that, as of 2003,
approximately 172,000 partnership long-term care policies were in force in these four
states alone.

To receive the reward (some degree of asset protection should they apply for Medicaid
assistance), the resident must purchase a partnership long-term care policy. The state
government, in order to comply with its role in the partnership, must reward the resident
for having insured his potential long-term care needs to the required level by allowing
assets to be retained by the insured resident should he apply to Medicaid for assistance.

The concept of the partnership is to provide a mechanism for the Medicaid program to
work together with private long-term care insurance companies to help a larger sector of
the population solve the long-term care equation. Many individuals who currently can’t
afford the costs associated with long-term care possess assets in excess of the Medicaid
eligibility limits.

The Omnibus Budget Reconciliation Act (OBRA) of 1993 prevented most states from
adopting partnership programs and thus slowed the spread of the partnership concept
beyond the initial four states. With the passage of The Deficit Reduction Act (DRA) of
2005, many of the barriers were removed and more states are now likely to establish
long-term care partnership programs.

In the absence of the Partnership, residents have three basis choices to finance the costs
of long-term care:

1. They can pay for needed care from assets and income, which can cause significant
   shrinkage in assets, even to the point of financial destitution.
2. They can attempt to transfer assets prior to needing long-term care services. The
   most common method is via gifting to children or a trust. The downside to this
   approach requires a consumer to give up of control of his major assets in order to
   divest himself successfully of his major assets. Many individuals have engaged in
   this type of planned impoverishment and found themselves never needing long-
   term care services. DRA increased the “look back” period during the Medicaid
   application process; it will soon stipulate 60 months on all transfers, which
   increases the likelihood of a transferee being considered ineligible for Medicaid
   assistance due to uncompensated transfers.
3. They can buy a traditional long-term care insurance policy. This is a sound
   approach but the policyholder still runs the risk of exhausting the policy benefits.
   He may still require care or find himself in the position that the amount of benefit
   purchased is not sufficient to cover the cost of the required care. This is most
   likely to occur when someone (due to affordability issues) decides not to buy the
inflation rider, buys a lower daily benefit than is needed to cover the cost of care, or buys a short benefit period.

The Partnership adds a fourth alternative. A resident may purchase a Partnership policy from an insurance producer. If the resident needs care and the policy pays benefits, for every dollar of benefits paid by the policy, the resident is able to exclude one dollar in assets from the “asset test” that is imposed when qualifying for Medicaid assistance. (It should be noted that only assets are sheltered by a Long Term Care Partnership--the income test is not affected).

Example: Assume a resident purchased a Partnership long-term care policy with a three-year benefit period and a $140 daily benefit amount (which is considerably less expensive than a lifetime benefit period). If he needs long-term care services and this policy pays, at the end of three years it will have paid $153,300 in benefits. If, after the three-year period, the resident still needs care and applies for Medicaid assistance, the reduction in his total countable assets will be $153,300. In other words, one dollar in assets will be disregarded for each dollar he received in benefits from a partnership long-term care policy.

To begin to understand the approach taken by a Long-Term Care Partnership, a review of the objectives most states have in mind when they implement a long-term care partnership program is necessary. Partnership goals are:

• Provide incentives for an individual to obtain or maintain insurance to cover the cost of long-term care.
• Provide a mechanism for qualification of coverage for the cost of long-term care needs under Medicaid without first being required to substantially exhaust assets, including a provision for disregarding any assets that equal the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under the program.
• Alleviate the financial burden on the state’s medical assistance program by encouraging the pursuit of private initiatives.
• In determining eligibility for Medicaid, long-term care services for an individual who is the beneficiary of an approved long-term care partnership program policy, an amount of resources equal to the amount of benefits paid under the long-term care partnership policy shall be excluded from the Department’s calculation of the individual’s resources. The department is authorized to adopt rules to implement this section.

In summary, the goals of state long-term care partnership programs are to provide an incentive--in the form of asset retention--for an individual to buy long-term care insurance coverage even if he can’t buy enough benefit amount or length to completely cover the risk.

The heart of all partnership plans is to reward the consumer for taking steps to become financially self-sufficient to the best of his ability. If the partnership program is successful in getting more people to buy long-term care insurance, it will help save
Medicaid funds so that policyholders will not require Medicaid assistance because their private policies will be sufficient to cover their long-term care needs.

The four pioneer states listed above offer one of three partnership program models:
1. Dollar-for-Dollar Asset Protection -- Assets are protected when receiving Medicaid assistance, up to the amount of the private insurance benefits paid.
2. Unlimited asset protection -- The New York Partnership took this approach. All New York partnership policies must provide a minimum of a three-year benefit period (in-patient) or six years of home care. If a policyholder exhausts the benefits contained in his private policy, he may qualify for Medicaid assistance regardless of the value of his assets. The key is that he must exhaust the benefit of his policy before he is entitled to asset protection. The average daily cost for a nursing home in New York is over $300. A drawback to this approach is that the policyholder may not be able to afford a daily benefit sufficient to cover the high cost of a nursing home. An individual would then be in a position to spend a large portion of his assets making up the difference between his policy benefit and the nursing home cost during the three-year period prior to being entitled to asset protection under the partnership program.
3. Hybrid Asset Protection -- Indiana provides a combination of the models discussed above. The hybrid plan provides dollar-for-dollar asset protection (like the Dollar for Dollar model above). In addition, the policyholder has the option of buying a policy with a four-year benefit period in an amount determined to cover the average nursing home cost at the time. The minimum amount of benefit purchased to obtain the Hybrid (or total asset protection), is set by the state and is adjusted periodically for increased long-term care costs. In 2005, if an Indiana resident bought a four-year benefit with a total dollar benefit amount of $196,994 (a $135 daily benefit) or more, he was guaranteed total asset protection. According to a 2005 GAO report, since the Hybrid model was introduced in Indiana in 1998, 87% of all partnership policies meet the four-year state minimum in the year they are purchased.

What all of the preceding partnership programs have in common is that the consumer’s income pays for the cost of care once he qualifies for Medicaid. Essentially, the Partnership programs protect assets, not income.

STATE RECIPROCITY

In 2001, the states of Indiana and Connecticut implemented a reciprocity agreement allowing Partnership beneficiaries who have purchased a policy in one state—but move to the other—to receive asset protection if they qualify for Medicaid in their new state of residency. Prior to this agreement, the insurance benefits of Partnership policies were portable; the asset protection component was state-specific. The asset protection specified in the agreement is limited to dollar-for-dollar, so Indiana residents who purchase total asset protection policies would only receive protection for the amount of LTC services their policy covered if they moved to Connecticut.

Since the Deficit Reduction Act requires all new partnerships to follow the dollar-for-
dollar asset disregard mode, the slight wrinkle in the Indiana/Connecticut reciprocity agreements will not be repeated.

Reciprocity is an attractive feature for many consumers, especially those who do not know in what state they will reside in future years. The DRA requires the secretary of Health & Human Services--in consultation with NAIC, insurance companies issuing policies, the states, and consumers--to develop standards of reciprocal recognition under which benefits paid would be treated the same by all such states. States will be held to the same standards unless a specific state notifies the secretary in writing that it wishes to be exempt.

**INCOME AND SUITABILITY**

Income level is an important element of determining suitability for a partnership policy. If the consumer’s income exceeds the costs associated with long-term care, he will not qualify for Medicaid and will not receive the reward offered by the partnership program. Consumers finding themselves in this position should consider a partnership or non-partnership long-term care insurance policy and insure an adequate benefit, with an inflation rider, and consider a lifetime benefit period.

Income level and the cost of nursing home care in the selected area are components that help a consumer decide what amount of benefit to purchase in a long-term care policy. For example, if the local cost for a nursing home averages $150 per day, and the consumer can afford to pay $60 per day from income received, he might want to consider daily benefit amount of $90 to $100. It is important for the consumer to determine accurately the daily cost of a nursing home in the area he chooses, since costs vary widely. They are usually significantly higher in urban areas than in rural areas. All Partnership policies include an inflation benefit based on the age of the policyholder to help keep the benefit in step with actual future costs.

Premium affordability is a major concern. Not only should the consumer be able to afford the LTC policy premium when he purchases it, he must also generate sufficient income in the future to continue paying premiums. Premiums for long-term care policies can be increased if the insurance company can demonstrate they have exceeded the required loss ratio. Generally speaking, an individual (or couple) with income below the current Medicaid income caps may not be able to afford the coverage. If a consumer has income below these levels and a modest amount of assets, he would probably qualify for Medicaid assistance immediately and the purchase of a long-term care insurance policy may not be appropriate.

**AFFORDABILITY OF PARTNERSHIP POLICIES**

Since a long-term care contract must meet several specific requirements in order to be considered a partnership policy, the costs of a partnership policy can be higher than a long-term care policy that does not meet these requirements. Most notable of the partnership requirements from a premium standpoint is the requirement for inflation protection. Adding an inflation protection component to a long-term care policy will
increase premiums between 35% and 50%, depending on the type of component added. Since the owner of a long-term care policy will most likely be paying premiums during times when he is living on a fixed income, the ability to initially and continually afford premiums for a long-term care policy should be a consideration during product selection. While addressing inflation is vital to a well thought-out plan, it is also important to consider that financing inflation protection is costly. Purchasing a long-term care policy without an inflation protection device will be much less expensive at issue and will not generate the increased premiums related to increased benefits. While future benefits will not increase to keep pace with inflation, the policy will be more affordable to a wider range of individuals.

On the other hand, if a consumer chooses to purchase a long-term care contract without inflation protection, he is gambling. The longer he owns the policy, the smaller the benefit becomes in relation to the services it will purchase. If the consumer does not need the benefits payable by the long-term care policy for 15 years or longer, he could very well experience costs associated with long-term care services that are more than double what they were when the policy was issued. This is such a serious issue that legislation requires all long-term care policies to offer inflation protection. It also graphically illustrates the impact of inflation on long-term care benefit.

**OTHER HEALTH COSTS**

Other health related coverages, such as Medicare Parts A and B, Medicare Supplements (or C Choice or Advantage Plans), and/or a Medicare Part D plan, will be necessary to complete the health care package for a senior citizen. The daily costs for a nursing home do not include prescription drugs and/or medical supplies.

As stated earlier, the ability of a state to implement a partnership plan was limited prior to the passage of The Deficit reduction Act. A summary follows and details a number of the changes contained in DRA that made the partnership plan more attractive to both the state and the consumer.

**EXPANSION OF STATE LONG-TERM CARE (LTC) PARTNERSHIP PROGRAM**

Section 6021(a)(1)(A) of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, expands state LTC Partnership programs, which encourage individuals to purchase LTC insurance. Prior to enactment of the DRA, states could use the authority of section 1902(r)(2) of the Social Security Act (the Act) to disregard benefits paid under an LTC policy when calculating income and resources for purposes of determining Medicaid eligibility. However, under section 1917(b) of the Act, only states that had state plan amendments approved as of May 14, 1993 could exempt the LTC insurance benefits from estate recovery.

The DRA amends section 1917(b)(1)(C)(ii) of the Act to permit other states to exempt LTC benefits from estate recovery, if the state has a state plan amendment (SPA) that provides for a qualified state LTC insurance partnership (Qualified Partnership). Many states passed a State Plan Amendment in 2005 in anticipation of the president signing the
DRA. The DRA then adds section 1917(b)(1)(C)(iii) in order to define a “Qualified Partnership.” States that had state plan amendments as of May 14, 1993 do not have to meet the new definition but, in order to continue to use an estate recovery exemption, those states must maintain consumer protections at least as stringent as those in effect as of December 31, 2005. Both types of states are referred to as “Partnership States.”

**DRA 05 DEFINITION OF “QUALIFIED STATE LTC PARTNERSHIP”**

Section 6021(a)(1)(A) of the DRA adds several new clauses to section 1917(b)(1)(C) of the Act. The new clause (iii) defines the term “Qualified State LTC Partnership” to mean an approved SPA that provides for the disregard of resources when determining estate recovery obligations in an amount equal to the LTC insurance benefits paid to, or on behalf of, an individual who has received medical assistance.

A policy that meets all of the requirements specified in a Qualified State LTC Partnership SPA is referred to as a “Partnership policy.” The insurance benefits on which a disregard may be based include benefits paid as direct reimbursement of LTC expenses, as well as benefits paid on a per diem, or other periodic basis, for periods during which the individual received LTC services. The DRA does not require that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied.

Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual beginning with the month of application, even if additional benefits remain available under the terms of the policy. The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination.

It should be noted that while an approved Partnership SPA may enable an individual to become eligible for Medicaid by disregarding assets or resources under the authority of section 1902(r)(2) of the Act, the use of a qualified Partnership policy will not affect an individual’s ineligibility for payment for nursing facility services, or other LTC services, when the individual’s equity interest in home property exceeds the limits set forth in section 1917(f) of the Act, as amended by the DRA.

**PARTNERSHIP REQUIREMENTS UNDER THE DEFICIT REDUCTION ACT**

The new clause (iii) also sets forth other requirements that must be met in order for a State plan amendment to meet the definition of a Qualified Partnership. These include the following:

- The LTC insurance policy must meet several conditions. These conditions include meeting the requirements of specific portions of the NAIC LTC Insurance Model Regulations and Model Act.
- The Qualified Partnership SPA must provide that the state’s insurance commissioner, or other appropriate state authority, certify to the state Medicaid agency that the policy meets the specified requirements of the NAIC Model Regulations and Model Act.
- The state Medicaid agency may also accept certification from the same authority.
that the policy meets the Internal Revenue Code definition of a qualified LTC insurance policy, and that it includes the requisite inflation protections.

- If the state Medicaid agency accepts the certification of the Commissioner or other authority, it is not required to independently verify that policies meet these requirements.
- Changes in a Partnership policy after it is issued will not affect the applicability of the disregard of resources as long as the policy continues to meet all of the requirements previously referenced.
- If an individual has an existing LTC insurance policy that does not qualify as a Partnership policy due to the issue date of the policy, and that policy is exchanged for another, the state insurance commissioner or other state authority must determine the issue date for the policy that is received in exchange.
- To be a qualified Partnership policy, the issue date must not be earlier than the effective date of the Qualified Partnership SPA.
- The state Medicaid agency must provide information and technical assistance to the state insurance department regarding the Partnership and the relationship of LTC insurance policies to Medicaid.
- The details of these requirements must be incorporated into the training of individuals who will sell LTC insurance policies in the state.
- The state insurance department must provide assurance to the state Medicaid agency that anyone who sells a policy under the Partnership will receive training and will demonstrate an understanding of Partnership policies and their relationship to public and private coverage of LTC.
- The issuer of the Partnership policy must provide reports to the Secretary, in accordance with regulations to be developed by the Secretary, that include notice about when benefits are paid under the policy, the amounts of those benefits, notice of policy termination, and any other information the Secretary determines appropriate.
- The State may not impose any requirement affecting the terms or benefits of a Partnership policy unless it imposes the same requirements on all LTC insurance policies.

**DRA QUALIFICATIONS**

The Deficit Reduction Act states that all Qualified State Partnership Plans require all partnership policies meet the definition of “qualified.” It is necessary for producers to gain a complete understanding of these requirements.

**DEFINITION OF QUALIFIED LONG TERM CARE POLICIES**

Qualified long-term care insurance is defined as a contract that:

- Provides insurance coverage only for qualified long-term care services
- Does not pay for or reimburse expenses that are covered by Medicare
- Is guaranteed renewable
- Does not provide a cash surrender value or can be assigned or pledged as collateral for a loan
- Provides that all refunds of premiums and policyholder dividends are to be applied
as a reduction of future premiums or to increase future benefits

- Must meet certain consumer protections which are outlined in the Model Regulations and Long-Term Care Insurance Model Act
- Must meet disclosure and non-forfeiture requirements

**A qualified long-term care policy meets the requirements for favorable tax treatment.**

The tax advantage of a qualified long-term care policy versus a non-qualified long-term care policy is the limited federal income tax deduction of the premiums. The policyholder of a long-term care policy will be able to deduct some, or all, of his long-term care premiums, depending on his age.

In order for the insured to deduct long-term care premiums, the insurance company must file IRS form 1099-LTC, Long Term Care and Accelerated Benefits, as required by law. The policyholder handles the deduction on schedule A (itemized deductions) under unreimbursed medical expense.

The following table shows the age thresholds and amounts of long-term care premiums that may be deducted in tax year 2010. These amounts are adjusted for inflation and will go up periodically.

<table>
<thead>
<tr>
<th>Attained Age as of December 31, 2010</th>
<th>Deductible Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 40</td>
<td>$330</td>
</tr>
<tr>
<td>41-50</td>
<td>$620</td>
</tr>
<tr>
<td>51-60</td>
<td>$1,230</td>
</tr>
<tr>
<td>61-70</td>
<td>$3,290</td>
</tr>
<tr>
<td>71+</td>
<td>$4,110</td>
</tr>
</tbody>
</table>

**NOTE:** Un-reimbursed medical expenses on schedule A (itemized deductions) are subject to a threshold of 7.5% of Adjusted Gross income. Generally, benefits received under qualified or non-qualified long-term care policies are not includable in income. Benefits from actual cost (also called reimbursement policies), which pay for the actual services a beneficiary receives, are not included in income. Benefits from per diem or indemnity policies, which pay a predetermined amount each day, are not included in income except amounts that exceed the beneficiary's total qualified long-term care expenses or $290 per day (for 2010), whichever is greater. Therefore, the real tax difference between qualified and non-qualified long-term care policies is the deductibility (subject to the above table) of some, or possibly all, of the premiums for the federal income tax return of the policyholder.

**CONSUMER PROTECTIONS IN QUALIFIED LTC POLICIES**

A group qualified long-term care policy must provide for continuation of coverage or conversion in the event the policyholder is no longer a member of the group and is subject to losing coverage. The policyholder must be permitted to maintain his/her coverage under the group policy through the payment of premiums. If the benefits or services covered are restricted to certain providers--which the insured can no longer use, the insurance company must provide for a continuation of benefits which are
substantially equivalent. Similarly, if a group policy is terminated, the insurance company must provide the policyholder with a converted policy that is substantially equivalent to the policy that was terminated. In order for a policyholder to benefit from this provision, he must have been covered under the terminated plan for at least six months immediately prior to the termination.

All qualified long-term care policies must include a provision to protect the insured against unintended lapse. The policy must not be issued until the company has received a written designation from the applicant identifying at least one other person who is to receive notice from the insurance company before the policy may be lapsed. The form used to identify the additional person must include a space for the person's full name and address. If, for any reason, the policy lapses, the insurance company is required to provide written notice to the insured and his/her designated agent identified on the form. In addition, the insurance company may not terminate a policy for non-payment of policy premiums until it has given the insured 30 days' advance written notice. Notice must be provided by first class mail, postage paid, and include all persons identified by the insured as subject to the notice provision.

**POST CLAIMS UNDERWRITING**

Another important feature of qualified plans is that post-claim underwriting is restricted and limited. Post-claim underwriting occurs when, after a claim is filed by the policyholder, the insurance company declines the coverage on the ground that it would not have issued to policy if it had known about some medical condition. Under HIPAA, applications for long-term care insurance must contain clear and unambiguous questions designed to elicit information about the healthy status of the applicant. Furthermore, if the application asks whether the applicant takes prescribed medications, it must ask for a list of those medications. The insurance company, if it receives the medication list, may not deny coverage for any condition that was being treated by any of the medications listed, even if that condition would have been grounds for a denial of coverage at the application stage. The application must contain a clear, bold caution to applicants stating that if the answers on the application are incorrect or untrue, the company has the right to deny coverage or rescind the contract. Therefore, it is essential for applicants to complete the application fully and correctly and list all the prescribed medications being taken. A producer should not only disclose this condition, he should emphasize and document it, as well.

HIPAA also established minimum standards for home health and community care benefits in qualified policies. If the policy provides benefits for home health or community care, it may not limit or exclude benefits by requiring skilled care to be offered first, that services be provided by registered or licensed practical nurses, or that the provider be Medicare-certified. The policy may not exclude coverage for personal care services provided by a home health aide or adult day care service, neither may it require benefits to be triggered by an acute illness. Inflation protection is also included as a required element of a qualified plan. The intent of the policy is to provide meaningful inflation protection. Legislation states that the insurance company use reasonable hypothetical or graphic demonstrations to disclose
how offered inflation protections will work.

**PREMIUM DEDUCTIBILITY FOR BUSINESS ENTITIES**

Different rules apply based on the type of business entity:
- **Sole Proprietor:** A business owner who files IRS form Schedule C (Profit or Loss from a Business or Profession) is considered an individual for tax purposes and may deduct the premiums as noted in the table previously shown. The deductible policy must be a qualified long term-care policy.
- **Sub (s) Corporation:** A sub (s) corporation can deduct the limits described in the table previously shown and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). The deductible policy must be a qualified long-term care policy.
- **C Corporation:** A C corporation is entitled to the deduction of 100% of the premiums paid. The covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). The deductible policy must be a qualified long-term care policy.
- **Limited Liability Company:** A limited liability company is allowed to deduct the limits described in the table previously shown and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). The deductible policy must be a qualified long-term care policy.
- **Partnership:** A partnership is allowed to deduct the limits described in the table previously shown and the covered employee does not pay income tax on the premiums or benefits (subject to the limits on benefits described above). The deductible policy must be a qualified long-term care policy.

**BENEFIT TRIGGERS**

HIPAA establishes the standard of care required before covered benefits can be paid. The person covered by the LTC policy must require either substantial assistance with two or more activities of daily living (substantial assistance requires either hands-on or standby assistance) OR substantial supervision due to cognitive impairment (see below).

The benefit trigger requirement of qualified long-term care insurance is considerably more restrictive than that of non-qualified policies. The services under a qualified plan can only be triggered after certification by a licensed health care provider that the beneficiary is chronically ill. Chronic illness is defined as:

- Being unable to perform, without substantial assistance, at least two activities of daily living for at least 90 calendar days due to a loss of functional capacity, or
- Requiring substantial supervision in order to be protected from threats to health and safety due to cognitive impairment. The 90-day period may be presumptive, which means the doctor may certify that, in his opinion, the impaired performance will last at least 90 days.

Benefit payments are usually made on a monthly basis. If the policy provides for a
benefit of $100 per day, the monthly payment will represent $100 times the number of days contained in that particular month.

**FINAL TREASURY REGULATIONS SECTIONS 7702B**

As required by HIPAA, final treasury regulations were implemented in December of 1998 and became Internal Revenue Code section 7702(b). A summary of this section includes:

- Long term care policies issued before January 1, 1997 and that meet state requirements in effect at that time are grandfathered as qualified long-term care policies (regardless of the new HIPAA sections); however, if a contract contains material changes, it will lose the grandfathered status,
- Qualified contracts cannot accrue cash values,
- Qualified contracts must be guaranteed renewable,
- Qualified contracts can only use policy dividends to reduce future premiums,
- Qualified contracts must be issued within 30 days of approval,
- If an insured request information pertaining to a claim denial, it must be delivered within 60 days
- Non-qualified policies do not qualify for premium deductions on the policyholders’ federal tax returns

While the value of Partnership LTC policies is evident, the process of marketing, selling, underwriting, and obtaining benefits from them is considerably complex. Producers must be trained in this product before even considering to discuss and sell it to consumers. Many policy requirements exist for the protection of consumers, as do state and federal regulations. Consumers rely upon insurance companies, the government, and their agents to assist them in the process of securing long-term care protection to preserve and maintain their financial well-being.

**NON-PARTNERSHIP LONG-TERM CARE POLICIES**

**HISTORY, FROM THE 1890S TO 1935**

In terms of history, there were three paths by which the origin of today’s nursing homes evolved: private homes for the aged, almshouses or country poor farms, and proprietary boarding homes. The almshouse was one of the first forms of living facilities for the elderly, dating back to the 1890s. In the early 1900s, the elderly population began to increase and so did the need for nursing home-type facilities. The Social Security Act of 1935 passed by the Roosevelt Administration gave the elderly population some financial stability, thus allowing it to be somewhat self-supporting.

Legislative, administrative, and regulatory federal policy toward nursing homes began in the year 1950. The federal matching of medical vendor payments was the first Act passed under the Old Age Assistance Program (OAA) during this timeframe. Insurance companies were reluctant, at first, to enter into the long-term care market. There were no
previous claims data or trend analyses to follow. It was difficult to set premium costs for long-term care policies without this vital information. However, even though history purports long-term care as being originally created for the elderly, keep in mind that it is no longer strictly for the aged.

Needing long-term health care is not rare. It is virtually guaranteed. The latest statistics show that nearly one out of every two persons age 65 and older will probably spend some time in a nursing home. Seventy percent of couples who are older than 65 can expect one spouse to need long-term care services. By the year 2020, one in three workers will provide some type of eldercare. By the year 2030, it is estimated that there will be at least 19 million people needing the assistance of long-term care. People are living longer, thanks mostly to advancements in medicine and technology. By the year 2050, it is projected that there will be one million people over 100 years of age. As people entering their Golden Years, long-term care coverage is emerging as an important tool to assure that consumers can afford the care they need and avoid depleting their estates.

According to most studies, women outnumber men in nursing homes. Thirteen percent of the women in a nursing home, as compared to four percent of the men, are projected to spend five or more years in a nursing home. And obviously, the risk of needing nursing home care increases with age; however, the nature and extent of the care to be required in the future is at best, a guess.

The estimated average length of time a person stays in a long-term care facility can only be estimated. Most statistics show that over 50 percent spend fewer than 90 days in a nursing home, but this figure distorts the real numbers that affect most people and do the most financial damage. Some stays are under 90 days (however, most of these are for transitional care), but in reality, most stays can total 9 years or more.

Age is not necessarily a gauge to use when determining the necessity of a long-term care policy. Long-term care facilities are not only available for use by the severely aged. Surprisingly enough, most residents are under the age of 65. They can range from the child who is brain-dead due to a horrific accident to the middle-aged person who has suffered a stroke to the more elderly Alzheimer disease patient.

**NATIONAL AVERAGE COST RANGES**

With the annual cost for a nursing home averaging from $74,095 (private room) to $64,240 (semi private room), long-term care has become one of the largest selling forms of protection for Americans. As the Baby Boomer generation reaches its elderly years, estimates on the need for long-term care are rising. In major metropolitan areas, the average long-term care costs escalates to $80,000 and even as much as $100,000 per year, not including medical bills and prescription medications. With an average nursing home stay of 19 months, seniors are finding it difficult to plan for these eventual expenses.

Fearful of losing economic independence, older Americans are looking for security in
long-term care insurance. For seniors over 65, premiums can range from $2,000 to $10,000 per year; despite that, long-term care insurance is the fastest growing type of health insurance sold in recent years. Still, only five percent of those over 65 have purchased private long-term care insurance. Uninsured seniors constitute a lucrative market and, as a result, over one hundred insurance companies now offer long-term care policies.

**PAYING FOR CARE**

One must consider that if such an arrangement becomes necessary, where will the money come from?

- Medicare benefits;
- Medicaid benefits;
- Personal resources;
- Managed Care plans;
- Medicare supplemental insurance; and
- Long-Term Care insurance.

Under certain limited conditions, Medicare will pay some nursing home costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, the individual must receive the services from a Medicare certified skilled nursing home after a qualifying hospital stay. A qualifying hospital stay is the amount of time spent in a hospital just prior to entering a nursing home; this is at least three days. Medicare covers up to 100 days of skilled nursing confinement per benefit period. However, after 20 days, beneficiaries must pay a coinsurance ($137.50 per day in 2010). Medicare will only pay for skilled nursing care preceded by an in-patient hospital stay of at least three days. Medicare's eligibility requirements are established at the federal level by the Centers for Medicare and Medicaid Services (CMS).

Medicaid is a state and federal program that will pay most nursing home costs for people with limited income and assets. Eligibility varies by state. Medicaid will pay only for nursing home care provided in a facility certified by the government to provide service to Medicaid recipients. About 70 percent of all nursing home residents are supported, at least in part, by Medicaid. Medicaid reimbursement systems for nursing homes vary considerably from state to state.

About half of all nursing home residents pay for the costs from their own savings. After these savings and other resources are depleted, many people who stay in nursing homes for long periods eventually become eligible for Medicaid.

For many seniors, a large portion of their net worth is not liquid and is tied up in their principle residence. A very common way to afford Long-Term Care services (in the absence of long term care insurance) is to somehow tap the equity in the home. The different ways to gain access to the equity vary widely. Most of the instances where a consumer uses home equity to pay these costs are reactionary in nature and evidence of a lack of proactive planning for the potential cost. In other words, most people would not
actively plan in advance to choose home equity as a way to finance eldercare costs.

From an organized commerce perspective, there is the reverse mortgage whereby the homeowner sells his home to a financial institution and receives monthly payments for life. While the homeowner is alive, no payments are due and upon death of the homeowner, the heir can elect to walk away from the home or pay off the mortgage lien.

Another way to use home equity to pay Long-Term Care costs is through the use of a home equity line of credit. One drawback to this method is that it requires the borrower (homeowner) to make monthly payments and can impose a burden for someone living on a fixed income. The advantage of using home equity is that it will often provide the immediate cash needed to afford long-term care and is often the largest concentration of wealth for a senior. In the case of a reverse mortgage, it does not require the senior to make payments immediately against the home equity used. The reverse mortgage, unlike the home equity loan, does not provide an immediate lump sum payment but rather makes monthly payments to the homeowner. The lump sum provided by a home equity loan will be viewed as an asset if the homeowner applies for Medicaid assistance and may be required to be spent down prior to eligibility for assistance. The monthly income provided by a reverse mortgage will be viewed as an income stream for Medicaid eligibility purposes and could make the individual ineligible for Medicaid assistance but still not provide sufficient income to pay Long-Term Care costs or provide needed income for a non-institutionalized spouse.

If a senior has an annuity, there are several ways that this asset can assist with the costs associated with eldercare. If the annuity is annuitized, it can provide an income stream that may be sufficient when added to other streams of income to afford long-term care. Since each individual’s financial circumstances is unique, much care must be taken when deciding how to handle an annuity owned by a senior needing long-term care services.

If the individual owns an annuity that has not yet been annuitized, it will be treated as an asset during the Medicaid eligibility determination whereas if it has already been annuitized, it will be treated as an income stream. Obviously, the risk the annuitant runs in annuitization is that the annuity income, when added to the existing income streams (Social Security, pension plan, etc.), will be sufficient to cause them to lose eligibility for Medicaid but not enough to pay for needed care and/or provide support for a non-institutionalized spouse.

In the recent past, many insurance agents would counsel a client to buy an immediate annuity with a three-year payout; this annuity and the income would be exempt from the Medicaid spend down (asset test) or income test. The loophole has been closed and an annuity no longer has special status under the Medicaid eligibility test.

**ANNUITIES WITH LTC RIDERS**

A newer form of annuity with a long-term care benefit has hit the scene in the last several years. Often, the sales approach will include the term “Asset Based Long Term Care” or
“Premium Elimination Long Term Care.” The approach taken by these annuities is that if the annuitant needs Long-Term Care services, the costs can be paid from of the annuity account value (usually up to three times the single premium paid for the annuity) before the Long-Term Care benefit runs out. If the annuitant never needs Long-Term Care services, he still has his annuity account value.

Upon closer inspection, it is discovered that Long-Term Care premiums are charged against the annuity account value and affect the account values (if only the growth) even if no Long-Term Care benefits are paid. These Long-Term Care riders within annuity contracts are usually not full-blown long-term care policies and, as such, are not regulated by the same laws as a standalone long0term care policy. Look for more product innovation and market share growth of this approach in the future.

A managed care plan will not help pay for care unless the nursing home has a contract with the plan.

Medicare Supplement Insurance is private insurance. It's often called Medigap because it helps pay for gaps in Medicare coverage such as deductibles and co-insurance. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by Medicare. Some people use employer group health plans or long-term care insurance to help cover nursing home costs.

**INCREASING COSTS WITH AGE**

It is estimated that 50 percent of all couples and 70 percent of single persons are impoverished within one year of entering a nursing home facility. The older the individual, the greater the chance he will one day need long-term care services. However, as with any time of life or health insurance, the older the individual is at the time of purchasing long-term care insurance, the higher the premiums will be. Therefore, it would be wise for the consumer to keep the following in mind:

- Buy long-term care insurance while still insurable and before illness, accident, or disability strikes;
- Buy after learning more about long-term care insurance and having received unbiased guidance (a consumer could be encouraged to consult the State Health Insurance Assistance Program (SHIP) available in the area); and
- If buying when younger, premiums will be lower (however, the consumer should realize that he will be paying them for a longer period of time).

The annual premiums for long-term care policies with good inflation protection are in the neighborhood of $2,000 for 65-year-olds. At age 75, the premium will be two and a half times greater than if the policy had been purchased at age 65 and six times higher than if bought at age 55. It is common for a husband and wife, aged 65, to spend approximately $7,500 a year for long-term care coverage. A policy with a large daily benefit that lasts for several years is more expensive. Inflation protection can add 25 to 40 percent to the benefits and non-forfeiture rights can add 10 to 100 percent to the bill. Premiums usually remain level for the duration of a policy. The table below is an example of premiums based on years of coverage. Premiums vary according to the benefit duration and benefit
types.

The illustration shown below indicates that a delay in purchasing can result in a drastically more expensive policy premium. The same policy that would cost a 50-year-old $600 per year would cost a 75-year-old $8,000 annually. This shows that a 75-year-old would pay more in two years than a 50-year-old would pay in 25 years.

<table>
<thead>
<tr>
<th>Policy Age</th>
<th>Annual Premium</th>
<th>Years of Coverage</th>
<th>Cumulative Premiums@ Age 85</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>$600</td>
<td>35</td>
<td>$21,000</td>
</tr>
<tr>
<td>60</td>
<td>$1,500</td>
<td>25</td>
<td>$37,500</td>
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<tr>
<td>70</td>
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<td>15</td>
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</tr>
<tr>
<td>75</td>
<td>$8,000</td>
<td>10</td>
<td>$80,000</td>
</tr>
</tbody>
</table>

However, buying long-term care insurance at a younger age can also be a mistake. Many policies limit increases for inflation after 20 years or at the point where the original benefit doubles, so a consumer buying early in life could be left with inadequate benefits when they are really needed.

**LTC POLICIES ARE NOT FOR EVERYONE**

Even with all the statistics on aging and needed care, long-term care insurance is not for everyone. For many people, it is not a good idea. To find out if a consumer is a good candidate for a long-term care policy and, if so, to assign the appropriate policy, requires a full financial analysis. Buying a policy is a function of age, health status, overall retirement objectives, income, and wealth. If the only source of income were a minimum Social Security benefit or Supplemental Security Income (SSI), it would not be in a consumer’s best interest to purchase a long-term care policy. Long-term care policies are only designed for people with significant assets they want to preserve for family members, to assure independence, and to not burden family members with nursing home bills.

**PLAN CHOICES—DECISION GUIDELINES**

There is a wide variety of choices available for the consumer once the decision has been made to buy long-term care insurance. What to buy depends on the coverage the consumer wants or needs. Following are few considerations:

- Nursing home only;
- Home care only;
- An entire continuum of care (nursing home, assisted living, adult day care, etc.);
- Daily benefit amount;
- Benefit period;
- Elimination (deductible) period;
- Inflation protection; and
- Non-forfeiture benefits.

Choosing a long-term care plan doesn’t have to be confusing. The consumer can follow four easy steps to determine which plan will best meet his needs:
1. Select a Plan Type;
2. Choose a Daily Benefit Amount;
3. Pick a Total Coverage Amount; and

All insurance companies offer various plans, however, there are three basic plans that most companies utilize in some way, shape, or form:
1. Comprehensive Plans;
2. Nursing Home/Assisted Living Facility Plans; and
3. Combination Home Care and Facility Plans.

Most Comprehensive Plans cover care at home, care in a nursing home, and care in an assisted living facility. For those individuals who want complete coverage no matter where circumstances lead them, this type of plan usually provides the best available options. This type of complete coverage plan is the most costly from a premium standpoint.

Nursing Home and Assisted Living Facility Plans cover any licensed facility, whether care is provided in a nursing home or in an assisted living facility. This type of plan is, of course, less expensive than a comprehensive plan, however, it calls for out-of-pocket expenses if the consumer’s long-term care is being provided at home. Since at-home expenses are not generally as costly as facility-based care, this type of plan may be very appealing.

Combination Home Care and Facility Plans cover both home care and facility-based care, although they do not provide the larger total coverage amounts that comprehensive plans do. Even though the premiums are lower, the coverage amounts are limited. Some consumers want a long-term care plan to pay for as much of their care costs as possible. Others are willing to pay some of those costs on their own in order to have a lower premium payment.

**LONG-TERM CARE SUMMARY**

Long-term care insurance is complex, rife with options and contingencies, and subject to a tremendous amount of regulation. Most states require insurance producers to complete specific continuing education courses before selling long-term care insurance and/or in order to obtain or renew a producer’s license if selling the coverage.

It is essential for a producer to be fluent in the language of long-term care coverage and to know the policies inside and out. Many consumers purchasing long-term care coverage are older, and more vulnerable in a financial sense than the typical insurance client. Special attention should be paid to the standard of care provided when selling long-term care insurance.
CHAPTER 6 REVIEW QUESTIONS

1. What percentage of the American population was covered by some form of health insurance during calendar year 2007?
   [a] 94%
   [b] 92%
   [c] 84%
   [d] 82%

2. Which of the following is an element of a health savings account (HSA)?
   [a] It is a tax-exempt trust or custodial account
   [b] It is created for the purpose of paying for non-qualified medical expenses
   [c] It must be connected to a low-deductible health plan
   [d] It is not portable

3. Disability income policies require a certain amount of time to elapse before benefits are paid. This amount of time is _____.
   [a] A benefit period
   [b] A waiting period
   [c] A lifetime benefit period
   [d] Waived on a long-term disability policy

4. Annuity suitability requirements were established to prevent individuals from _____.
   [a] Buying life insurance policies
   [b] Entering into contracts that are not appropriate
   [c] Buying annuity policies
   [d] Entering into contracts that are illegal

5. Agreements between private insurance companies, state governments, and residents for the purpose of purchasing private long-term care policies are called _____.
   [a] Contracts
   [b] Partnerships
   [c] Annuities
   [d] Policies
Chapter 7

THE INSURANCE INDUSTRY & THE INTERNET

Although the Internet is currently indispensable to most people in the United States, it wasn’t available commercially until the 1990s! It took only thirty years for technology to expand so that an individual, room-sized, self-contained computer valued at hundreds of thousands of dollars could evolve into a hand-held device, valued at less than $1,000, for the purpose of connecting with other computers all over the world.

HISTORY

Originally known as ARPANET, the Internet was born in 1962, the brainchild of several researchers at MIT, each specializing in a distinct technological field of study. J.C.R. Licklider left MIT to work at the Defense Advanced Research Products Agent (DARPA), Leonard Kleinrock went on to work at UCLA, and Lawrence Roberts—who was the first person to connect computers via a dial-up connection. In 1965, Roberts connected a computer in Massachusetts with a computer in California and is considered to be the father of the ARPANET. Of course, may other individuals were singly and collectively responsible for early Internet technology and its advancement, but these three names continually crop up in early research.

The Internet was first used exclusively by researchers, developers, scientists, and the military to provide a communication network that didn’t rely on other communication systems in the event they failed during wartime or nuclear attack. Unknown to the average person, the common use of e-mail actually predates commercial use of the Internet.

As technology advanced, more and more universities and research sites used the Internet to store and archive data. In 1969, four universities became linked by online computers: UCLA, Stanford Research Institute, UCSB, and the University of Utah. Within a matter of years, the number of colleges and universities, researchers, and other such organizations utilizing the Internet was too lengthy to list.

Because the Internet and its related research were initially funded by the government, its use was limited to researchers, educational facilities, and the government. Commercial use of the Internet was expressly prohibited unless commercial enterprises were directly linked to the goals of research and education. Delphi became the first national commercial online firm to offer its subscribers access to the Internet. Its e-mail service

The ban on commercial use of the Internet was lifted in the early 1990s. Depending upon sources, some say it occurred in 1991 and others say it occurred in May 1995 when the National Science Foundation (NSF) ceased sponsoring the backbone of the Internet and AOL, Prodigy, and CompuServe went online. Because commercial use of the Internet proliferated, the loss of funding previously provided by NSF to educational institutions was hardly noticed. When Microsoft entered the playing field as a browser, server, and Internet Service Provider (ISP), the Internet became commercially based.

The first personal computer, the IBM PC, was launched in August 1981 and *Time* magazine named “the computer” as its Man of the Year. Apple released the MacIntosh in January 1984 and, because of its user-friendliness, the number of computer users grew exponentially. In 1989, the number of hosts increased from 80,000 in January to over $160,000 in November. At the same time, other countries joined the Internet: Australia, Germany, Israel, Italy, Japan, Mexico, Netherlands, New Zealand, and the United Kingdom. In 1990, ARPANET formally shut down. The Internet has grown from its original 4 hosts to over 300,000 hosts.

**INSURANCE CONSUMERS**

According to Tim Sawyer, over 80% of consumers perform research about insurance online. Sawyer is the president of Astonish Results, a digital marketing firm based in Rhode Island. Sawyer and his firm have trained hundreds of insurance professionals in every aspect of the business with a focus on leadership, digital marketing, and best sales practices. Here are some statistics they provide to their clients:

- 1 out of every 10 people use the newspaper or Yellow Pages before they buy insurance
- 3 out of every 10 people use TV and radio before they buy any product or service
- 8 out of 10 people use the Internet before they buy insurance

Using the Internet provides insurance consumers with a number of advantages when transacting business, including:

- Research into insurance products, features, benefits and pricing is easily accessible—from a vast number of insurance companies and other sources
- Contacting insurance companies, agencies, and producers can be facilitated either via web sites or e-mail

If a consumer makes several transactions with an insurance company or producer through a particular medium, he tends to forge a bond with the company/producer and the method of communication—if the process is convenient and nets him positive results. The insurance industry, being service-oriented, has a tremendous opportunity to improve its client-relationships with consumers who prefer to use the Internet as a method of facilitating communication and insurance transactions.
Typically, an insurance consumer personally initiates contact with his agent or company in certain circumstances:
- When he must buy an insurance policy (as in his lender or mortgage company require the purchase of coverage)
- When he pays his premium
- When he reports a loss or makes a claim
- When he feels the need to make a change to the policy
- When he has a specific question

Many consumers, especially younger consumers who are more adept at using computers and are more likely to use them, will utilize Internet access to their agent/company for these transactions. A producer can increase his client contacts using e-mail and other Internet uses. Many property and casualty insurers have designed access to their web sites for the express purpose of allowing clients to make payments and initiate change or service requests. Not only does the access to such online services bring about a heightened sense of teamwork, but it also creates a comfort level and builds trust in an insurance company and its online services.

Another way of enhancing consumer relationships and building trust through the use of the Internet is to offering online complaint and claim services help lines. More and more consumers are availing themselves of online services—in all business industries. The demand for increased access to relevant and updated information, along with customer attention and service, cannot be ignored if a business intents to grow.

As with any form of technology involving the sales and servicing standards within a business industry, utilizing the Internet is viewed by some consumers as being advantageous and by others as nothing short of impossible. Advantages of utilizing the Internet in consumer transactions:
- Easy access to quotes and other information
- Ability to apply for coverage, or determine eligibility, quickly and conveniently
- Ability to locate potential insurance companies or agents by area of expertise or location
- Accessibility – either from a perspective of response time or time of day/night
- Availability of account status, premiums information, and online bill pay options

Disadvantages of utilizing the Internet in consumer transactions:
- Eliminates face-to-face and personal interaction
- Does not allow the opportunity for in-depth conversation and review of policy terms, conditions, limits, exclusions, and recommendations by the producer
- Offers greater opportunity for misunderstanding and miscommunication
- Security breaches and privacy concerns

The popularity of the Internet is unquestionable; as is the convenience it often allows insurance companies and producers. Unfortunately, regular use of the Internet also gives rise to complications and, since no universal legislation exists, producers can often find themselves on questionable grounds if consumers file complaints or experience losses.
ELECTRONIC INSURANCE PAYMENTS

Few people will argue that the ability to pay for something with a credit or debit card is a way of life in this country. More and more insurance companies allow consumers to pay their insurance premiums with either credit/debit cards or electronic checks. While the convenience of these payment methods is indisputable, neither is the potential for serious liability on the part of the insurance company or producer if the consumer’s privacy and security of information is not protected.

As mentioned in Chapter 1 with respect to the GLBA, the Financial Privacy Rule governs the collection and disclosure of customers' personal financial information by financial institutions. It also applies to entities receiving such information, whether or not they are financial institutions, such as insurance producers.

The Federal Trade Commission (FTC) believes that “any information should be considered financial information if it is requested by a financial institution for the purpose of providing a financial product or service.” Since the GLBA clearly indicates that insurance companies are considered “financial institutions,” the information collected by insurance companies to process credit/debit card payments, and electronic check payments is subject to the Financial Privacy Rule. When a consumer enters information pertaining to his credit/debit card or bank account during an online transaction, or when he provides it to a producer for processing the payment either online or in some other way, he has the expectation of, and legal right to, privacy.

It is in the best interests of all parties involved in these payment transactions for insurance producers to be familiar with the Financial Privacy Rule and to adopt routine procedures when handling consumers’ personal nonpublic private information. Many insurance agencies do not retain consumer credit card numbers, bank account numbers, or social security numbers on file—unless required to do so by the insurance company—for the express purpose of protecting the consumer.

CAN-SPAM ACT OF 2003

One person’s version of insurance marketing is another person’s version of spam. Spamming is illegal and, if an insurance producer is unfamiliar with the CAN-SPAM Act, can find himself being slapped with fines of up to $16,000 per each separate e-mail if he violates the law. The Controlling the Assault of Non-Solicited Pornography and Marketing Act of 2003 (CAN-SPAM Act) applies not only to bulk e-mail, but also to all commercial messages. Yes, ALL commercial e-mails!

How can an insurance producer know if the e-mail he’s sending is subject to the CAN-SPAM Act? By evaluating the primary purpose of the e-mail. The FTC classifies the primary purpose of an e-mail as having one of the following types of content:

1. Commercial Content – Advertises, markets, or promotes a commercial product or
service, including web site content

2. Transactional or Relationship Content – Assists in the completion of an already agreed-upon transaction or communicates with a customer about an ongoing transaction or relationship

3. Other Content – Is neither commercial, transactional, or relationship-based

If an e-mail contains only commercial content, it is subject to all requirements of the CAN-SPAM Act. If an e-mail contains only transactional or relationship content, it is not permitted to contain false or misleading routing information. Otherwise, it is exempt from most of the requirements of the Act.

Another concern to producers should be the forwarding of e-mail messages. If an insurance producer’s e-mail contains a request for the recipient to forward the message to a friend or some other party, the producer may be responsible for violations of the CAN-SPAM Act when the message is forwarded. The deciding factor usually centers on whether or not the producer is compensating the forwarder in some way, such as offering money, coupons, discounts, awards, additional entries in a raffle or sweepstakes, etc. If the producer is compensating the forwarder, he will likely be accountable for violations of the Act.

Taken from the FTC web site, here is a list of the major requirements of the CAN-SPAM Act:

- Don’t use false or misleading header information. The “From,” “To,” “Reply-To,” and routing information – including the originating domain name and email address – must be accurate and identify the person or business who initiated the message.
- Don’t use deceptive subject lines. The subject line must accurately reflect the content of the message.
- Identify the message as an ad. The law gives you a lot of leeway in how to do this, but you must disclose clearly and conspicuously that your message is an advertisement.
- Tell recipients where you’re located. Your message must include your valid physical postal address. This can be your current street address, a post office box you’ve registered with the U.S. Postal Service, or a private mailbox you’ve registered with a commercial mail-receiving agency established under Postal Service regulations.
- Tell recipients how to opt out of receiving future email from you. Your message must include a clear and conspicuous explanation of how the recipient can opt out of getting email from you in the future. Construct the notice in a way that’s easy for an ordinary person to recognize, read, and understand. Creative use of type size, color, and location can improve clarity. Give a return email address or another easy Internet-based way to allow people to communicate their choice to you. You may create a menu to allow a recipient to opt out of certain types of messages, but you must include the option to stop all commercial messages from you. Make sure your spam filter doesn’t block these opt-out requests.
- Honor opt-out requests promptly. Any opt-out mechanism you offer must be able to
process opt-out requests for at least 30 days after you send your message. You must honor a recipient’s opt-out request within 10 business days. You can’t charge a fee, require the recipient to give you any personally identifying information beyond an email address, or make the recipient take any step other than sending a reply email or visiting a single page on an Internet website as a condition for honoring an opt-out request. Once people have told you they don’t want to receive more messages from you, you can’t sell or transfer their email addresses, even in the form of a mailing list. The only exception is that you may transfer the addresses to a company you’ve hired to help you comply with the CAN-SPAM Act.

- Monitor what others are doing on your behalf. The law makes clear that even if you hire another company to handle your email marketing, you can’t contract away your legal responsibility to comply with the law. Both the company whose product is promoted in the message and the company that actually sends the message may be held legally responsible.

Each separate e-mail sent in violation of the CAN-SPAM Act is subject to fines of up to $16,000 and more than one person may be fined for violations. For example, Jane is a producer sending e-mail marketing messages and she works for the ABC Corporation. If Jane sent 100 e-mails in violation of the Act, both Jane and the ABC Corporation can be fined up to $1,600,000 for the sending of the mass mailing.

In addition to penalties for violating the Act, separate penalties exist for sending deceptive advertising and for criminal violations. Criminal violations include:

- Using another person’s computer without permission to send spam
- Using false information to register for multiple e-mail accounts or domain names
- Relaying or transmitting multiple spam messages through a computer to mislead others about the origin of the messages
- Harvesting e-mail addresses, or generating them, through the practice of sending messages comprised of random letters and numbers with the intention of reaching valid ones
- Taking advantage of open relays and proxies without permission

While the sending and receiving of e-mail can make an insurance producer’s life much easier, it can also create nightmares if the producer is not familiar with the law. The Do Not Call Registry and the CAN-SPAM Act have each, in their own way, affected a producer’s ability to reach and market to consumers. The components of these laws, however, were designed for the protection of the consumer and also enhance a producer’s professionalism when complying with them.

**ELECTRONIC SIGNATURES**

Legislation concerning electronic signatures began with the Utah Digital Signature Act, which was enacted in 1995. As other states adopted legislation, California was the
second, the focus diverged somewhat. Each state in the U.S. has enacted some type of legislation concerning electronic signatures and it is imperative that insurance producers understand the particulars of the laws in each of the states in which they are licensed.

Two terms are commonly used with respect to online signatures: electronic and digital. Although the terms are often used interchangeably, they have different meanings. An electronic signature is a generic term that encompasses all methods of affixing a signature to an electronic record: a name typed at the end of an e-mail, a digitized image of a hand-made signature that is attached to, or inserted into, an electronic document, a secret code or PIN, an electronic fingerprint or retinal scan, or a digital signature. A digital signature is a specific type of signature: it utilizes public key cryptography to “sign” a message, form, or document.

When a person affixes his signature to a document, regardless of the document’s format, he is signaling intent. The intent is either to identify himself or to confirm the accuracy of information contained in the document. A signature can also signal two other purposes: (1) to identify the person affixing his signature, and (2) evidence of the authenticity or integrity of a document.

Three legal issues continue to crop up with respect to electronic signatures:
1. Are they legal?
2. Are they trustworthy?
3. What are the rules concerning them?

Clearly, insurance consumers and producers are concerned with the perspective of the state and federal governments with respect to the legality of electronic signatures. Why should a consumer purchase an insurance policy online with an electronic application signature or a producer accept a client’s authorization to change or cancel a policy via an e-mailed signature if neither “document” or signature is considered legal in the jurisdiction in which it was made—and/or received? Some legal concerns include:

- Do electronic signatures satisfy legal requirements concerning writing and signatures?
- Do electronic signatures constitute being an “original” for evidentiary purpose?
- Do electronic signatures inherently risk being denied admissibility because of their electronic format?
- Can a recordkeeper establish the authenticity of a document with an electronic signature?

Many state statutes and requirements compel legal transactions to be made “in writing” and “signed” by the involved parties in order for the transaction to be legally enforceable. If an electronic signature does not meet the jurisdiction’s specific requirements, then it is not legally binding nor is the transaction enforceable. In the case of an insurance application or change request, this could create a serious consequence.

Writing requirements, traditionally, are not limited to ink on paper. The spirit of the writing requirement is to document a communication in tangible form. Courts have
found that “writings” include those documented in ink, by wire scratched on paper, via telexes, in Western Union Mailgrams, and on tape recordings. According to the Statute of Frauds, magnetic recordings of data on computer disks have been held to meet the definition of “writings” under forgery statues and copyright law.

Likewise, courts have found that the following types of signatures meet the requirements of “signed:” names on telexes and telegrams, typewritten names, faxed signatures, and names on letterheads. Again, the intent and the mark, symbol, or code on an electronic document should meet the requirement.

What constitutes a signature? Since legislation varies from state to state, the answer can’t be pinned down to a single response. Legislation in this regard tends to take one of three different approaches:
1. All electronic signatures satisfy legal requirements, or
2. Electronic signatures satisfy legal requirements only when they meet certain security measures, or
3. Only digital signatures meet legal requirements

According to the Uniform Commercial Code (UCC), 1303.41 Signature – UCC 3-401., the definition of a signature on paper includes: “(B) A signature may be made manually or by means of a device or machine and by the use of any name, including a trade or assumed name, or by a word, mark, or symbol executed or adopted by a person with present intention to authenticate a writing.” Some states have adopted this definition with respect to electronic signatures but many have not. Those states that adopt this perspective, and their courts, will accept an “X” as a signature—so long as the symbol (aka signature) exists and the intent of the signer was to authenticate.

Most states requiring security components in electronic signatures take a technology-neutral stance. In general, the following components of a signature are required—and are based on original California legislation enacted in 1995:

- It is unique to the person using it,
- It is capable of verification,
- It is under the sole control of the person using it, and
- It is linked to data in such a manner that if the data are changed, the digital signature is invalidated

It is estimated that approximately one-third of all state legislation takes this approach to the validity of electronic signatures.

Still other states have enacted legislation based on the technology used when signing. They consider electronic signatures valid only if they are digital signatures. Five states have adopted this stance: Minnesota, Missouri, New Hampshire, Utah, and Washington.

Are electronic signatures trustworthy? The foremost concern when receiving an electronic signature is the component of trustworthiness: Are the message, document, and signature precisely what the sender sent? Has the message or document been intercepted and/or altered? Is it authentic? Is it complete and accurate? Can the
recipient expect that the sender will be held accountable for his electronic message in the event a dispute arises?

In circumstances where authenticity, integrity, and accountability are essential, it is generally recommended to require paper documents and signatures instead of, or in addition to, electronic documents and signatures.

**CYBERFRAUD**

Insurance fraud is not a new concept. However, with its ease of use, the Internet now offers dishonest individuals and companies a new venue with which to perpetrate insurance fraud. Because of the anonymity afforded by the Internet, and the ability to set up and take down web sites in a matter of moments, perpetrators of insurance fraud abound.

The most common fraudulent Internet schemes, according to the North Carolina Department of Insurance, involve unauthorized insurance. “Unauthorized Insurers” are entities that appear to be legitimate insurance companies or organizations that have been duly licensed, registered, and/or approved by state or federal regulators to transact insurance business in one or more states. They look, sound, and act like lawful insurance companies—but they’re not.

They offer much lower rates and premiums than legitimate insurance companies and seldom engage in the underwriting of risks. Policies are issued quickly and claims, if they’re paid, are paid very slowly.

Other fraudulent insurance schemes include:

- Imposter web sites illegally and fraudulently using a logo of a legitimate insurance company. For example, an online insurance application guarantees the issuance of an auto insurance policy but the consumer never receives a policy and eventually learns that the insurance company being portrayed never received an application, the premium payment, and has no knowledge of the imposter web site.

- Theft by an “insurance agent.” An insurance agent advertises on the Internet, or even has a web site, and provides a phony policy or insurance ID card after accepting an online insurance application and/or premium payment. The “agent” simply keeps the money and, after receiving sufficient complaints, shuts down his Internet operation.

- A marketing or pyramid scheme that offers financial inducements, including insurance policies, for those who become members and pay a membership fee. The inducements are devised to recruit more members and increased cash flow. New members are convinced to sell new memberships and are promised the opportunity to borrow money against their insurance policies.
INTERNET SECURITY

Many businesses, including insurance companies and large insurance agencies, have IT departments that handle security for their web sites and other Internet functions. But what about agents and brokers who operate smaller businesses and act as their own IT departments? How can a producer be sure he’s protecting himself and the consumers with whom he works when transacting insurance business online?

The Federal Trade Commission publishes an online guide concerning Internet security, as do a number of other regulatory agencies. Information is available, at little or no cost, to individuals who are concerned with security. The FTC lists seven practices for computer safety:

1. Protect personal information
2. Know who you’re dealing with
3. Use software that automatically updates security measures
4. Keep the computer’s operating system and web browser up-to-date and learn about their built-in security measures
5. Keep passwords safe, secure, and strong
6. Back up important files
7. Learn what to do in an “e-mergency”

Before communicating with consumers via e-mail, producers should be sure to obtain authorization from them to use their e-mail and be sure to protect their e-mail addresses. When communicating via e-mail, producers should avoid opening or replying to messages from individuals whose identity they don’t recognize immediately. If a hacker or other individual gains access to a producer’s computer, not only can the producer’s personal information be obtained, the entire contents of his address book can also be acquired.

It’s a good idea to avoid file sharing, especially if a person is not familiar with the proper settings to enable safe, secure transactions. Failure to appropriately choose settings may make the entire contents of a computer accessible to another party.

Password protection is something endorsed and required by all insurance companies when accessing their web sites and applications. In fact, most insurance companies require producers to change their passwords on a regular basis, usually every 60 to 90 days. Their reasoning is that it is becoming increasingly easier for hackers to obtain passwords. Some hackers utilize programs that run through words in the dictionary because many people use common words as passwords. The longer the password, and the more diverse the types of characters it contains, the more difficult it will be for a hacker to obtain. Avoiding the use of personal information (nicknames, dates of birth, etc.) in passwords is another way to reduce the likelihood of a hacker figuring out your password.

Many businesses offer wireless Internet services to customers and employees with laptops. The convenience and mobility of this type of service is attractive but it involves
inherent risks. Here are some tips to maintain the security of a wireless network:

- The network should use encryption to scramble communications
  - WPA has stronger security measures than WEP
- The wireless router should have its identifier broadcasting mechanism turned off so that it does not announce its existence to the world
- Be sure to change the manufacturer’s default on the router’s identifier to prevent a hacker from accessing it
- Change the router’s default administrative password
- Turn off the wireless network when it is not being used

These warnings sound very basic and, to some people, insulting. However, an insurance producer should keep in mind that any breach of security involving a consumer’s nonpublic personal information could result in regulatory action against the producer. Just because a producer is not currently working on a consumer’s insurance account when online doesn’t mean a security breach can’t occur and that business information stored on the computer is not accessible.

**HITECH ACT**

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) is part of the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA contains universal incentives pertaining to health care information technology, such as the creation of a national health care infrastructure, and also contains incentives designed specifically to hasten the adoption of electronic health record (EHR) systems among health care providers.

The HITECH Act has expanded the required privacy and security protections available under HIPAA because a tremendous expansion in the exchange of electronic protected health information (ePHI) is expected. The HITECH Act provides for more enforcement and increases the potential legal liability of those individuals and entities failing to comply with the Act.

Although a number of financial incentives are included in the Act, as well as other precise details, this discussion will focus on key provisions of the Act that are specifically related to HIPAA. Many requirements of the HITECH Act will become effective 12 months after the date of enactment (2/18/2009), however, other requirements involve different effective dates. Precise details of the Act’s provisions and effective dates can be found on the web site of the U.S. Department of Health and Human Services at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitechenforcementifr.html.

**ENFORCEMENT**

It is common knowledge in the health care industry that HIPAA has not been meticulously enforced. Based on language contained in HITECH, it appears that
regulatory intent concerning enforcement has changed and that consequences of non-compliance have increased significantly:

- Mandatory penalties will be imposed for “willful neglect”
  - “Willful neglect” will be judged on a case-by-case basis but it seems that if a provider has “no story” or a story that indicates a disregard toward compliance, the provider will run a high risk of being penalized
- Civil penalties for willful neglect are increased
  - Can extend to $250,000
  - Repeat/uncorrected violations can extend to $1,500,000
- In certain circumstances, both civil and criminal penalties extend to business associates
- As in HIPAA, individuals are unable to bring a cause of action against a provider
  - A state attorney general may bring a cause of action against a provider on behalf of the residents of his state
- The U.S. Department of Health and Human Services (HHS) is required to perform periodic audits of covered entities and business associates

**NOTIFICATION OF BREACH**

In the event of unauthorized uses and disclosures of “unsecured PHI,” HITECH requires notification requirements for data breaches. In most cases, the breach requirement pertains to stored health information that is not encrypted or otherwise made impossible to read—such as information contained on insurance applications. (Until HITECH was passed, only two of the 48 states that required data breach notifications included PHI as a specified data type—California and Arkansas.) The notification requirements are similar to those data breach laws currently in place per state law with respect to personally identifiable financial information. HHS must define “unsecured PHI” within 60 days of enactment and, if it fails to do so, then the HITECH definition will apply. HITECH defines “unsecured PHI” as meaning “unencrypted PHI.”

Basically, patients must be informed if unsecured breaches occur. HHS must be notified if a breach affects 500 or more patients and it will post the name of the breaching entity on its web site. In certain circumstances, local media will also be notified. It should be noted that notification procedures are triggered regardless of how the breach occurred: internally or externally. The severity of this provision is further evidence of the attention regulators intend to devote to security and the protection of privacy. California reported that in the first five months after state legislation required notification of data breaches, over 800 notifications were made. This underscores the need for security and the rate at which breaches are occurring.

In an April 19, 2009 press release by HHS, “Entities subject to the HHS and FTC regulations that secure health information as specified by the guidance through encryption or destruction are relieved from having to notify in the event of a breach of such information. This guidance will be updated annually.” This requirement means that in order for providers and business associates (i.e. insurance companies, agencies, and producers) to be relieved of data breach notification and to protect PHI, they must either
encrypt PHI or destroy it. Essentially, encryption is the only secure way to store PHI. Keeping unencrypted PHI of consumers exposes a producer to virtually all of the HITECH requirements.

**ELECTRONIC HEALTH RECORD ACCESS**

If a health care provider has adopted an EHR system, consumers will have the right to obtain their protected health information (PHI) in electronic format (ePHI). Consumers will also have the right to appoint a third party to receive their ePHI. If a health care provider charges a fee for providing this information, it cannot exceed the cost of labor for doing so. While some of the EHR systems may not have immediate ability to transmit electronic records, it will be incumbent upon providers to be able to respond to consumers’ requests since it is expected that electronic records will be requested far more often than paper records.

A provider unwilling or unable to comply with these requests for electronic information may find itself disqualified from participation in the financial incentives. Their use of the EHR system may not qualify as “meaningful use” if a provider fails to comply, or fails to comply promptly, with consumer requests for ePHI.

**BUSINESS ASSOCIATES**

HIPAA contains some provisions that relate directly to business associates. (Insurance companies and producers meet the definition of business associate.) Before enactment of HITECH, privacy and security requirements were imposed upon business associates only if contractual agreements existed with covered entities. It has been suspected that many small providers did not have contracts in place or that if contracts were in place, they did not comply with all HIPAA rules. Lack of required contractual agreements has not, in the past, generated a serious problem for the provider community.

With the enactment of HITECH, business associates are now officially required to comply with the Safety Rule. Which means that although an insurance producer does not have a contract with a health care provider, if he is involved in a transaction that involves EHR, he will be directly accountable under the HITECH Act. Because HITECH allows for the tremendous growth in the exchange of electronic PHI, all involved parties have increased concerns about privacy and security. It is anticipated that virtually all software providers of EHR systems will be considered business associates and, as such, they will be subject to direct compliance with HITECH—even in the absence of contractual agreements.

In addition, business associates are obligated by the Act to report security breaches to covered entities in compliance with the notification requirements. As previously mentioned, they will now be subject to civil and/or criminal penalties under HIPAA if certain conditions exist. In addition to the business associate requirements discussed here, additional requirements exist based on the definition of the relationship between the business associate and the provider. While large firms may have little difficulty adopting the changes necessitated by HITECH because they already possess legal counsel and
specialized staff to meet regulatory demands, small firms (or individual producers) may find themselves wading into waters that are difficult to navigate.

**SUMMARY**

HITECH also contains requirements pertaining to marketing communications, restrictions, and accounting—each of which modifies HIPAA in important ways.

On February 18, 2010, the following requirements become effective:
- Application of rules to, and accountability for, business associates.
- Clarification regarding which entities are required to be business associates.
- Patient's right to restrict disclosures to health plans.
- Deeming of limited data set as satisfying the minimum necessary standard.
- Patient's right to electronic access to, and an electronic copy of, their health record.
- Clarification regarding marketing provisions.
- Opt-out for fund raising communications; HIPAA's current provisions regarding fund raising remain in full force an effect.
- Clarification regarding the ability to impose criminal penalties against individuals.
- Civil monetary penalties and settlements flowing to HHS/OCR (Office of Civil Rights) for enforcement.
- Requirement for HHS to begin conducting mandatory audits.

By August 18, 2010, the following requirements become effective:
- Secretary's guidance on minimum necessary
- Regulations regarding the sale of data prohibition (effective 6 months post promulgation)
- GAO report on methodology for providing individuals with a percentage of HIPAA penalties
- Regulations on imposition of civil monetary penalties in cases of willful neglect (and with respect to when the Secretary can civilly pursue violations of HIPAA that qualify as criminal)


For convenience in determining which sections of HITECH most directly and urgently impact a producer, an outline of the Act follows:
- **Division A: Title XIII—Health Information Technology**
  - **Subtitle A—Promotion of Health Information Technology**
    - Part 1—Improving Health Care Quality, Safety, and Efficiency
    - Part 2—Application and Use of Adopted Health Information Technology Standards; Reports
  - **Subtitle B—Testing of Health Information Technology**
  - **Subtitle C—Grants and Loans Funding**
  - **Subtitle D—Privacy**
    - Part 2—Relationship to Other Laws; Regulatory References; Effective
Date; Reports

• Division B: Title IV—Medicare and Medicaid Health Information Technology;
  Miscellaneous Medicare Provisions
  o Subtitle A—Medicare Incentives
  o Subtitle B—Medicaid Incentives
  o Subtitle C—Miscellaneous Medicare Provisions
CHAPTER 7 REVIEW QUESTIONS

1. If an insurance agent takes a client’s electronic payment, what section of the GLBA governs the collection of that information?
   [a] Safeguards Rule
   [b] Financial Privacy Rule
   [c] PreTexting
   [d] Federal Trade Commission

2. If an e-mail contains only _____ content, it is subject to all requirements of the CAN-SPAM Act.
   [a] Transactional content
   [b] Relationship content
   [c] Commercial content
   [d] Other content

3. What kind of signature utilizes key cryptography to “sign” a message?
   [a] Electronic signature
   [b] Digital signature
   [c] Online signature
   [d] Scrivener signature

4. The HITECH Act has expanded the required privacy and security protections for electronic technology information available under what Act?
   [a] GLBA
   [b] HIPAA
   [c] FCRA
   [d] ePHI

5. With the enactment of HITECH, _____ are now officially required to comply with the Safety Rule.
   [a] Insurance agents
   [b] EHRs
   [c] Health care providers
   [d] Business associates
In light of AIG’s financial woes and the Lehman Brothers bankruptcy, both occurring in 2008, the insurance industry and consumers alike have been paying very close attention to the financial stability of insurance companies. Although most states have guaranty funds in place for the protection of consumers, it’s never in a consumer’s best interests to be forced to rely on a guaranty fund for payment of a claim.

Insurance companies, like all other businesses, operate from a business model. An insurance company’s business model involves charging policyholders earned premium for the number of days they have insurance in place, adding any investment income to those earnings, subtracting incurred losses, and then subtracting underwriting expenses. After these calculations, the insurance company hopes to realize a profit.

Underwriting insurance risks is a complicated enterprise and, if an insurance company doesn’t handle the practice prudently, can find itself experiencing financial woes. Because of the potential for financial disaster, insurance companies use actuarial statistics to determine what types of risks they choose to assume and to determine the premium rates they must charge for those risks. Underwriting performance dictates, to a large degree, whether an insurance company will earn a profit or loss.

Underwriting performance is calculated by comparing an insurance company’s ratio of losses and expenses to the premiums it collects in a particular year. This calculation is called a *combined ratio*. If an insurance company’s combined ratio is less than 100% it means the company earned a profit on the policies in force for that year. For example, if a company’s combined ratio were 95% it would mean that for every dollar of premiums it collected, it paid out $.95 in claims and underwriting expenses. An insurance company can be profitable with a combined ratio over 100% but that profit will be the result of investment earnings covering the underwriting loss.

Insurance companies earn investment income on available reserve, which is the amount of premiums it has collected but has not yet paid out in claims. This available reserve is also called “float.” Sometimes, in a good economy, investment income can offset underwriting losses.
RISK-BASED CAPITAL

The NAIC developed a method to measure the minimum amount of capital an insurance company needs to have to sustain its business operations. This method is called Risk-Based Capital (RBC). It is used to establish capital requirements based on the size and degree of risk assumed by the insurance company. RBC is also used in the banking industry and regulators, rating agencies, and company management may each use their own procedures and formulas for estimating Risk-Based Capital.

In general terms, RBC is usually expressed as a ratio. The ratio represents the total capital of the company--as determined by the RBC formula, divided by the company’s risk-based capital--as determined by the formula. A company with a 200% RBC ratio actually has capital equal to twice its risk-based capital.

There are currently four major categories of risk that must be calculated to arrive at a general risk based capital amount for an insurance company. They are:

1. Asset Risk is the risk of an asset’s poor investment performance or its fluctuation in market value as the result of market changes
2. Credit Risk is the risk of loss due to the payment default of policyholders, reinsurance companies, or other creditors
3. Underwriting Risk is the risk that premiums collected will not cover future incurred losses and related expenses
4. Off-Balance Sheet Risk is the risk of excessive growth rates in premiums, contingent liabilities, or other items not mentioned on the balance sheet

The RBC system also raises a safety net for insurance companies, is uniform among the fifty states, and provides regulatory authority. Each of the following types of insurance has its own RBC formula: property & casualty, life, and health. The formulas for each type of insurance involve a generic formula approach instead of a modeling approach.

In a generic formula, an insurance company need not include every single risk exposure. Instead, the formula concentrates on the material risks that are common to the specific type of insurance. For example, the life insurance RBC formula includes interest rate risk because the risk of losses due to interest rate level changes is a material risk for most life insurance products. Because investment risks and asset risks are shared by all insurance companies, they are included in all of the RBC formulas.

Investment risk includes default of principal and/or interest for bonds and mortgage loans, default and passed dividends for preferred stock, and decrease in fair value for common stock and real estate. Asset risk includes credit risk and concentration risk.

In order to calculate an RBC risk charge, the generic formula usually pulls an amount from the statutory financial statement and applies a factor. The factor is based upon pertinent statistics. For example, bond default rates are used to establish factors applied against the six credit quality designations of bonds. “1” is the highest quality and is assigned the lowest factor and “6” is the lowest quality and is assigned the highest factor.
The specific RBC formula calculates an RBC risk charge for every individual risk item included in the formula.

The NAIC RBC system has two major elements:
1. The risk-based capital formula, which creates a theoretical minimum capital level that is compared to an insurance company’s actual capital level, and
2. A risk-based capital model law that confers automatic authority to the state’s insurance regulators to initiate explicit actions based on the level of an insurance company’s financial impairment

The NAIC’s Risk-Based Capital for Insurers Model Act (Volume II-312) applies to property & casualty and life insurance companies. It is an accreditation standard and most states have either adopted either it or similar statutes and regulations. The Health Organizations Model Act (Volume II-315) applies to health insurance companies and is not currently an accreditation standard, although over 30 states have adopted either it or similar statutes and regulations.

Once an RBC calculation is completed, it is considered confidential and is not made available to the public. Overall results of RBC calculations, however, are reported on the Five-Year Historical Data Page of the Statutory Annual Statement. The Five-Year Historical Data Page includes two amounts: the Total Adjusted Capital, which is the insurance company’s actual amount of capital and surplus, and the Authorized Control Level Risk-Based Capital, which is one of four levels of calculated minimum capital.

Separate types of insurance companies, as previously stated, are subject to different formulas. The different models reflect the dissimilar economic environments faced by the companies. Some common risks in the models include:
- Asset Risk—Affiliates
- Asset Risk—Other, which includes credit risk, interest rate risk, and market risk
- Underwriting or Insurance Risk
- Business Risk

The RBC formula for life insurance companies includes:
- Asset Risk—Affiliates
- Asset Risk—Other
- Insurance Risk
- Interest Rate Risk
- Health Credit Risk
- Market Risk
- Business Risk

The RBC formula for property & casualty insurance companies includes:
- Asset Risk—Subsidiary Insurance Companies
- Asset Risk—Fixed Income
- Asset Risk—Equity
- Asset Risk—Credit
• Underwriting Risk—Reserves
• Underwriting Risk—Net Written Premium

The RBC formula for health insurance companies includes:
• Asset Risk—Affiliates
• Asset Risk—Other
• Underwriting Risk
• Credit Risk
• Business Risk

Asset Risk—Affiliates is the risk of default of assets for affiliated investments. The RBC requirement of downstream insurance subsidiaries owned by the insurance company is calculated based on the Total Risk-Based Capital After Covariance of the subsidiary company, then it is pro-rated based on the ownership percentage. The RBC requirement for affiliates not subject to RBC (i.e. title insurance companies, monoline financial guaranty insurance companies, and monoline mortgage guaranty insurance companies) is calculated based on an established factor. The parent insurance company must hold an equal amount of risk-based capital to guard against its affiliates’ financial declines. This risk component includes off-balance sheet items (i.e. non-controlled assets, derivative instruments (life insurance companies only), guarantees for affiliates, and contingent liabilities.

Asset Risk—Other is the risk of potential for default of principal and interest or the fluctuation in the fair value of assets. Fixed income assets include bonds, collateral loans and mortgage loans, short-term investments, cash, and other long-term invested assets. Equity assets include unaffiliated stock (common and preferred), real estate, and long-term assets. An asset concentration factor applies to all insurance companies and reflects the additional risk of high concentrations in a single issuer.

Insurance risk, for life insurance companies, is the equivalent of the underwriting risk for health and property & casualty insurance companies. The life insurance risk factors calculate the surplus needed to provide funds for excess claims--both from random fluctuations and from the inaccurate pricing for future level of claims (e.g. experience fluctuation risk). Property & casualty insurance companies calculate underwriting risk for reserves and premiums. These calculations reflect the risk of pricing and reserving errors. Because the reserves for various types of insurance business involve different frequency and severity characteristics, the formula applies separate factors to each major line of business. These factors are adjusted based on insurance company experience and investment potential. The Underwriting Risk for Reserves and Premiums Written are calculated in much the same manner, by multiplying a set of factors times the reserves or the net written premiums. The predominant risk faced by health insurance companies is that medical expenses will exceed the premiums collected. The health insurance formula recognizes that larger blocks of business will have relatively fewer fluctuations; therefore, tiered factors are used to recognize the increased stability that comes with higher volume. The health insurance formula also includes an adjustment for recognizing the beneficial effect of managed care arrangements in decreasing the fluctuations in
medical expenses. Managed-care credits reduce the base underwriting risk for each of the major lines of business. Property & casualty and health insurance companies also calculate excessive growth. This calculation recognizes that companies growing rapidly may generate greater reserve deficiencies.

*Interest Rate Risk* (life insurance companies) is the risk of losses due to changes in interest rate levels. The factors in this calculation represent the surplus necessary to provide for a lack of synchronization of asset and liability cash flows. The impact of interest rate change is greatest on those products where the guarantees are most in favor of the policyholders and where the policyholder is most likely to respond to changes in interest rates by withdrawing funds from the insurance company. Therefore, risk categories vary by the withdrawal provision (i.e. whether there is substantial penalty for withdrawal).

*Business Risk* (life and health insurance companies) is the risk based on premium income, annuity considerations, and separate account liabilities. Exposures in litigation, expenses relating to certain accident and health coverages, ASO and ASC expenses are also included. Business Risk for health insurance companies includes the following sub-components:

- Administrative Expense Risk, which is the variability of operating expenses,
- Non-Underwritten and Limited Risk, the collectability of payments for administering third party programs,
- Guaranty Fund Assessment Risk, and
- Excessive Growth

These sub-components recognize that instability can result from poor controls on administrative expenses, in addition to instability in medical expenses.

The formulas apply a covariance calculation to determine the appropriate risk-based capital. Basically, the covariance calculation reduces the collective amount of RBC because it is unlikely that all risk components will be impaired at the same time. The levels of regulatory action are determined based on the risk-based capital after covariance. The covariance adjustment reflects the fact that the cumulative risk of several independent components is less than the sum of the individual risk. The formulas do not include the insurance affiliate equity investment risk and off-balance sheet risk inside the covariance adjustment. The covariance adjustment follows the steps of adding together items that are believed to be connected, leaving the balance of risks that are not connected. The covariance adjustment then squares these resulting groups, adds the resulting squares together, and obtains the square root of the sum of the squares. The covariance adjustment reduces the volatility of the smaller risks and increases the importance of the largest risks affected by the adjustment.

Once the RBC level is determined by comparing an insurance company’s Total Adjusted Capital to its Authorized Control Level Risk-Based Capital, it is reported annually. One of five outcomes will occur.

1. No action: Total Adjusted Capital of 200% or more of Authorized Control Level results in *No Action*. 
2. Company Action Level: Total Adjusted Capital of 150% to 200% of Authorized Control Level results in *Company Action Level* under which the insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company’s financial condition. The Plan must contain proposals to correct the financial problems and provide projections of the financial condition, both with and without the proposed corrections. The Plan also must list the key assumptions underlying the projections and identify the quality of, and the problems associated with, the insurance company’s business. If a company fails to file the comprehensive financial plan, the failure to respond triggers the Regulatory Action Level.

3. Regulatory Action Level: Total Adjusted Capital of 100% to 150% of Authorized Control Level triggers a Regulatory Action Level. At this level, an insurance company is also required to file an action plan, and the state insurance commissioner is required to perform any examinations or analyses to the insurance company’s business and operations that he or she deems necessary. The state insurance commissioner also issues appropriate corrective orders to address the insurance company’s financial problems.

4. Authorized Control Level: Total Adjusted Capital 70% to 100% of the Authorized Control Level triggers an Authorized Control Level. This is the first point that the regulator takes control of the insurance company. This authorization is in addition to the remedies available at the higher action levels. It is important to note that the law grants the insurance commissioner this power automatically. This action level occurs at a point where the insurer may still be technically solvent.

5. Mandatory Control Level: Total Adjusted Capital of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place the insurance company under control. This situation can occur while the insurance company still has a positive level of capital and surplus. A number of insurance companies that trigger this action level are technically insolvent (liabilities exceed assets).

**TREND TESTS**

Life insurance companies with total adjusted capital between 2 and 2.5 time their Authorized Control Level of Risk-Based Capital are subject to a trend test. This test calculates the greater of the decrease in the margin between the current and prior years and the average of the past three years. The assumption is that the decrease could occur again in the coming year. Any insurance company with a negative trend below a certain level would trigger a company action level event.

Property & casualty insurance companies with a RBC ratio between 200% and 300% and a combined ratio greater than 120% trigger a company action level event if the property & casualty trend test has been enacted in the regulations by the particular states in which they companies are domiciled or in the states in which they are licensed.

Health insurance companies will also be subject to a trend test beginning with year-end 2009. If the RBC ratio is between 200% and 300% and the combined ratio greater than
105%, a company action level event will be triggered if the Health trend test has been enacted in the regulations by the particular states in which they companies are domiciled or in the states in which they are licensed.

**RBC SUMMARY**

While RBC is designed to determine a minimum capital level, it is often used to measure the relative financial strength of two or more companies. Clearly a RBC calculation with many false positives and false negatives will be even less reliable at determining relative financial strength. False positives indicate companies that have low RBC ratios but have kept their financial commitments to customers; false negatives indicate companies that have high RBC ratios but were unable to keep their financial commitments to customers. Other types of review are also possible, including the comparison of RBC ratios to credit ratings.

**INSURANCE COMPANY RATING SERVICES**

Noted insurance journalist, Phil Zinkewicz, stated in an article he wrote for *Rough Notes*, “Insurance rating organizations are at the very heart of the insurance industry’s credibility—credibility with individual and institutional investors, policyholders, regulators and legislators. Organizations such as A.M. Best, Standard & Poor’s, Moody’s, and TheStreet.Com, Inc., are among the ‘observers’ of the insurance industry. They keep a watchful eye on how insurance companies perform, as well as on issues that might affect a company’s performance. In addition, there are insurance industry research and consulting firms, such as Conning and Tillinghast, that, although they do not provide ratings, also observe the industry and conduct studies on insurance industry issues.”

Considering the facts that a consumer’s primary expectation with respect to his insurance company is that it will pay in the event of a claim and that his insurance agent will place coverage with a financially sound insurance company, one can imagine the negative fallout when a consumer experiences a loss and his carrier is insolvent. An insurance producer should *always* be familiar with the current financial ratings of *all* his carriers.

Here is a quick rundown of the three major rating services that evaluate insurance companies:

- **A.M. Best Company** was founded in 1899 and is a full-service credit rating organization dedicated to serving the financial services industry, including banking and insurance. It is an international firm with locations in the United States, the United Kingdom, and Hong Kong and also provides the following services, among others: fixed-instrument debt ratings; books, directories, CD-ROM products, internet-based insurance services; and *Best’s Review* magazine; regulatory statement information.

- **Standard & Poor’s** is a worldwide provider of investment research, market indices, credit ratings, financial data, and fixed income research and analysis. Henry Varnum Poor began publishing an investor’s guide to the state of railroad
company finances in 1860 and Luther Blake founded the Standard Statistics Bureau in 1906 to provide previously unavailable financial information on roughly 100 U.S. companies. The Standard Statistics Bureau subsequently began to assign debt ratings to corporate bonds, sovereign debt ratings, and municipal bond ratings. Poor’s Publishing and Standard Statistics merged in 1940 to form the Standard & Poor’s Corporation.

- Moody’s Investors Services is a worldwide source of credit ratings, research, and risk analysis. It provides research data and analytic tools for assessing credit risk and publishes market-leading credit opinions, deal research, and commentary, serving approximately 2,400 international institutions. John Moody founded Moody’s in 1900, when his company first published Moody’s Manual of Industrial and Miscellaneous Securities, which provided information and statistics on the stocks and bonds of financial institutions, government agencies, and businesses such as manufacturers, mining companies, utility companies, and food companies.

A.M. BEST COMPANY

A Best’s financial strength rating is the company’s independent opinion about an insurance company’s financial strength and its ability to meet ongoing obligations with respect to its policies and contracts. It is based on a comprehensive evaluation of the insurance company’s balance sheet, operating performance, and business profile. Specific methodologies are incorporated into the evaluations are designed to address the individual segments of the insurance industry: Property/Casualty (non-life) and Life/Health/HMO. A complete list of their methodologies is listed on their web site.

Although a Best financial strength rating is not a guarantee, the company has a proven track record on indicating which insurance companies, over time, may encounter financial troubles. An A.M. Best rating is recognized worldwide as a standard for “assessing and comparing” an insurance company’s financial strength.

The following ratings indicate the scale used to rate an insurance company:

<table>
<thead>
<tr>
<th>Secure</th>
<th>Vulnerable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A++, A+ (Superior)</td>
<td>B, B- (Fair)</td>
</tr>
<tr>
<td>A, A- (Excellent)</td>
<td>C++, C+ (Marginal)</td>
</tr>
<tr>
<td>B++, B+ (Good)</td>
<td>C, C- (Weak)</td>
</tr>
<tr>
<td></td>
<td>D (Poor)</td>
</tr>
<tr>
<td></td>
<td>E (Under Regulatory Supervision)</td>
</tr>
<tr>
<td></td>
<td>F (In Liquidation)</td>
</tr>
<tr>
<td></td>
<td>S (Rating Suspended)</td>
</tr>
</tbody>
</table>

In addition, rating modifiers may be applied to the above ratings:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Descriptor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>u</td>
<td>Under Review</td>
<td>Indicates the rating may change in the near term, typically within six months. Generally, event-driven, with positive, negative, or developing implications.</td>
</tr>
<tr>
<td>pd</td>
<td>Public Data</td>
<td>Indicates rating assigned to an insurer that chose not to participate in A.M. Best’s interactive rating process.</td>
</tr>
<tr>
<td>s</td>
<td>Syndicate</td>
<td>Indicates a rating assigned to a Lloyd’s syndicate.</td>
</tr>
</tbody>
</table>
A.M. Best also adds Affiliation codes to identify companies whose assigned ratings include consideration of the following affiliations with other insurance companies:

- “g” – a group
- “p” – a pooling
- “r” – a reinsurer

A rating Outlook is also assigned to interactive financial ratings of A++ through D for the purpose of indicating the insurance company’s potential direction over an intermediate term, which is usually 12-36 months. Rating Outlooks are:

<table>
<thead>
<tr>
<th>Outlook</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Indicates possible rating upgrade due to favorable financial and market trends relative to the current rating level</td>
</tr>
<tr>
<td>Stable</td>
<td>Indicates low likelihood of a rating change due to stable financial and market trends</td>
</tr>
<tr>
<td>Negative</td>
<td>Indicates possible rating downgrade due to unfavorable financial and market trends relative to the current rating level</td>
</tr>
</tbody>
</table>

To “enhance the usefulness” of its ratings, A.M. Best assigns each company rated A++ through D a Financial Size Category (FSC). The FSC is based on the insurance company’s adjusted policyholder surplus (PHS). Although most insurance companies, regardless of their size, utilize reinsurance to reduce their net retention of insurance limits written, many consumers feel more secure when purchasing their insurance from “larger” insurance companies.

<table>
<thead>
<tr>
<th>Class</th>
<th>Adjusted PHS ($ Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Less than 1</td>
</tr>
<tr>
<td>II</td>
<td>1 to 2</td>
</tr>
<tr>
<td>III</td>
<td>2 to 5</td>
</tr>
<tr>
<td>IV</td>
<td>5 to 10</td>
</tr>
<tr>
<td>V</td>
<td>10 to 25</td>
</tr>
<tr>
<td>VI</td>
<td>25 to 50</td>
</tr>
<tr>
<td>VII</td>
<td>50 to 100</td>
</tr>
<tr>
<td>VIII</td>
<td>100 to 250</td>
</tr>
<tr>
<td>IX</td>
<td>250 to 500</td>
</tr>
<tr>
<td>X</td>
<td>500 to 750</td>
</tr>
<tr>
<td>XI</td>
<td>750 to 1,000</td>
</tr>
<tr>
<td>XII</td>
<td>1,000 to 1,250</td>
</tr>
<tr>
<td>XIII</td>
<td>1,250 to 1,500</td>
</tr>
<tr>
<td>XIV</td>
<td>1,500 to 2,000</td>
</tr>
<tr>
<td>XV</td>
<td>2,000 or greater</td>
</tr>
</tbody>
</table>

If A.M. Best does not assign a rating category to an insurance company, it indicates the reason for the lack of a rating:

- NR-1 Insufficient Data
- NR-2 Insufficient Size and/or Operating Experience
- NR-3 Rating Procedure Inapplicable
- NR-4 Company Request
- NR-5 Not Formally Followed

**STANDARD AND POOR’S**

S & P’s credit ratings are “forward-looking opinions about credit risk.” They reflect the agency’s opinion about the willingness and ability of the party assigned the rating. Their long-term ratings are based, in different degrees, on their evaluation of the following:

- Likelihood of payment capacity and willingness to meet its financial commitments and obligations
- Nature and provisions of the financial obligation(s)
- Protection afforded by, and relative position of, the financial obligation in the event
of bankruptcy, reorganization, or other similar laws

- Assessment of default risk

S & P’s ratings are not intended to be a guarantee of credit quality or an exact measurement of the likelihood that a particular issuer will default. They are intended to be a relative opinion. For example, a rating of AA is viewed by S & P as having a higher credit quality than a rating of B; the AA rating isn’t a guarantee that the company will not default, it is just S & P’s opinion that it is less likely to default than the company with the B rating is.

The meanings of S & P’s letter ratings are:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Highest rating: Extremely strong capacity to meet financial commitments</td>
</tr>
<tr>
<td>AA</td>
<td>Very strong capacity to meet financial commitments</td>
</tr>
<tr>
<td>A</td>
<td>Strong capacity to meet financial commitments, but somewhat susceptible to adverse economic conditions and changes in circumstances</td>
</tr>
<tr>
<td>BBB</td>
<td>Adequate capacity to meet financial commitments, but more subject to adverse economic conditions</td>
</tr>
<tr>
<td>BBB-</td>
<td>Considered lowest investment grade by market participants</td>
</tr>
<tr>
<td>BB+</td>
<td>Considered highest speculative grade by market participants</td>
</tr>
<tr>
<td>BB</td>
<td>Less vulnerable in the near term but faces major ongoing uncertainties to adverse business, financial, and economic conditions</td>
</tr>
<tr>
<td>B</td>
<td>More vulnerable to adverse business, financial and economic conditions but currently has the capacity to meet financial commitments</td>
</tr>
<tr>
<td>CCC</td>
<td>Currently vulnerable and dependent on favorable business, financial, and economic conditions to meet financial commitments</td>
</tr>
<tr>
<td>CC</td>
<td>Currently highly vulnerable</td>
</tr>
<tr>
<td>C</td>
<td>Currently highly vulnerable obligations and other defined circumstances</td>
</tr>
<tr>
<td>D</td>
<td>Payment default on financial commitments</td>
</tr>
</tbody>
</table>

Note: Ratings from AAA to CCC may be modified by the addition of a (+) or (-) sign to show a relative standing within the major rating category.

MOODY’S INVESTORS SERVICES

Moody’s ratings are different gradings of creditworthiness, with each grade indicating a group in which the credit characteristics are roughly the same. The letter gradings designate least credit risk to greatest credit risk:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaa</td>
<td></td>
</tr>
<tr>
<td>Aa</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Baa</td>
<td></td>
</tr>
<tr>
<td>Ba</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Caa</td>
<td></td>
</tr>
<tr>
<td>Ca</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>

Numerical modifiers (1, 2, and 3) are added to each generic rating classification from Aa through Caa. If Moody’s has not assigned a rating, or if it has withdrawn a rating, it may have nothing to do with the creditworthiness of the company.
1. An application was not received or accepted
2. The issue or issuer belongs to a group of securities or entities that are not rated as a matter of policy
3. A lack of essential data exists pertaining to the issue or the issuer
4. The issue was privately placed, in which case Moody’s does not publish a rating.

Like the other rating services, Moody’s does not guarantee its ratings and states that they are the opinions of the company and not commercial credit ratings.

**STATE GUARANTY FUNDS**

Two national organizations exist for the benefit of consumers in each state should their insurance company become insolvent and be unable to pay claims. The National Conference of Insurance Guaranty Funds (NCIGF) is a non-profit, member-funded association of property and casualty state guaranty associations in all 50 states, Puerto Rico, and the District of Columbia and the National Organization of Life & Health Insurance Guaranty Associations (NOLGHA) is a voluntary association comprised of the life and health guaranty associations of all 50 states, the District of Columbia, and Puerto Rico.

Each state has its own guaranty association and the particulars of that association will prevail when an insurance company domiciled and/or writing insurance in that state becomes insolvent. In general, however, certain practices are common among state funds.

The insurance department of each state is responsible for monitoring the financial health and stability of the insurance companies authorized to write insurance in that particular state. When the insurance commissioner of a state determines that an insurance company is in financial trouble, he is authorized by state law to protect the policyholders and claimants of the insurance company. Depending upon the nature of the financial trouble, the insurance commissioner may issue an Order of Supervision, an Order of Suspension, an Order of Rehabilitation, or an Order of Liquidation.

- An Order of Supervision may require the insurance company to take specific action or to obtain authorization from the commissioner before it enters into certain transactions. Usually, an Order of Supervision issued alone does not require changes in the policies issued by the company or changes to the way claim payments are made.
- An Order of Suspension may require the insurance company to stop doing some, or all, of its business in the state.
- An Order of Rehabilitation is issued by the Court at the request of the commissioner because financial troubles are severe or the commissioner believes it is necessary for the protection of policyholders and creditors. The commissioner is usually appointed Rehabilitator and is invested with the authority to manage the insurance company until the financial troubles are rectified. The commissioner may take whatever actions he deems necessary, subject to supervision of the court, and control may be returned to the company once issues are resolved. If, after taking
corrective action, the commissioner believes that continued operation of the insurance company will prove damaging to its policyholders and creditors, he can request an Order of Liquidation from the court.

- An Order of Liquidation appoints the insurance commissioner as Liquidator, who then appoints a Receiver to manage the process of the insurance company’s liquidation. Policyholders and creditors are sent notices informing them that the insurance company is being liquidated and the required steps for submitting a claim against the insurance company. Policyholders and claimants are also informed that a guaranty association or fund may handle the processing of future claims and that their policy will be cancelled on a future, specified date.

State guaranty funds are non-profit associations created by statute to protect policyholders from financial loss and delays in claim payments if their insurance company becomes insolvent. In order for an insurance company to receive a certificate of authority to do business in a state (becoming an admitted, or authorized, insurer), it is required to become a member of the state’s guaranty association. Each association is funded by assessments made against its solvent member insurance companies. The guaranty association actually assumes responsibility for the payment of claims the insolvent insurance company would have paid had it not become insolvent. Not all claims are covered by guaranty associations and even those that are covered are subject to limits.

According to the NCIGF’s publication, *Insolvency Trends—2010*, at least 20 insurance companies became impaired in 2009, which was up from 15 in 2008 and 14 in 2007. Impairments do not necessarily prompt a guaranty fund to begin assuming claim payments. As of November 2009, two Florida insurance companies were declared insolvent and are in the process of being liquidated. In October 2009, a Georgia workers’ compensation carrier was placed into liquidation. The California Conservation & Liquidation Office completed five final distributions since 2008 and expects to complete two additional final distributions in 2010. The liquidator in the state of Illinois reported that seven estates were closed in 2008, five were closed in 2009, and at least four are anticipated in 2010. Other states reporting liquidation include Massachusetts, Ohio, and Missouri.

The NAIC adopted new model acts for both property/casualty and life/health guaranty funds in 2009. No major revamping of the Acts have been proposed, however, it does appear that some states are interested in increasing the covered claim cap level to the $500,000 recommended by the NAIC. Most states currently cap property & casualty claims paid by their guaranty associations at $300,000 although recent increases have been made by Connecticut (to $400,000), Rhode Island (to $500,000), and Vermont (to $500,000). Iowa and Illinois have proposed raising their cap levels to $500,000.

The basic limits and types of policies covered by life and health guaranty associations vary by state, but most states set basic limits as follows:

- $300,000 in life insurance death benefits
- $100,000 in cash surrender or withdrawal value for life insurance
• $100,000 in withdrawal or cash values for annuities
• $100,000 in health insurance policy benefits

After an insurance company becomes insolvent, it is possible that a solvent insurance company may take over the insolvent carrier and assume responsibility for continuing coverage under the policies already issued, collecting premiums, and paying claims. Otherwise, the guaranty association will either provide coverage by continuing the insolvent insurance company’s policies or issuing replacement policies. In some circumstances, the state guaranty association may work with other state associations to develop a broader plan to provide protection.

Although each state designates what types of policies are afforded protection by its life and health guaranty association, most state guaranty associations do not provide coverage for:
• Non-indemnity health plans, i.e. HMOs
• Non-guaranteed policy or annuity
• Variable annuity or other policy where investment risk is assumed by the policyholder

It is especially important for producers to be aware of not only the financial stability of their insurance companies but also to know what types of insurance products are protected by the state guaranty associations. Consumers expect that their claims will be paid and, if a producer fails to properly disclose details concerning an insurance company’s financial strength or lack of participation in a state guaranty association, the producer may find himself personally liable for the oversight. Most insurance agent Errors & Omissions policies now contain exclusions for insurer insolvency.

REINSURANCE

Reinsurance is a type of insurance purchased by one insurance company from another insurance company as a way to transfer risk. The reinsurer and the insurance company enter into a contractual agreement (reinsurance agreement) that spells out the details of how the reinsurer will pay the insurance company’s losses—either on an excess or proportional basis. The reinsurer is paid a premium by the insurance company which is based on the portion of the risk assumed by the reinsurer.

Virtually all insurance companies participate in reinsurance. The objective of securing reinsurance is for an insurance company to reduce its exposure to loss by transferring some of its risk to another insurance company. The insurance company buying reinsurance is referred to as the ceding insurer; the insurance company selling reinsurance is referred to as the reinsurer.

While most consumers, and many agents, are unfamiliar with the concept of reinsurance, it existed as long ago as the 1300s. Marine and fire insurance were the first lines of
business to use reinsurance on a regular basis; during the past century, it has developed to the point that it is involved in all aspects of the modern insurance marketplace.

**Ceding insurance companies may purchase reinsurance from any one of three sources:**

1. U.S. reinsurers
2. Reinsurance departments of U.S. primary insurance companies
3. Alien reinsurers

Coverage may be purchased directly from a reinsurer or through a reinsurance broker.

Reinsurance is written on one of two bases. Proportional reinsurance contracts pre-arrange a pro-rata sharing of all premiums, losses, and expenses between the ceding company and the reinsurer. Most property reinsurance is written on this basis. Excess of loss reinsurance contracts require the ceding company to retain a predetermined level of losses and the reinsurer assumes responsibilities for losses in excess of that level, up to the limit of the reinsurance contract.

When a ceding company seeks to reinsure its book of business, it does so for a particular reason. It could be seeking to limit its liability. By limiting its loss exposure through a reinsurance contract, an insurer may be able to offer policy limits at higher levels than they could otherwise offer. This purpose of reinsurance allows all insurance companies to offer coverage that meets the needs of its clients while, at the same time, giving them the ability to compete with other, larger, carriers. Before choosing a level of reinsurance, a ceding company will evaluate its amount of available surplus and compare it to the level of loss that can be absorbed. An insurance company’s ability to absorb a financial loss can range from very little to millions of dollars.

A ceding company may also choose to enter a reinsurance contract to stabilize operating results by limiting its loss experience or to protect against catastrophe exposures. Finally, a ceding company may choose to increase its capacity through the purchase of reinsurance. Capacity is an insurance company’s ability to write new business. As it writes new policies, it pays expenses (taxes, commissions, operating expenses) and places premium dollars into its unearned premium reserve. The more money it transfers from surplus into the payment of expenses, the less money it has available to write new business. Through reinsurance, and the ability to share the cost of expenses with the reinsurer, the ceding company increases its capacity to write new business.

Reinsurers may often provide ceding companies with certain services, such as assistance with underwriting, claim reserving and handling, investing, and general management. Because a smaller company has limited resources, a reinsurer can often help it expand into other lines of business.

It is important to note that reinsurance has its limits, as do other types of insurance. Reinsurance doesn’t change the nature of a risk or magically transform a bad risk into a good risk. Reinsurance is simply a method of spreading risk.
THE REINSURANCE CONTRACT

Unlike many property and casualty contracts, reinsurance contracts are not written on standard forms. Two basic types of reinsurance contracts exist and every agreement will reflect the needs and requirements of the parties.

A treaty reinsurance contract is a comprehensive agreement to cover a particular type of business or several types of business, such as a company’s general liability exposures or all its property policies. Reinsurance treaties are usually issued for long periods of time and are automatically renewed. If one of the parties to the treaty wishes to make a change, the change is typically addressed at a renewal.

Treaties do not address specific risks; instead, they address all risks written by the ceding company that fall within the type of business stipulated in the agreement. The reinsurer will typically review the following aspects of the ceding company’s operations before deciding to enter into a treaty:

- Underwriting philosophy
- Business practices and historical experience
- Attitude toward claims management
- Engineering control
- Planned objectives and goals

A facultative reinsurance contract, by comparison, covers individual risks that are written on an individual basis. Terms are hammered out between the ceding company and reinsurer for every facultative contract issued. Catastrophes and unusual exposures are frequently the subject of facultative reinsurance. Because of the highly specialized nature of facultative contracts, reinsurers writing this type of business often utilize extensive staffs and technical resources.

One lesser-known fact about reinsurers is that they, themselves, purchase reinsurance. This type of protection is called retrocessions and it’s written precisely the same way traditional reinsurance is written. Another lesser-known fact is that ceding insurance companies may purchase reinsurance in layers, as in obtaining coverage through several treaties to cover different exposures at different levels.

No matter how complex a reinsurance agreement may be, certain standards apply to all contracts. The only parties to a reinsurance contract are the reinsurer and the ceding company; all legal rights, obligations, and duties are shared between the two parties and no one else—and especially not the subjects of the reinsurance contract. Payments collected under the contract are considered assets of the ceding company. Finally, because the reinsurance agreement is a contract of indemnification, the reinsurer does not pay losses until after the ceding insurer pays all losses under its own policies and existing reinsurance agreements.

REINSURANCE RISK CHARACTERISTICS

Because both the ceding company and reinsurer share all premiums and losses covered
by the reinsurance contract on a pre-arranged basis in proportional contracts, no unique risk characteristics exist with respect to this type of reinsurance. The same cannot be said of excess of loss reinsurance. Several types of risk exist with these contracts because, in addition to the inherent underwriting risk of the exposure, the reinsurer is also assuming risk with regard to the ceding company: its financial stability and the layers of coverage in which the reinsurer participates.

All reinsurance, but especially excess of loss agreements, tend to experience low loss frequency but high severity—neither of which is predictable. As a result, reinsurers often retain an unequal share of total losses. Compounding this issue is the fact that reinsurers experience more risk with respect to lines of insurance that don’t manifest claims right away, such as workers’ compensation and medical malpractice (and other forms of liability insurance). Because these lines of insurance tend to take longer to settle claims than lines of insurance such as property, retaining premiums to pay the losses—which are often settled years after submission—can create problems for the reinsurer.

When determining loss costs, three factors are considered:
1. Frequency – how many claims occur per unit,
2. Severity—the average cost of each claim, and
3. Total number of units insured

Due to the law of large numbers, the higher the number of similar units insured, the more reliable is the data taken into consideration. Auto physical damage claims are a perfect illustration of this calculation. Because of the very high number of vehicles insured each year, frequency remains comparatively stable.

This method is not often used when calculating reinsurance loss costs. Because of the nature of the risks that are reinsured, pertinent and realistic statistics may not be available. Instead of relying more on the nature of an individual exposure, as an insurance underwriter does, a reinsurance underwriter depends more on subjectivities such as professional judgment and past experience.

Because property losses are generally paid quickly, property insurance contracts pose few problems for reinsurers. On the other hand, because occurrence liability contracts permit a very long time between the occurrence of a loss and the submission of a claim, they pose more problems. Reporting delays raise havoc with all insurers but have significantly more impact on reinsurers. When a loss appears to fall within the ceding company’s retention limit—as established by the reinsurance agreement, the ceding company does not often report the loss to the reinsurer. When that happens, the reinsurer doesn’t value the loss or establish a reserve. Moreover, when, three years down the road, the claim is finally paid, the claim payment may exceed the ceding company’s retention—creating a shortfall of surplus for the reinsurer. As a result, reinsurers are tightening some of their requirements, such as requiring all serious losses to be reported to them, regardless of the ceding company’s reserve or reinsurance retention, and conducting on-site examination of the ceding company’s files.
Because of the tendency in commercial lines for claims to take a long time to be settled, many commercial insurers seek reinsurance to help ease the frequency and severity of their claims. All insurance companies set aside loss reserves for claims that have been “incurred but not reported” (IBNR) and, when the claims are reported, the reserves are reduced. IBNR is a major element of reinsurance reserves; reinsurers spend much time and attention calculating these figures. Unfortunately, they are, quite often, just an educated guess because they are so responsive to legal, economic, and social issues.

If IBNR reserves represent a small portion of an insurance companies total loss reserves, the impact of the actual losses when reported will probably be correspondingly small. Correspondingly, if the IBNR reserves are a significant portion of all loss reserves, the impact of the actual losses when reported will likely be sizeable.

Inflation may also have a serious impact on an insurance company’s reserves. If a claim is paid within a short time of policy issuance, inflation has little effect. However, in cases where a reinsurer does not know about a claim for years, and payment is made some time after the report, inflation may have a very serious effect. Because of unexpected frequency in the past ten years, nearly all lines of insurance experienced problems with retention levels being reached and/or exceeded.

REGULATION

Solvency is the major concern of reinsurance regulation. When seeking reinsurance, primary insurance companies focus more on the reinsurer than the contract. The element of direct concern for the consumer is not part of the reinsurance process because reinsurance contracts do not involve consumers. Reinsurance contracts come in all shapes and sizes and are determined by the unique needs of the ceding company. Each contract has its own retention levels, coverages, and exclusions; each contract requires the tailoring of a special premium.

Public policy cannot be ignored; as a result, most states have adopted regulations that pertain specifically to reinsurance agreements. One standard regulatory requirement is an insolvency provision, which permits the receiver of an insolvent insurer to collect on reinsurance contracts. Although most states do not require reinsurance contracts to be filed with, or approved by, them, state regulations concerning premiums affect reinsurance premiums.

Reinsurance laws do not restrict the purchase of reinsurance to the United States and, subject to a few exceptions, a ceding company can purchase reinsurance from a reinsurer anywhere in the world. Because the U.S. insurance and reinsurance markets need the additional capacity provided by non-U.S. reinsurers—and also want to guarantee that reinsurance purchased outside the country can be collected, state insurance departments often impose certain restrictions on U.S. insurance companies requiring them to obtain security arrangements between ceding companies and reinsurers.

Recoverable reinsurance is considered an asset, therefore, insurance companies want to satisfy the state credit for reinsurance laws. Most states enforce some sort of credit for
reinsurance laws, which helps balance insurer capacity and security. Credit for reinsurance requirements can be obtained in one of two ways:

- If the reinsurer is licensed or accredited in the same state where the primary insurer does business
- If the reinsurer is domiciled and licensed in a state that utilizes substantially similar credit for reinsurance standards as those of the primary insurer’s state of domicile

Most U.S. reinsurers meet one of these criteria, therefore, primary carriers doing business with them will receive favorable treatment of assets and liabilities on their annual statements.

If a ceding company chooses to purchase reinsurance from an alien reinsurer and receive favorable treatment of assets and liabilities, the alien reinsurer must either establish a sizeable U.S. trust fund that satisfies state requirements with respect to reporting, solvency, and collectability OR if it establishes security in the U.S., such as a clean, irrevocable, and unconditional letter of credit issued by an approved bank.

One item of note is that virtually all primary insurers are permitted to sell reinsurance. Most states allow insurers to sell reinsurance in the same lines it writes on a direct basis. No other requirements are necessary for an insurance company to get into the reinsurance market.

The purpose of reinsurance regulation is to guarantee that reinsurance contracts will be paid. Because of the inherent differences in the regular insurance and reinsurance marketplaces, regulation is necessarily different. When sufficient collateral to meet a reinsurer’s contractual obligations is secured, or when direct solvency regulation is imposed on a reinsurer, it is able to meet its financial and contractual obligations.

**HOW REINSURANCE WORKS**

So, how can reinsurance be explained in a way that producers and consumers understand? The most important thing to keep in mind when discussing the purpose of reinsurance is solvency: insurance companies purchase reinsurance to keep themselves financially sound. When an insurance company issues insurance policies, it is legally obligated to pay claims. Purchasing reinsurance is a way for insurance companies to meet their obligations.

If a small regional insurance company writes auto, homeowner, and small commercial lines of insurance it will be concerned about the risks it assumes in commercial lines. Auto losses can be predicted with a fair amount of accuracy and although the homeowner line of business does involve liability exposure, the majority of losses will arise from property. The general liability and workers’ compensation exposures, on the other hand, are much harder to predict with any accuracy. The small regional insurer will likely sign a treaty reinsurance agreement with a reinsurer for its commercial lines book.

The reinsurer will want to examine the ceding carrier’s loss exposure data, claims experience, underwriting and operating philosophy, and other matters pertinent to the
dollar amount and type of risk the primary carrier wants to transfer. The treaty may involve the ceding carrier’s retention of the first $1,000,000 of losses, with the reinsurer becoming responsible for losses over that amount. In exchange, the reinsurer may impose some additional underwriting requirements in some, or all, of the commercial lines of business being written by the ceding carrier and determines the reinsurance premiums to be charged.

Once a policyholder purchases a commercial lines policy, for example, a general liability policy with limits of $2,000,000/$4,000,000, the ceding company pays the reinsurance premium to the reinsurer and retains the balance of the premium paid by the policyholder. If the policyholder is subsequently sued for $1,500,000, the ceding carrier pays the first $1,000,000 of the claim and the reinsurer pays $500,000.

One aspect of reinsurance that many people are unaware of is that it often dictates the underwriting guidelines of small, primary insurers. If a carrier has a treaty reinsurance agreement in place, its reinsurer has definite requirements with respect to the risks it wishes to undertake. A ceding company can jeopardize its reinsurance agreement and relationship with its reinsurer if it writes business outside the limit of the reinsurance agreement. Although a carrier may approach a reinsurer with a request to enter into a facultative agreement pertaining to a particular exposure, it may choose not to secure reinsurance because the reinsurance premium is too high—or other elements of the agreement are not agreeable. Large commercial insurers may actually decline to write a particular risk because of reinsurance concerns.

The reinsurance marketplace experience cycles just as the standard insurance market does. For example, in the two years immediately following the terrorist attacks on September 11, 2001, total insurance losses in the industry exceeded $50 billion. Global equity values fell during this same time frame, resulting in capital losses of over $180 billion. A hard reinsurance market ensued because demand exceeded supply and reinsurance premiums rose sharply. In turn, this contributed to a slight hardening of the primary insurance market.

Some professionals believe the reinsurance market is softening due to the previously noted increase in reinsurance premiums and a notable lack of catastrophic losses in 2006—which experienced a mild hurricane season. In a report released by the Reinsurance Association of America (RAA) in March 2010, a group of 19 U.S. property & casualty reinsurers wrote $23.9 billion of net premiums in calendar year 2009, which showed neither an increase nor a decrease over 2008. The combined ratio for the group, however, improved to 93.5% from 101.8% in the previous year. In addition, policyholder surplus for the group increased to $77.3 billion from $64.4 billion.

Roughly half of reinsurance purchases are made through reinsurance brokers, while the remaining purchases are made directly with the reinsurance companies. The majority of reinsurance placements are not made with a single reinsurer but are shared between a number of reinsurers. The lead reinsurer establishes the contract terms and the premium and the following reinsurers participate in the transaction. Ceding carriers are very
careful when choosing their reinsurers because they are exchanging one form of risk for another: insurance risk for credit risk.

Some of the top global reinsurers include:
- Berkshire Hathaway/General Re, Reinsurance Group of America, and Transamerica Re (USA)
- Munich Re and Hannover Re (Germany)
- Swiss Re (Switzerland)
- SCOR (France)
- Everest Re, Partner Re, and XL Re (Bermuda)
- Syndicates at Lloyd’s of London (United Kingdom)
CHAPTER 8 REVIEW QUESTIONS

1. A *combined ratio* is calculated by comparing an insurance company’s ratio of losses and expenses to the _____.  
   [a] Premiums it collects in a particular year  
   [b] Claims it pays in a particular year  
   [c] Loss ratio  
   [d] Reinsurance premiums it pays in a particular year

2. All of the following are among the four major categories of risk that must be calculated to arrive at a general risk based capital amount for an insurance company EXCEPT ____.  
   [a] Asset Risk  
   [b] Credit Risk  
   [c] Speculative Risk  
   [d] Off-Balance Sheet Risk

3. All of the following are among the top three rating services that rate the financial strength of insurance companies EXCEPT ____.  
   [a] Standard & Poor’s  
   [b] Lloyd’s of London  
   [c] Moody’s Investors Services  
   [d] A.M. Best Company

4. The members of the National Conference of Insurance Guaranty Funds and the National Organization of Life & Health Insurance Guaranty Associations include the guaranty associations in all 50 states and ____.  
   [a] Puerto Rico  
   [b] The District of Columbia  
   [c] Puerto Rico and the District of Columbia  
   [d] Puerto Rico and Canada

5. The object of securing reinsurance is for an insurance company to reduce its exposure to ____ by transferring some of its risk to another insurance company.  
   [a] Underwriting risk  
   [b] Loss  
   [c] The economy  
   [d] Catastrophes
Chapter 9

MARKET CONDUCT ISSUES

What is “Market Conduct?” In general terms, it is a business’ pattern of behavior when executing its pricing and promotion strategies and its response to the needs and requirements of the market it serves. In the insurance industry, it is the methods used by an insurance company to distribute its products in the marketplace.

Although much regulatory attention has been focused on the market conduct of insurance companies and investment firms, along with their regulatory compliance, what about agents and producers? What about their market conduct?

Yes, state and federal laws exist to outline how producers and agents are supposed to behave. Agent/company contracts add still more rules and regulations. Ethical considerations further narrow the playing field of what are acceptable business practices. As the insurance and financial services industry becomes more regulated, agents and producers are required to spend more time complying and disclosing and documenting—which leaves them less time to do what they really want to do: get face-to-face with the consumer.

A recent AARP study reveals what consumers over age 50 want from the insurance and financial services providers. Of those surveyed:

- 59% doubt that bankers and insurance salespeople practice due diligence before offering a service for sale
- 66% believe that the states should be empowered to enact consumer protection laws that are stronger than federal laws
- 89% want protection from predatory practices such as excessive fees on mortgages and credit cards
- 90% want deceptive salespeople held accountable for their actions
- 92% believe investment companies should be required to disclose the costs, risks, and benefits of the financial products they market and sell, along with using plain language and user-friendly formats
- 93% believe consumers should be able to research an investment advisor’s background for professional misconduct
- 93% believe that 401(k) sponsors should be required to explain and clearly state fees on annual statements
- 96% believe banks should be required to explain the terms and conditions of loans, including mortgages and credit card debt, in plain language people can understand

It should come as no surprise that consumers want to be dealt with fairly and also want to avoid purchasing insurance and financial products (or anything, for that matter) from
individuals who lie, cheat, steal, or focus on self-interest rather than the interest of their clients.

Here are a few examples of “indiscretions” recently perpetrated by insurance agents and financial services professionals across the country:

- According to the L.A. Times, Los Angeles radio host John Farahi has been accused of swindling investors in a $20-million fraud scheme. The U.S. Securities and Exchange Commission has filed suit in federal court, alleging Farahi, his wife, and their company, of losing millions of dollars in “volatile investments” they promoted as safe. The SEC also claims the Farahis transferred clients’ funds to bank accounts under their control and also used clients’ money to build a multi-million dollar home in Beverly Hills. According to SEC allegations, investors were falsely informed they were investing in federally insured CDs, government bonds, and corporate bonds issued by companies backed by funds from the Troubled Asset Relief Program. Farahi, the host of a daily financial talk show called Economy Today, is said to have targeted the Iranian American community.

- According to the Insurance & Financial Advisor, a Florida insurance agent lost his insurance license because he and his agency earned over $100,000 in commissions from a “free lunch” annuity seminar scheme. He allegedly lured seniors into purchasing unsuitable and inappropriate annuities by inviting them to free meal deals and seminars. The state of Florida filed a three-count complaint against Mitchell Brian Storfer for misrepresentation, senior suitability, twisting, and fraudulent and deceptive annuity sales practices. Storfer requested a hearing to challenge the complaint but an administrative law judge recommended revocation of his license.

- The Stockton (CA) Record reports that life insurance agent Ghassan Ibrahim’s license was revoked by the state of California and he faces charges of fraud, theft, and violating California Insurance Code with respect to the marketing and sales of annuities to seniors. The insurance department investigators claim Ibrahim forged seniors’ signatures on insurance applications, created fictitious customers to complete additional insurance applications, and met with seniors claiming to update their living trust documents (although he had no expertise in this area) when what he really wanted to do was sell them annuities. This sales approach is illegal in California.

- A Waterbury, Connecticut insurance agent lost her license after being convicted of fraud relating to a plot with two other people to torch her car to collect the insurance payment from her insurer. Traci Lynn Mortagua surrendered her license to the state of Connecticut after being convicted of the felony, to which she entered a guilty plea of third-degree larceny.

- Both Minnesota and North Dakota revoked the resident and non-resident insurance licenses of Michael Antonello because he allegedly used fraudulent means to purchase 44 life insurance policies for one man, totaling $127 million. Six months after being charged, he consented to revocation of his resident Minnesota license and to that of the agency where he served as chairman; he and the agency were ordered to pay a fine of $250,000. His North Dakota non-resident license was suspended when that state learned of the action taken in Minnesota.
According to the Minnesota order, Antonello and his firm obtained excessive life insurance, made material misrepresentations on insurance applications, profited by selling life insurance policies to life settlement companies, forged a signature, and tried to do business on behalf of a company to which he was not appointed.

The previous examples all exhibit blatant behavior; it is doubtful any of the individuals who lost their insurance licenses honestly believed their actions were accepted business practices—or legal. Most insurance agents and producers wouldn’t engage in similar behavior. Yet these are the types of scenarios we see on the news, hear on the radio, and read about in magazines or online. These are the types of scenarios consumers fear and these are the types of scenarios that prompt regulatory action.

Market conduct examinations of insurance companies often result in fines for mistakes, oversights, and violations of insurance code that were not prompted by scenarios like those just cited. In order to be in compliance, a person or company needs to know what the rules are. And it’s tough, sometimes, knowing precisely what the rules are because there are so darned many of them!

Because so many insurance companies and agents are being reprimanded and fined, compliance has become a major issue in today’s insurance marketplace. While stating that a company or agent is “in compliance” on a brochure or web site may not seem to be a big deal, it can certainly help instill consumers with a degree of trust and confidence. If a consumer is “shopping” and an agent finds himself in competition with one or more agents, having a spotless record may make the difference in choice between insurance companies and/or agents.

Part of the obligation to exhibit due diligence entails an agent explaining why he chooses to do business with a particular company or companies; its financial strength is certainly one of the criteria, as is its compliance record. On the personal front, an agent will find it easier to acquire new insurance companies to represent if he has a clean record. A clean record is also usually a prerequisite to earning any type of business-related or industry honor or award. Advisors can refer consumers to the FINRA web site to “check them out.” In addition, state insurance departments often provide access to a listing of licensed agents, producers, and adjusters.

Steven McCarty is executive director of the National Ethics Bureau and his articles appear regularly in the Senior Market Advisor. He recommends to agents that they follow four steps to practicing good market conduct and meeting compliance requirements:
1. Commit yourself to ongoing client contact – Educate clients, respond quickly to their service requests, conduct periodic account reviews; communication is key
2. Become an excellent recordkeeper – Save copies of solicitation materials, meeting notes, needs analyses, illustrations and proposals, signed client authorizations and requests; documentation is necessary in the event a complaint or suit is filed
3. Get serious about protecting client privacy – Never disclose client information unless permitted by law; be sure to provide privacy notices and disclosures
4. Make sure your office technology doesn’t leak confidential information – Protect all client data on computers, paper records, wireless networks, and phone/fax systems; promptly report any breaches as required by law

His advice to agents? “When you adhere to best practices in solicitation, disclosure, suitability, and client service, you’ll never have to worry about your business blowing up on you—and taking your future with it.”

A Minneapolis financial services firm works with insurance companies to help them meet compliance when state regulators conduct market conduct exams. According to the firm of Wolters Kluwer Financial Services, the top ten criticisms cited in market conduct exams of insurance companies are:

1. Failure to acknowledge, pay, or deny claims within specified time frames
2. Failure to properly terminate a policy, including inadequate days’ notice and omission of required language
3. Improper documentation of claim files
4. Using unapproved or unfiled rates and/or rating errors
5. Failure to provide required disclosures (such as the selection, rejection, or coverage notices in the underwriting process or notices such as statute of limitations, reasons for denials, and bill of rights in the claims process
6. Failure to provide notification of producer appointments or terminations
7. Improper documentation of underwriting and policy files
8. Failure to communicate a delay in the settlement of claims in writing
9. Using unapproved or unfiled forms
10. Failure to produce requested records for an examination

In her interview with Claims, an online insurance magazine, Kathy Donovan, Senior Compliance Counsel with Wolters Kluwer, answered questions about market conduct exams and the research she has conducted. She stated that claims issues seem to be a targeted area of concern. Many insurance companies fail to provide sufficient documentation for their reasons for denials or to provide required notices and disclosures. In addition, many carriers are cited for using unlicensed adjusters and appraisers. Donovan stated that “Claims compliance violations seem to be perennial in nature” and that they require exhaustive internal resources to deal with examiner inquiries and corrective action plans. Repercussions for being out of compliance include the potential for significant monetary fines, restitution orders, and negative publicity when the findings are made public. The more noncompliance issues noted during an exam, the higher is the likelihood that the examiners will re-examine in the future.
Donovan suggests that companies can take charge in several ways to proactively solve market conduct issues. Self-audits, especially with respect to claims, may help companies recognize areas of concern before examiners arrive. Being familiar with the precise details of pertinent state insurance code and regulation will further help alleviate problem areas.

Three recent announcements emphasize the negative consequences of market conduct exams, all occurring in March 2010. In the first situation, the state of New York fined Axa Equitable Life Assurance Company $1,900,000 after its market conduct exam revealed that the insurance company made improper disclosures when consumers bought replacement annuities and life insurance policies. A number of other insurance code violations were noted, including failing to obtain written consent before subjecting applicants to tests for HIV, failing to use product comparisons as required by law, and those involving variable annuities. The second situation involved CIGNA Healthcare – Centennial State, Inc. The state of Colorado fined the insurer $32,000 for failing to provide required information before denying claims and failing to provide written denial signed by licensed physicians. Colorado also fined Aetna Health, Inc. and Aetna Life Insurance Company for multiple violations and the total of fines to both companies totaled $660,000. Aetna’s violations included providing missing, incomplete, or inaccurate information in policy forms, provider contracts, and certificates of creditable coverage; failing to pay claims on a timely and accurate basis; and failing to offer coverage under state-mandated basic plans to individuals whose small group coverage had been terminated/denied.

MARKET CONDUCT ANNUAL STATEMENT (MCAS)

The NAIC developed its first handbook for market conduct examinations in the 1970s, after which it performed its first market conduct exam. By 2002, nearly 1,500 market conduct exams had been performed by state insurance departments and nearly 500 combined financial/market conduct exams had been performed.

The National Conference of Insurance Legislators (NCOIL) Model Act was adopted in 2003, with the support of the NAIC, and includes a market conduct examiner’s handbook, collaborative interstate efforts, the appointment of market conduct coordinators in each state, and a data call project. Market analysis, collaboration, and uniformity are components of the program.

In 2002, the NAIC began collecting uniform market conduct-related data on its Market Conduct Annual Statement (MCAS). The MCAS provides insurance regulators with information they might not otherwise have available when performing their market initiatives. The MCAS helps promote consistent and standardized assessments when analyzing insurance companies.

According to the NAIC’s Market Analysis Procedures (D) Working Group, 29 states
participated in the 2009 data collection via the MCAS. Insurance companies writing in excess of a specific amount of premium in participating states are required to complete the MCAS. Data is collected using Microsoft Access 2003 or 2007 database and when the state sends the insurance company a call letter, the insurance company submits the information, as required.

Each insurance company receives a “report card” after submission of its MCAS. This report card helps the insurance companies achieve a clearer understanding of where they fit in the insurance marketplace because it includes statewide industry ratios to which it can compare its company ratios. It also helps the insurance companies identify opportunities to improve performance. Participation in the MCAS program does not guarantee that a Market Conduct Examination will occur or not occur.

The goals of the NAIC’s Market Conduct Examination Standards (D) Working Group for its Spring 2010 Meeting were to begin updates to the confidentiality sections in the *Market Regulation Handbook*. Regulators and insurers, alike, are very concerned about the confidentiality of information contained in the MCAS and Market Conduct Exam.

**NCOIL PROPOSED MARKET CONDUCT ANNUAL STATEMENT MODEL ACT**

In March 2010, the NCOIL submitted its Proposed Market Conduct Annual Statement Model Act to its State-Federal Relations Committee. The purpose of the Model Act is to establish exclusive procedures for the collection, analysis, and sharing of information on Market Conduct Annual Statements. The Model Act would apply to admitted insurance companies writing more than $100,000 of direct written premium in a jurisdiction in any of the following lines of business: certain individual and group life and annuity policies, private passenger auto policies, homeowner and renter policies, and other lines of insurance as determined by the state insurance commissioner.

The Model Act includes the following definitions:

- “Market Analysis” means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports and other sources in order to develop a baseline and to identify patterns or practices of insurers licensed to do business in this state pertaining to company operations and management, complaint handling, marketing and sales, producer licensing, policyholder services, underwriting, and claims. Such analysis may include, but is not limited to, practices that may pose a potential risk to the insurance consumer. Market Analysis does not represent standards for market behavior and does not establish compliance or non-compliance.

- “Market Conduct Annual Statement” or “MCAS” means the Market Conduct Annual Statement as adopted by the National Association of Insurance Commissioners (NAIC) and as amended by the NAIC from time to time in
accordance with the established procedures of that organization, provided that the MCAS and any changes thereto have been approved by the Commissioner.

If the state insurance commissioner opts to collect MCAS information, every insurance company to which the Model Act applies will have to file an MCAS. Designated statistical agents will be appointed by the commissioner for the purpose of collecting information. All information submitted by the insurance companies will be held as confidential by all parties with access to the information. The information will not be subject to subpoena or discovery, nor will it be considered as admissible evidence in a private civil action. It will also be held exempt from applicable freedom of information laws, public records laws, public records disclosures laws, and other similar statutes.

With the authorization of the commissioner, MCAS data and analysis may be shared with the following entities:
- State, federal, and international regulatory agencies; law enforcement agencies
  - Subject to the recipient’s compelling need to review the information and that the recipient agrees to, and has the legal authority to, maintain confidentiality of the information
- The NAIC, so long as it enters into written agreement with the insurance company to maintain confidentiality

MARKET CONDUCT EXAMS—GENERAL INFORMATION

According to a firm that assists insurance companies with compliance during market conduct exams, “Market conduct examinations harbor significant risks for most insurance companies because of the regulator’s focus on the business practices of insurers (and their producers) as well as the demand for evidence of compliance with all legal and regulatory statutes. In some cases, market conduct examinations include a look-back period of three to four years and even more. This delayed timing can pose a challenge to the insurance company due to staff turnover, acquisitions, and document retrieval. Regardless of the circumstances precipitating a market conduct examination, the outcome of a market conduct examination is generally expected to be more positive for the insurance companies that are organized and responsive, providing easy access and thorough, accurate data, throughout the process.”

In 2002, President Bush signed the Sarbanes-Oxley Act of 2002 (SOX) into law. He called it “the most far-reaching reforms of American business practices since the time of Franklin Delano Roosevelt.” According to the SEC, the Act mandated a number of reforms to boost corporate responsibility, enhance financial disclosures, and fight accounting and corporate fraud. It also created the Public Company Accounting Oversight Board (PCAOB), which oversees the behaviors of the auditing profession. SOX is commonly known as Congress’ response to a number of major accounting and corporate scandals, including Enron, Tyco International, Adelphia, Peregrine Systems, and Worldcom. Collectively, these scandals cost investors billions of dollars and undermined public confidence in the U.S. securities markets. The NAIC has amended its
model regulation to include requirements of the Sarbanes-Oxley Act.

Market conduct exams are not always conducted because complaints are received. State insurance regulators are required to routinely examine domestic insurance companies on a regular basis, usually every five years. Therefore, a market conduct exam is quite often simply a regulatory instrument required by state legislation. Market conduct exams review the following, depending upon the type of exam and the reason precipitating it:

- Operations and Management
- Complaint Handling
- Producer and Adjuster Licensing
- Policyholder Services
- Underwriting and Rating
- Claims

In addition, if a market conduct exam is performed because of a specific allegation against an insurance company, the focus of the exam may be on a particular line of business or a particular business practice. During the exam, a broad range of company and market information will be collected and analyzed to help identify problems. Many states also conduct market conduct exams with respect to self-insured employers and workers’ compensation insurance and claims.

Failure on the part of insurance companies to meet compliance during a market conduct audit can generate fines, penalties, and public exposure. Insurance producers, especially independent agents and agencies, need to know precisely how their insurance companies are performing with respect to market conduct. With the current condition of the economy, it has never been more important for a producer to exhibit his own ethical conduct and that of his insurance company(-ies).

MARKET CONDUCT EXAMS—INDIVIDUAL REPORTS

Many states publish reports concerning their market conduct exams. Some states publish the legal actions, orders, and fines assessed—others do not. To illustrate the types of market conduct issues arousing the interest and concern of regulators and consumers, details of randomly selected published reports obtained on the state’s web sites follow.

WEST VIRGINIA


- Market conduct exam was instituted because it was found by the state to have committed unfair claims settlement practices
- Report of Market Conduct was filed on July 31, 2009 and copies were sent to St. Paul; the report included violations of WV Insurance Code
- In August 2009, St. Paul responded and did not dispute certain facts contained in the
report; it also waived notice of administrative hearing

- The report also found violations of two other WV state rules but, because the infractions were considered to be “minimal in nature,” the state did not impose fines or penalties
- No intentional misconduct by St. Paul was found to be exhibited
- Only third-party claims were reviewed and findings in the report were limited to third-party claims
- St. Paul and the state of West Virginia entered into an Agreed Order and to the imposition of corrective action and an administrative penalty
  - St. Paul agreed to cease and desist from failing to comply with statute concerning claims as outline in the order
  - St. Paul agreed to continue to monitor compliance with particular sections of WV Insurance Code and provide reports of compliance to the state
  - St. Paul’s Board of Directors will each submit affidavits stating under oath that they’ve received copies of the Report of Market Conduct Examination and the Order adopting the report
  - St. Paul agreed to review 239 claims that were not part of the exam to determine if they require further action; if further action is required, St. Paul will re-open the pertinent files and complete the investigations
  - St. Paul agreed to send communication to all claims offices reinforcing the need for proper documentation of claims
  - St. Paul agreed to file a Corrective Action Plan with the state of WV
  - St. Paul agreed to pay an administrative penalty of $15,000

SAFE INSURANCE COMPANY—EXAMINATION PERIOD ENDING DECEMBER 31, 2006

- Market conduct exam was instituted according to state insurance code
- Report of Market Conduct was filed on February 14, 2008 and copies were sent Safe
- Safe responded March 6, 2008 and disputed facts contained in the exam
- It was ordered that Safe’s Board of Directors will each submit affidavits stating under oath that they’ve received copies of the Report of Market Conduct Examination and the Order adopting the report
- The only recommendations made in the report were
  - That the Company adopt and implement a procedure to annual reconcile their agent list with the list maintained by the state’s insurance commission, and
  - That the Company send appointment cancellation letters to producers whose licenses are canceled by the insurance commission except in the case of death
- No regulatory action was taken and no fines or penalties were imposed

MASSACHUSETTS

BOSTON MUTUAL LIFE INSURANCE COMPANY—EXAMINATION PERIOD ENDING DECEMBER 31, 2007

- Market conduct exam was instituted according to state insurance code
• Report of Market Conduct was filed on October 6, 2008
• Although recommendations were made, no violations of NAIC standards were found

ONE BEACON AMERICA INSURANCE COMPANY—EXAMINATION PERIOD ENDING JUNE 30, 2007

• Market conduct exam was instituted according to state insurance code
• Report of Market Conduct was filed on October 24, 2008
• Although recommendations were made, no violations were found

MISSOURI

AMERICAN HERITAGE LIFE INSURANCE COMPANY—EXAMINATION PERIOD ENDING DECEMBER 31, 2005

• Market conduct exam was instituted according to state insurance code
• Report of Market Conduct was filed on August 7, 2009
• The report found 17 areas of concern, including the company’s:
  o Failure to maintain a producer appointment register in accordance with state insurance code
  o Failure to include two complaints in its complaint register
  o Failure to appoint producers properly and maintain proper records concerning producers (including 9 producers without proof of licensing or with incorrect names)
  o Denial of a credit life claim because of a pre-existing condition that had nothing to do with the death of the policyholder
  o Use of advertising that contained incorrect Missouri-specific coverage and/or limitations
  o Use of policy language that did not conform to Missouri law with respect to its suicide provision
  o Use of insurance application that permitted questions about AIDS or HIV without also asking questions about other major illnesses and conditions
  o Use of tobacco rate classifications to applicants under the age of 19, which violates Missouri law; furthermore, the policy does not contain provisions explaining how tobacco rate classifications may apply when the insured attains age 19; advertising at the time of sale does not inform the applicant about how tobacco rate classifications apply; policy rate form filings did not contain contractual language pertinent to this issue
  o Failure to pay over $4,000 of unearned premium and interest for credit disability insurance when paying three credit life claims; four additional instances involved the company issuing unearned premium refunds to the creditor rather than the appropriate beneficiaries or estates
  o Denial of the existence of claim reports before subsequently providing them after examiners identified their existence and location
  o Failure to acknowledge 29 claims within the required 10 working days
  o Failure to investigate four claims in timely manner and notify first-party claimants of the reason for delay
• Failure to pay or deny 20 claims in a timely manner
• Cancellation of LTC coverage on two policies before the renewal date and failure to refund unearned premium

• The company did not agree with all of the previous charges but did agree to take corrective action to prevent future recurrence of the errors noted
  • It also agreed to file an endorsement to certain policies regarding the insured’s right to receive non-tobacco rates

• The company agreed to file documentation of all remedial actions taken to implement compliance

• The company neither admitted nor denied the findings and violations found in the exam, it stated its position that it compromised with respect to disputed factual and legal allegations, and agreed to pay a fine to resolve disputes and avoid litigation

• The company agreed to pay fines totaling $93,905.50

COUNTRY CASUALTY INSURANCE COMPANY & COUNTRY MUTUAL INSURANCE COMPANY—EXAMINATION PERIOD ENDING DECEMBER 31, 2008

• Market conduct exam was instituted according to state insurance code
• Report of Market Conduct was filed on April 22, 2009
• Although recommendations were made, no violations were found

WISCONSIN

NATIONAL GUARDIAN LIFE INSURANCE COMPANY—EXAMINATION PERIOD ENDING FEBRUARY 28, 2009

• Market conduct exam was instituted in order to verify compliance with recommendations made in a previous market conduct exam in 2004
• Report of Market Conduct was filed on February 25, 2010
• The previous exam noted 6 recommendations in the areas of advertising, producer licensing, and underwriting that required compliance; the current exam noted that compliance was met for all 6 recommendations

• Five new recommendations were written in the areas of policy forms, advertising, and underwriting; examiners found numerous instances where policy forms did not comply with Wisconsin insurance code

• The report was prepared on an exception basis and was limited to a review of company operations, management, sales and advertising, policy forms, policyholder services and complaints, prearranged funeral plans, producer licensing, and underwriting new business and replacement

SENTRY INSURANCE COMPANY—EXAMINATION PERIOD ENDING NOVEMBER 18, 2005

• Market conduct targeted exam was instituted to determine whether the company’s practices and procedures comply with Wisconsin insurance code

• The examiners closely examined auto insurance underwriting, homeowner insurance
underwriting, and terminations for workers’ compensation policies because the company had previously experienced four legal files that were adjudicated against them in these areas

- The report was prepared on an exception basis
- A total of 22 recommendations were made concerning modification of certain forms, underwriting, and rating procedures, producer licensing processes, and claims handling procedures
- It was recommended that the company identify more precisely the reason for its consistent above-average number of complaints
- Of the 22 recommendations, 12 pertained to underwriting
- Of the 22 recommendations, 6 pertained to claims
- Of the 22 recommendations, 4 pertained to producer licensing

OKLAHOMA

THE MEGA LIFE AND HEALTH INSURANCE COMPANY—EXAMINATION PERIOD ENDING DECEMBER 31, 2007

- Market conduct exam was instituted according to state insurance code
- Report of Market Conduct was filed on March 25, 2009
- The report noted the following insurance code violations in its summary:
  - Error ratio of 10.6% in Consumer Complaints (15 inquiries)
  - Error ratio of 41% in Advertising (14 of 34 items submitted for review)
  - Error ratio of 86.2% in Producer Licensing (25 files)
  - Error ratio of 4% in Policyowner’s Service (3 errors)
  - Underwriting – 6 policy forms failed to provide mandated coverage for OB/GYN exams
  - Claims Practices – 2 life claims didn’t have proof of loss forms released within 10 days after receiving notice
  - Error ratio of 26.2% in Claims Practices (241 claims for mammography expense paid less than the mandated amount)
  - Life Claim Handling – none of the 104 life claim files utilized the approved forms to establish proof of death
  - Error ratio of 35.5% in Health Claims Handling
    - 22 claims had errors on EOBs concerning application of co-insurance
    - 42 claims had errors on EOBs concerning application of deductibles
    - 5 claims were not paid according to mandate with respect to OB/GYN exams
    - 2 credit disability claims had errors on EOBs concerning how benefits were determined
    - 9 EyeMed claims were incomplete
    - 2 dental claims were not paid in accordance with contract provisions

GEICO GENERAL INSURANCE COMPANY—EXAMINATION PERIOD ENDING DECEMBER 31, 2006

- Market conduct exam was instituted according to state insurance code and was
limited in scope
• Report of Market Conduct was filed on October 22, 2007
• Of the 125 claims that were randomly selected for review, it was noted that 5 company forms did not contain the required fraud warnings

COLORADO

ALLSTATE INSURANCE COMPANY—EXAMINATION PERIOD ENDING DECEMBER 31, 2004
• Targeted Market conduct exam was instituted according to state insurance code and covered specific file handling during the examination period
  o The examination was triggered by an investigation conducted by the CO Division of Insurance as a result of a complaint that the company was inappropriately delaying the payment of Personal Injury Protection (PIP) claims without providing notice
  o Information provided by Allstate indicated that all claims in question were related to a Special Investigation Unit’s investigation of possible fraud by a medical provider
  o Only PIP claims file handling was examined
• Report of Market Conduct was filed on July 29, 2005 and was written by exception
• 29 claims files were reviewed for compliance
• 3 claims indicated findings involving a lack of compliance with state insurance code and pertinent recommendations were made

NEW ENGLAND LIFE INSURANCE COMPANY—EXAMINATION PERIOD ENDING
• Market conduct exam was instituted according to state insurance code and was limited in scope
  o The purpose of the examination was to determine the company’s compliance with CO statute and with generally accepted operating principles related to small group sickness and accident insurance laws
• Report of Market Conduct was filed on May 26, 2006 and was written by exception
• The examination resulted in a total of 47 findings in which the company did not appear to be in compliance with CO insurance code
  o 4 areas of concern in Company Operations/Management
  o 28 areas of concern in Policy Forms; the most frequently sold small group coverage forms were noted, along with violations of provisions for mandated coverages
  o 4 areas of concern in Applications
  o 1 area of concern in Cancellations/Non-Renewals/Declinations
  o 4 areas of concern in Claims Handling
  o 4 areas of concern in Utilization Review
KANSAS

SAFECO INSURANCE GROUP—EXAMINATION PERIOD ENDING JUNE 30, 2006

• A Targeted Market conduct exam was instituted according to state insurance code and reviewed underwriting files, claims, and complaints
• The examiners indicated that no findings warranted follow-up, fines, and/or penalties
• The Executive Summary states: “The Company passed most tests; and in terms of delivering good service to its insureds, the examiners were impressed with the overall positive and very professional performance by the Safeco staff and management to their policyholders. The exam team has made recommendations on several issues.”

UNIVERSAL UNDERWRITERS INSURANCE COMPANY—EXAMINATION PERIOD ENDING JUNE 30, 2007

• A Targeted Market conduct exam was instituted as a follow up to a 2005 marked conduct examination that identified certain deficiencies and the company was ordered to make restitution to policyholders and implement changes to its underwriting and rating practices
• The examiners stated in their report: “The company passed all rating and underwriting tests, and the examiners were impressed with the overall positive and very professional performance by the UUIC staff and management.”
  • While the examiners issued no future recommendations, they did cite two recommendations on several complaint handling issues

MARYLAND

UNUM LIFE INSURANCE COMPANY OF AMERICA—EXAMINATION PERIOD ENDING DECEMBER 31, 2006

• A Targeted Market conduct exam was instituted according to state insurance code regarding its LTC business in the state
• Report of Market Conduct was filed on July 20, 2009
• The Executive Summary stated, “The examination identified certain non-compliant practices, some of which may extend to other jurisdictions. The Company is directed to immediate corrective action to demonstrate its ability and intention to conduct business in Maryland according to its laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.”
• Violations noted in the examination included:
  • The company failed to issue appointment notifications to 4 producers
  • The company processed a claim payment beyond 30 days of its receipt
• Unum agreed to correct the violations within 90 days of the execution of a Consent Order
• Unum was fined $4,000
STATE FARM COMPANIES—EXAMINATION PERIOD ENDING MARCH 31, 2008

• A Targeted Market conduct exam was instituted according to state insurance code regarding the private passenger automobile and personal property homeowner’s lines of business to determine if the companies’ underwriting practices comply with Maryland insurance code

• Report of Market Conduct was filed on March 12, 2010

• The Executive Summary stated, “The examination identified certain non-compliant practices, some of which may extend to other jurisdictions. The Company is directed to immediate corrective action to demonstrate its ability and intention to conduct business in Maryland according to its laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.” (Emphasis was included in the Executive Summary.)

• In general, ten violations of Maryland insurance laws and regulations occurred:
  o Failure to clearly and specifically state the reason for policy cancellation
  o Failure to maintain documentation that notice of cancellation or non-renewal was issued (Auto)
  o Failure to maintain documentation that notice of non-renewal was issued (Homeowner)
  o Failure to issue notice of proposed action by certificate of mailing or with proof of mailing (Auto)
  o Failure to issue notice of proposed action by certificate of mailing or with proof of mailing (Homeowner)
  o Refusal to renew insurance based on an inquiry that did not result in the payment of a claim
  o Failure to provide the required 45 days notice when terminating a policy
  o Failure to offer the named driver exclusion on a policy where more than one individual is insured
  o Issued policies with premiums greater that than determined under the filed rating plan
  o Failure to provided the required 45 days notice for auto policy renewals

• State Farm admitted to the violations, subject to its responses as set forth in Exhibit I in the Administration Report, but denied liability to any third party as a result of the violations

• State Farm agreed to correct the violations within 90 days of the execution of a Consent Order

• Unum was fined $175,000

MARKET CONDUCT EXAM SUMMARY

While the preceding market conduct examination results are, admittedly, a random selection of those examinations made available to the public by a limited number of states, they clearly indicate the market practices of insurance companies that are a) being reviewed by state regulators, and b) generating a call for corrective action.

Insurance producers often tend to innocently believe that everything they are told by their
insurance companies is accurate and legal. As can be seen by these market conduct examinations, insurance companies are not perfect, often make mistakes, and overlook following procedures that are required by insurance code. In addition to confirming that an insurance company is financially sound, a producer should also verify the market conduct practices of his insurance companies in order to preserve his own reputation and for the protection of consumers.
CHAPTER 9 REVIEW QUESTIONS

1. Market conduct examinations often result in fines for which of the following?
   [a] E & O claims
   [b] High loss ratios
   [c] Violations of insurance code
   [d] Employment Practices claims

2. All of the following are among the top ten criticisms cited in market conduct exams of insurance companies EXCEPT _____.
   [a] Using unapproved or unfiled forms
   [b] Failure to acknowledge, pay, or deny claims within specified time frames
   [c] Failure to use unfiled rates
   [d] Improper documentation of claims files

3. _____ developed its first handbook for market conduct examinations in the 1970s.
   [a] The SEC
   [b] FINRA
   [c] The NAIC
   [d] Congress

4. NCOIL’s Proposed Market Conduct Annual Statement Model Act would apply to admitted insurance companies writing more than _____ of direct written premium.
   [a] $10,000
   [b] $100,000
   [c] $1,000,000
   [d] $10,000,000

5. Market Conduct exams review which of the following?
   [a] Producer and adjuster licensing
   [b] Reinsurance
   [c] Combined ratios
   [d] Market Conduct Annual Statements
AVOIDING E & O TRAPS

Depending upon an insurance producer’s Errors & Omissions carrier, a producer will hear all kinds of statistics and advice with respect to E & O claims: how many agents will be sued in a given year, why they’re being sued, and how to avoid litigation. As the insurance industry grows and changes, some of those statistics change; many of them remain the same.

It has been proven that people do business with people they like and/or trust. An agent’s relationship with his clients, regardless of his role within the insurance industry, is essential to maintaining his reputation, income, and NO E & O loss experience. It has also been proven that agents interacting with their clients 4-6 times per year have higher client/customer retention than those who interact with their clients fewer times a year. They also fall prey to E & O claims less often than agents who don’t have regular and ongoing relationships with their clients.

Here are some of the things an agent can be saying to, and doing for, his clients that will not only help strengthen the relationship with them but will also provide them with the best possible insurance protection they care to purchase. It will also help prevent E & O losses!

• Call the client before his policy renews to verify that everything is in order and that he has coverage and limits to cover his needs
  o Inform the client about all discounts offered by his company(-ies)
  o Offer him coverages he hasn’t purchased
  o Offer him higher limits – *along with pricing*
  o Offer him other lines of coverage he hasn’t purchased
  o **Document** the conversation

• When processing a policy change for the client:
  o Inform him of all discounts offered by his company
  o Offer him all coverages he hasn’t purchased
  o Offer him higher limits – *along with pricing*
  o Offer him other lines of coverage he hasn’t purchased
  o Be sure to obtain the client’s written authorization for the change—not just when reducing or cancelling coverage but when increasing or adding coverage, as well

• When a client calls with ANY service request, always pull his account up on the computer (or pull the file if they are maintained on paper instead of in computer files or databases). Review coverages and limits requiring attention, note lines of insurance not written through the agency, and scan the most recent transactions between the client and the agent/agency.
Many agents and producers believe that if they discuss these items, their clients will think the agent being pushy. In reality, clients appreciate the time and attention received.

If clients do object to the agent bringing these topics up, perhaps it’s more the agent’s approach than it is the content the client is objecting to.

- Periodically ask clients how the agent/agency is doing—either during a conversation or in a note, letter, or card. Ask for referrals; if they give the agent/agency a good grade; ask for improvement suggestions if they don’t give the agent/agency an A+.
  - Clients want to be appreciated; they want to know that they matter to their agent. If the agent doesn’t appreciate them, they’ll eventually find an agent who does.
  - When clients KNOW they’re appreciated, they send referrals.

- Any time a client makes a payment—either in person or over the phone, an agent should use the opportunity to THANK him, ask him if he has any questions about his insurance account, and offer to provide more information.

Agents who appreciate their clients, who handle insurance transactions properly, and who know their stuff, suffer fewer E & O losses than agents who don’t do those very same things. Why? Because they have better relationships with their clients and have taken the time and care to build a strong foundation of trust and confidence.

Information provided in this chapter has been obtained directly from insurance agent Errors & Omissions carriers to provide producers with the most up-to-date information and statistics available. Of course, following advice and paying attention to hints and tips doesn’t guarantee a producer protection from litigation or E & O claims. Following advice and understanding why insurance agents are sued does reduce the likelihood a producer will suffer from an E & O claim.

STATISTICS

In recent years, just over 40% of all agent E & O claims stem from personal lines. The most commonly occurring lines of business include flood, auto, homeowner, inland and wet marine, and umbrella. The majority of personal lines claims were attributed to:

- Uninsured or Underinsured Motorist Bodily Injury
  - Not offering limits at the Bodily Injury limit
  - Not obtaining required rejections or reduction waivers from all named insureds
  - Not obtaining required rejections or reduction waivers at all

- Auto Physical Damage (Collision and/or Comprehensive)
  - Not documenting that coverages were offered
  - Not documenting that coverages were accepted or declined and at what pricing

- Homeowner
o Property losses are the subject of the majority of E & O claims
  ▪ Valuation
    • NO building valuation was completed
    • Building valuation was not thoroughly or accurately completed
  ▪ Agent failed to inspect the property
    • Failed to note, and adequately insure, pools, outbuildings, and ongoing construction
    • Failed to note nearby bodies of water which resulted in future flood/water claims being denied on the policy

o Liability issues
  ▪ Agent failed to note the presence of pools or trampolines
  ▪ Agent failed to note the presence of dogs
  ▪ Agent failed to note the presence of business being conducted on the premises

Although personal lines claims occur more frequently than commercial lines claims, commercial lines claims, on average, are two or more times greater than personal lines claims. In the beginning of 2008, one national insurer of agent E & O insurance predicted that the top four lines of business that would likely generate a future E & O claim were:
  1. Commercial General Liability
  2. Personal Auto
  3. Homeowner
  4. Workers’ Compensation

One national insurer of agent E & O insurance reported the top claims submitted in 2007 were:
  • Additional Insured Endorsements
    o Lack of authority
    o Failure to submit
    o Wrong endorsement coverage form
    o Completed operations not covered
  • Certificates of Insurance
    o Issued when policy was not in force
    o Incorrect coverage was certified
    o Although notice of cancellation was completed, the agent did not notify certificate holders
  • Homeowner
    o Underinsurance
      ▪ Only insured the loan value
      ▪ Undervaluation of home to reduce premium
      ▪ Valuation form not accurately completed
    o Misrepresentations on application
      ▪ Not completed correctly
      ▪ Not signed by the applicant
• Failure to disclose home businesses, heating appliances, or homes held for rental

• Placement Through Wholesalers
  o Agent did not comply with his duty to the insured; wholesaler doesn’t have the duty to disclose—the agent does
  o Unexpected terms
  o Overlooked subjectivities/requirements
  o Failure to understand policy exclusions and limits
  o Application issues
    ▪ Information not verified, but carried forward from previous years’ applications
    ▪ Material facts known by agent and not disclosed
    ▪ Scrivener errors (copied info incorrectly from previous policies and applications)

• Workers’ Compensation
  o Policy cancelled for non-payment of premium and not replaced
  o Agent binds coverage and doesn’t realize policy is not issued/bound by company because State Fund or NAIC discovers employer owes money to prior carrier
  o Out of state coverage not properly addressed (this issue created the insurer’s most complex workers’ compensation E & O claims)
  o Coverage C – excludes monopolistic states and agent isn’t aware of this issue
  o Claims for lack of coverage were amplified by the employer’s exposure to suits, shutdowns, and fines

• Group Health
  o Failure to place coverage with an approved carrier
  o Multiple families with serious health issues

• Individual Health
  o Agent doesn’t disclose waiting periods or other conditions and exclusions

• General Agency Practices
  o Agent’s failure to document:
    ▪ Advice
    ▪ Offering of specific coverages
    ▪ Offering higher limits
  o Advertising material asserts agents or staff are experts or that they will handle all the client’s needs
  o Failure to report known claims
  o Misreported claims (agent reports to the wrong carrier)
  o Failure to place requested coverage
  o Failure to detect an error

Another national insurer of agent E & O insurance reports these claims statistics for 2009:

• 51% of its claims were for failure to obtain proper coverage—this appears at the top of the list for the 15th year in a row
• 7% of its claims were for failure to give proper advice
• 5% of its claims were for failure to place coverage after agreeing to do so
• 4% of its claims were for failure to renew or service policies
• 3% of its claims were for delaying to forward loss reports

The majority of agent E & O claims are submitted because of the actions of producers—not customer service representatives. The reason may be the result of the fact that producers are out in the field much of the time, and not sitting in front of a computer or with a pen and paper in hand. Regardless, the majority of E & O claims result directly from the agent’s failure to document the details of the transaction that forms the basis for the claim.

TRENDS

Different E & O insurers report different claims trends because of a number of factors: their underwriting practices, their market concentration of agents (i.e. life/health agents versus property/casualty agents), past claims, etc. In the current marketplace, agents who are properly trained and who regularly attend insurance education courses tend to be sued less often than those agents who are either not trained or who attend only the education courses required by the state for them to renew their licenses. Years ago, the existence of an office procedures manual was the biggest deterrent to agent E & O claims. Now, it’s education.

What are some of the trends that seem to be appearing in the insurance agent’s E & O marketplace?

MISUSE OF CERTIFICATES OF INSURANCE

Only licensed agents should issue certificates of insurance. They should also be extremely careful to include proper coverages and limits. Many E & O claims have resulted from the agent’s failure to confirm that a policy is actually in force before issuing a certificate of insurance. Information used for completion of the certificate should always be obtained from the current policy and not a previously issued certificate.

Another problem that arises from the issuance of a certificate of insurance involves language concerning the addition or inclusion of an Additional Insured endorsement. If a certificate holder requests to be added as an Additional Insured (AI), and the client confirms he wants the certificate holder added to the policy on an AI endorsement, it is imperative for the agent to confirm several facts. First, precisely what type of AI endorsement is required? Adding the AI on the wrong endorsement form creates an E & O exposure for the agent and a number of complications for the insured, not to mention the certificate holder. Using language on the certificate that is not policy language is another issue because it does not bind the company. Then there’s the fact that many insurance companies charge a premium for adding certain types of AI endorsements. Finally, the issue of mailing a copy of the certificate can raise a very tricky situation.
Although most agent/company contracts require the agent to mail copies of all certificates, binders, and additional insured endorsements issued by the agent, many underwriters and other staff of the insurance company claim they don’t need copies mailed. Technically, a certificate listing an additional insured requires a change endorsement to be issued, so that has to be mailed to the company. Depending upon who is required to provide the certificate holder advance notice of cancellation—you know, the endeavor to provide notice clause on the certificate?—if the company doesn’t have a copy of all certificates issued, how can they issue notice? If the agent is responsible for providing notice, he should keep a log of all certificates issued so that notices can be sent when policies are cancelled or are pending cancellation.

**FLOOD INSURANCE**

Although property policies have excluded coverage for flood damage for years, many consumers are unaware of this fact. Many agent E & O claims arise from the fact that consumers claim their agents never told them flood or water damage was excluded from their property policies OR that they advised flood insurance was available. The easiest way for an agent to combat this issue is to include a flood brochure in with the mailing (or delivery) of the property policy and to document that the brochure was provided.

But that’s not the only issue with flood insurance. Many agents have incomplete or inaccurate understandings of coverage, primarily because they don’t write much flood insurance. Two big issues involve the definition of *flood* and flood zones.

FEMA and the National Flood Insurance Program (NFIP) define flood as *A general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties (at least one of which is your property) from: Overflow of inland or tidal waters; Unusual and rapid accumulation or runoff of surface waters from any source; Mudflow*; or Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels that result in a flood as defined above. *Mudflow is defined as A river of liquid and flowing mud on the surfaces of normally dry land areas, as when earth is carried by a current of water...*

When spring rains pour down for forty days and forty nights, rendering the consumer’s front and back yards into sponge-like states, the condition does not constitute flood unless all the conditions in the italicized definition above apply. Agents and producers should also note that a flood policy does not pay for flood damage unless the conditions causing damage are declared a flood by FEMA.

Another issue has to do with flood zones. Agents have advised consumers they are not eligible for flood policies unless their properties are located in flood zones. Well, everyone’s property is located in a flood zone. Some areas have a higher probability of flooding than others, but every piece of property is eligible based on location—*if it’s located in a participating community*. Only property owners in communities participating in the NFIP are eligible for coverage, regardless of their proximity to bodies of water or the likelihood of suffering flood damage. Property located in areas less likely
to flood are eligible for Preferred policies, which generate much lower premiums than those with eligibility for Standard policies.

The final area of concern with flood insurance agent E & O claims has to do with limits of liability. The Regular and Emergency programs include maximum limits of coverage, such as $250,000 for personal dwellings and $500,000 for commercial buildings. Agents have been known to advise consumers that these limits are the maximum amounts of coverage available. They may be the maximum limits offered by the NFIP or a Write Your Own carrier, but excess flood insurance IS available. If a client owns a $500,000 home, he may purchase the first $250,000 of coverage from the NFIP or a WYO and the balance of coverage on an excess flood policy.

**FAILURE TO DOCUMENT**

Regardless of the reason an agent receives an E & O claims, the vast majority of the time an agent is on the losing end of a claim or suit it’s because he was unable to document his position. Failure to document was the leading reason E & O claims were paid in 1988 and it’s still the leading reason E & O claims are paid.

Without written documentation to support his case, the average insurance agent will find the judge siding with the insured. In many states, if a case goes to trial, the jurors only receive copies of evidence to review—they don’t receive copies of verbal testimony. If the agent possessed written documentation to support his position, it would be passed along to the jurors. If the agent relied on his memory to support his position, nothing tangible would be provided to the same jurors.

Consistency is also important when it comes to documentation. Can an agent show that he records all incoming phone calls? Can an agent show that he saves all client e-mails and correspondence? Or are his efforts at documentation hit and miss? Does he only record phone calls received on the office phone but not those received on his cell phone? Does he only document details of meetings that take place at the office and not those that take place on the golf course or at a restaurant?

Checklists are another great documentation tool. Each line of insurance should have its own checklist for new business and renewals. When a client purchases new insurance, or secures a renewal, the items on the checklist should be reviewed and marked off when they are addressed. If it is possible to secure the insured’s signature or initials, and the date, that simply makes the agent’s documentation more credible.

All changes should be documented, even those requiring the addition of coverage. Agents should also document offers of coverage and any pricing that accompanies the offer. An excellent way to document a coverage offer is to have the consumer initial and date a proposal or illustration. One agent has a practice of providing two proposals or quotes for her clients. If an auto client, for example, wants a quote with minimum liability limits and collision and comprehensive with $500 deductibles, she provides a proposal with precisely those coverages and limits. She also provides a proposal showing higher liability limits, deductibles at both $250 and $1,000, and additional
coverages, such as Uninsured Motorist, Underinsured Motorist, Medical Payments, Towing, and Rental Reimbursement. She requires the consumer to circle the coverages and limits he wants to purchase and/or to cross off of those he doesn’t want. Either she retains all proposals in the consumer’s paper file or she scans them into the computer.

MISTAKES

Curtis Pearsall, who spent 29 years working for Utica National and is a noted authority on insurance agent E & O coverage, has been asking insurance agents this question for years: Are you good, or are you lucky? Many insurance agents believe they’ve never been sued because they’re “good.” And maybe they are. But what if they’ve been luckier than they’ve been good?

Everyone makes mistakes—even “good” insurance agents. One of the biggest trends Curt Pearsall has noticed is that agents who don’t learn from their mistakes are far more likely to suffer from the submission of repeat E & O claims than agents who learn from their mistakes.

OTHER ISSUES

PROMISES

There are times when agents make promises. Promises that the policy will do this or that, promises that a claim will be paid, promises that a refund will be issued, and promises of future service. An agent can get himself into trouble either intentionally or unintentionally by misquoting policy coverages or limits, providing incorrect facts about coverage, and offering assurances that are outside his authority.

Another promise an agent should avoid making is that coverage will begin immediately. The binding of coverage depends upon so many things: the type of coverage (workers’ compensation, life insurance, etc.), whether a premium has been paid with the application, the agent’s binding authority, etc.

ADVERTISING AND MARKETING MATERIALS

Many insurance companies require that their advertising and marketing materials and brochures receive their stamp of approval before being published or distributed. An agent can find himself sued for a host of offenses when deciding to create his own sales and/or marketing material.

Using a logo or other symbol that is protected by copyright or trademark without the owner’s permission is illegal. A number of personal injury offenses concerning copyright and trademark infringement are specifically excluded on both general liability and E & O policies. If an agent makes a false claim in his advertising, even if it’s unintentional, he can find himself in violation of both insurance code and other laws.
Proposals and illustrations, especially life and health illustrations (including those for annuities and LTC products), must be prepared according to state and other regulations. If an agent opts to prepare his own, personalized version of a life of health illustration, he may be looking at a lawsuit.

CLAIMING EXPERTISE

Although many agents are exceedingly knowledgeable and possess the insurance designations to prove it (i.e. CIC, CLU, CPCU, AAI, CFP), claiming to be an expert or to have expertise often backfires. The higher the level of knowledge and professionalism an agent claims to possess, the higher standard of care he will be held to in the event of a client dispute or claim. If a consumer walks away from a meeting with an insurance agent who claims to be an expert in the field of property insurance, and later suffers an uninsured loss because he didn’t understand all the exclusions in his homeowner policy, he is far more likely to prevail in an E & O claim against the expert than he is against a producer with a year’s experience in the insurance industry.

E-MAILS

Although e-mail messages and other forms of electronic correspondence have the advantage of speed and convenience, treating them with less attention and care than traditional forms of paper correspondence can be dangerous. E-mails are considered, in the legal arena, to be as binding and acceptable as a letter or fax.

Not only do most states recognize the employer’s right to oversee the security and content of e-mail messages, they do not recognize an employee’s expectation of privacy or confidentiality when e-mailing at work. If an agent mails a letter to an individual, it is the only copy floating around in the world—unless the agent made duplicates before mailing or unless the recipient makes duplicates after receiving it. E-mails can be intercepted during transmission, they can be sent to the wrong person(s), and they can be forwarded by any number of people.

When using e-mails to document insurance transactions, an agent should save the e-mail in its entirety (including all headers), as he would a paper letter or fax. E-mails can either be printed and filed or saved in electronic format in a computer file. E-mails should also be attended to as if they were telephone calls or visits. Leaving an e-mail unattended in the agent’s Inbox is the same thing as leaving a voice mail message unanswered on a telephone.

OFFICE PROCEDURES MANUALS

Most insurance agencies publish procedures manuals to ensure consistent standards of operation. They often contain workflows, rules, regulations, and guidelines to assist the agents and customer service representatives in the execution of services provided to clients. Procedures manuals can also be used as records and evidence in court.

Consistency is one of the most important elements of establishing and using a procedures
All employees should be required to comply with the manual and enforcement should be consistent and uniform. An agency is better off NOT having a procedures manual than having one and not utilizing it or enforcing its use. The routine practicing of “exceptions” violates the credibility of any procedures manual or workflows that are in place.

Topics typically addressed in procedures manuals include:
- The method of documenting incoming phone calls, faxes, e-mails, and client visits
- The method of documenting outgoing phone calls, faxes, e-mails, and other client correspondence
- The insurance application submission process
- The endorsement request process
- The policy mailing and delivery process
- The process of issuing binders
- The process of issuing certificates of insurance
- The processing of premium payments
- The process of arranging for premium financing
- Binding authority
- The process for cancelling and/or non-renewing policies
- The acceptable methods of inter-office communication
- Consequences for failure to comply with procedure
- Grievance or dispute processes
- Personnel/Human Relations issues

**ANSWERING HYPOTHETICAL QUESTIONS**

At some point in his career, every agent is asked a hypothetical insurance question. *If my dog bites the mailman, will my policy cover me?* The absolutely worst thing an insurance agent can do is answer the question. Even if he knows the answer.

An agent might be inclined to answer the question about the dog biting the mailman. It seems pretty straightforward, doesn’t it? But what if the client isn’t referring to his homeowner policy? What if he’s referring to his health insurance policy or his business policy?

What if the agent answers that the homeowner policy will provide coverage and then, a year later, the client’s dog bites the mailman. But the client is now operating a home-based business that he didn’t disclose to the agent. In addition, the mailman isn’t visiting in the capacity of a letter carrier, he’s visiting because he’s doing business with the agent’s client. In that scenario, it’s quite likely the policy will NOT cover the client.

Answering hypothetical questions can get producers and agents into all sorts of troubles. Policy language can change between the time a question is asked and answered and an actual loss occurs. The client’s and the agent’s recollection of the question—and answer—may differ. The perspectives of the client and agent can vary. If an agent feels compelled to answer a hypothetical question, he should emphasize that his answer is as hypothetical as the question, that an actual coverage determination is based on real facts.
and not hypothetical circumstances, and he should also document the entire conversation.

**TRAINING**

As evidenced by previous scenarios in this material involving lawsuits against insurance agents, and as contained in the claims scenarios later in this chapter, may E & O claims are settled against agents because they were not properly trained. Checklists should be provided by trainers to all producers when they are learning new office procedures and technology. Even if an agent is, himself, learning about a new type of insurance, he can provide himself with a checklist to be sure he researches all relevant sources.

Many insurance companies provide Internet learning sources, manuals, guides, and materials. One particular company has a section on its web site devoted to personal lines policies. All an agent has to do to obtain a copy of the most recent edition of an auto, homeowner, condo-unit owner, or umbrella policy is click on the appropriate link. A PDF document pops up on the computer screen and contains the entire policy form. In a similar form, agents can access policy endorsements, notices, and disclosures.

**MAINTAIN DUE DILIGENCE FILES ON CARRIERS**

All the major rating services, A.M. Best, Moody’s, and S & P’s, have online access to their financial ratings—free of charge. Agents should maintain a file indicating that they perform regular checks on the carriers they represent. Although most states require surplus lines agents and brokers to monitor the financial strength of the non-admitted carriers it represents, a retail agent should still hop online to verify information. In addition, it is recommended that when an agent writes insurance with a non-admitted carrier, he provide a disclosure to the consumer and have the consumer sign the disclosure, acknowledging his awareness that coverage was placed in the surplus market, that the carrier does not participate in the state’s guaranty fund, and any other pertinent facts that may crop up later—when the client doesn’t remember the initial discussion.

Now that market conduct exams are available publicly, it’s a good idea for an agent to check with state departments of insurance to see how his companies are performing—especially in the area of claims payments. Consumers purchase insurance so that in the event of tragedy, they can remain financially whole. They do not like paying premiums to a carrier who subsequently denies coverage, thus placing them in financial jeopardy.

**COSTS AND POTENTIAL CONSEQUENCES**

The premium charged for an E & O policy is an obvious and up-front cost. However, other costs and consequences result when an agent is smacked with an E & O claim.

The first thing that often comes to mind is the policy deductible. What is it ? Who is going to pay it, the agency or the employee (producer or CSR) who is alleged to have made the boo-boo that caused the “incident?” Some agencies/companies pay the
deductible, some require the producer or CSR to pay it, and some document terms for payment of the deductible.

Then there’s the loss of productivity and time after a claim has been filed. Someone has to dig through the files and photocopy them for the E & O carrier. If that person is researching and photocopying files, he’s not doing his regular work. Worse, he’s working overtime or spending his own personal time. The person who made the boo-boo will have to give a statement, may have to give a deposition, and may be required to spend additional time assisting the E & O carrier in the defense of the claim. Fellow employees and supervisors may be required to spend their time in similar fashion.

Agency morale will likely plummet. The employee who made the boo-boo will be embarrassed, angry, and/or defensive. His fellow employees and manager will probably be upset or irritated to some degree. Jobs may be in jeopardy, procedures may have to be changed, and the workload will be increased or shifted. Everyone will be talking, that’s for sure. And the talk may not be nice…

Undoubtedly, the agency will lose the client who filed the claim. Then, the agency will probably lose the clients the plaintiff referred to the agency: his parents, siblings, children, neighbors, co-workers, employees, business associates, etc. Word will get around.

And the agency’s reputation may be impaired. Depending upon the client and his penchant for sharing the details of his life, news of the claim may hit the local TV and radio stations, newspapers, etc.

The agency owner will be thinking about things like his E & O renewal: pricing, deductible, and terms.

Oh…and what if the claim isn’t covered? That’s right. What if the claim isn’t covered? As in, what if one of the policy’s exclusions applies? What then?

Here are a few of the more common exclusions in agent E & O policies today:

- Claims related to or arising in any way from a breach of privacy or security
- Insolvency of an insurer
- Breach of contract
- Claims arising from duties as a plan manager or fiduciary under ERISA or COBRA
- Conversion, misappropriation, or commingling of client funds
- Intentional acts
- Personal profit
- Dishonest, fraudulent, criminal, or malicious acts
- Infringement of copyright, trademark, patent, trade name, trade dress, service mark, etc.
- Contractual liability
- Employment-related practices
- Pollution
• Punitive damages
• Arising from alleged tax advice

Many agents, producers, and other agency staff operate under the assumption that they don’t have to worry about “every little thing” because they have E & O insurance. Like a lot of consumers, they believe their policy will take care of everything. None of an agent’s policies covers everything—why would he believe his does?

CLAIMS SCENARIOS

One of the easiest ways for agents to acquire a clear picture of the types of activities that generate E & O claims is to take note of actual claims that have occurred and evaluate where the unfortunate agent went wrong. In an effort to provide that opportunity, the following claims scenarios were obtained directly from carriers wrote, and paid claims for, insurance agents’ E & O insurance.

PROPERTY & CASUALTY – BUSINESS INTERRUPTION

Claim #1: This is a case where the agent failed to duplicate coverage for a client. The client, Mr. Delaney, had a Businessowners Policy. The limit for Business Interruption, with no coinsurance, was $1,400,000 and coverage was issued by Carrier A. At renewal, the agent rewrote insurance on a new policy with Carrier B. It was written at the same limits of $1,400,000 but the policy included a coinsurance clause of 100%. The agent overlooked the change in the coinsurance clause.

A loss occurred and a shortfall of over $800,000 was claimed due to the application of coinsurance on Carrier B’s policy—which wouldn’t have applied on the policy written by Carrier A. Mr. Delaney brought suit against Carrier B with respect to coverage, and the agent was brought into the litigation. Carrier A mistakenly put an endorsement on the policy, which in essence removed coinsurance, even though the policy declarations page listed 100% coinsurance. The E & O carrier was able to convince Carrier A to contribute 50% toward the loss and the case was settled against the agent for $135,000 on his E & O policy.

Claim #1 Lesson: If the agent had carefully examined the clauses of both policies, he would have noticed the disparity between the endorsement removing coinsurance on Carrier A’s policy and the 100% coinsurance designation on the policy declarations page AND the fact that Carrier B’s policy invoked a coinsurance clause of 100%.

Claim #2: The agent wrote property coverage for the client, ABC, which is in the business of refurbishing railroad cars. Hurricane Ivan (September 2004) destroyed the ABC’s Alabama location and a claim for Business Interruption was made with Carrier X.

The policy had been placed through a Managing General Agent. At issue, the policy contained stated value coverage for Business Interruption and on the last renewal, the
company changed coverage to include 90% coinsurance clause.

Following the loss, it was determined the client was drastically underinsured, resulting in an 82% coinsurance penalty. The agent was confused about how the coinsurance clause worked and that a coinsurance penalty existed in the contract. The agent knew the limit of coverage requested by the client and should have known, based on the Business Interruption worksheets prepared by the client (which were shared with the agent), that the client was grossly underinsured. The loss to the client due to the coinsurance penalty was approximately $160,000. The agent’s E & O policy settled for $140,000.

Claim #2 Lesson: If an agent does not understand the details of coverage, he shouldn’t write it or he should learn about it. This is a clear-cut case of the agent showing a lack of due diligence with respect to his knowledge of the policy he sold AND his failure to compare the renewal policy to the previously issued contract. If the agent had noticed the appearance of the 90% coinsurance, he should have asked the insurance company to explain it or he should have read the endorsement. In either case, once he’d learned about the coinsurance clause, he could have explained to the client the issue of underinsurance and application of the coinsurance penalty.

PROPERTY & CASUALTY—CERTIFICATES OF INSURANCE

Claim #1: This is a claim where the agency's client, Charlotte, was asked by a customer, Jones Brothers, to be added as an additional insured to Charlotte's Commercial General Liability (CGL) policy. The agent issued a certificate of insurance indicating Jones Brothers was an additional insured, mistakenly believing Jones Brothers would be covered under a blanket vendor's endorsement present in the CGL. Unfortunately, Jones Brothers was not a vendor; Jones Brothers’ relationship with Charlotte involved them utilizing parts they bought from Charlotte and later incorporating them into a product they sold—a wheelchair. Jones Brothers did not sell the product as Charlotte’s vendor.

A fire resulted in the death of an elderly woman and it was alleged the fire was caused by the wheelchair. Jones Brothers was sued and it eventually settled for $17,250,000. Jones Brothers and their carriers sued Charlotte and her insurance companies. Charlotte’s insurance companies have refused payment, stating that Jones Brothers was not listed as an additional insured and that the part Charlotte supplied to them was not the cause of the fire.

We believe the agency is positioned well, as there is coverage available, and even if Jones Brothers were named as an additional insured on Charlotte’s policy, that coverage would only apply if it could be proved that Charlotte had been negligent. If Charlotte were to proven negligent, then her carrier would have to pay for that negligence. Based on the huge exposure, the reserves on the agent’s E & O policy were increased to $500,000.

Claim #1 Lesson: Before issuing a certificate of insurance and binding coverage on an additional insured endorsement, be sure to verify with the insurance company that the proper AI coverage form is used.
Claim #2: The agency's client, Tyson Corporation, manufactured a tent-like covering for infant cribs designed to prevent toddlers from climbing out of the cribs. Their customer, The Baby Store, was a retailer. It requested in writing that they be added as additional insured on Tyson Corporations General Liability policy and that the policy limit be at least $3,000,000.

Tyson Corporation forwarded the written request to the agent. The agent then issued a certificate of insurance to The Baby Store showing them as an additional insured with a $3,000,000 policy limit. The problem was the fact that the policy only had a $2,000,000 limit.

A toddler got caught up in the crib cover manufactured by Tyson Corporation and suffered serious, permanent, and irreversible brain damage. The Baby Store has its own liability coverage in the amount of $25,000,000, but is claiming they relied on the certificate for the first $3,000,000 to come from Tyson Corporation’s General Liability policy.

The underlying case is worth between $10,000,000 and $15,000,000. A gap of $1,000,000 exists between the policy limits and what was represented to be policy limits—per the certificate of insurance. Issues of coinsurance may exist between The Baby Store's carrier and the General Liability carrier for Tyson Corporation.

The problem is the huge value of the underlying case. Another potential claim could be one brought by Tyson Corporation against the agent for not raising the General Liability limits from $2,000,000 to $3,000,000 when the written request to add The Baby Store was sent to the agent. The agent’s E & O carrier has set a $250,000 reserve on the case.

Claim #2 Lesson: When issuing a certificate of insurance, the agent should never indicate limits that are not factual. If a disparity exists between the in-force policy and the limits requested by a party seeking a certificate of insurance, the agent should always bring the disparity to the attention of the client for instructions. If the client wishes to increase a policy limit or add coverage, the change should be processed only after documenting the client’s request. If the client declines to increase a policy limit or add coverage, that should also be noted and the certificate should be issued only for the limits and coverages in place on the policy.

CLAIMS BROUGHT AGAINST AGENTS BY CARRIERS

Claim #1: The agent’s client, Sam, was having an old school building renovated and contacted the agent to secure coverage. The agent misunderstood communications from Sam following demolition work and requested that the carrier issue a Commercial Package Policy. Since renovations to the building were not complete, a builder’s risk policy should have been requested instead.

A fire occurred and the old school building was destroyed. After initially balking, the carrier paid $2,600,000 to Sam. Sam claimed that the amount of coverage procured by the agent was insufficient and presented a claim against the agent for an additional
$1,000,000. The carrier then submitted a claim against the agent, stating they were misled by the agent since the building was vacant at the time of the loss.

Both Sam and his carrier sued the agent. During trial, Sam’s claim was settled for $725,000 and the carrier’s case proceeded to verdict. The verdict was rendered against the agent for $2,900,000.

The agent’s E & O carrier believed the trial judge committed an error in not allowing testimony as to the Actual Cash Value of the building--the carrier’s payment to Sam far exceeded the building’s Actual Cash Value--and Sam testified he had no intention of replacing the building.

On appeal, the Court reversed the trial court’s decision to exclude evidence regarding Actual Cash Value and ordered a new trial for damages be held with evidence pertaining to Actual Cash Value allowed into testimony. Mediation was unsuccessful. The E & O carrier had engaged a property expert who opined the Actual Cash Value of the building prior to the loss at $770,000. The case was tried again and the court awarded the carrier $3,200,000, which was paid by the agent’s E & O carrier.

Claim #1 Lesson: If the agent had inspected the property, he would have known the building was still undergoing renovations AND was vacant. Even if the inspection had taken place after coverage was issued, it could have been cancelled and rewritten appropriately. While the facts revealed do not indicate whether the applicant completed and signed an application, it is possible that had the applicant done so, this case would have progressed differently.

Claim #2: The agency wrote coverage on a log cabin for its client, Betsy, with an insurance company it represented. Betsy had a history of late payments, policy cancellations, and reinstatements. After the log cabin suffered a loss, the insurance company paid Betsy $532,117, then filed suit against the agent. Betsy had previously been insured with another carrier and had a history of late premium payments, cancellations, and reinstatements. Although the agent knew Betsy’s dwelling was log home and that the carrier did not write log homes, she did not disclose the fact to the new carrier. After paying the loss, the carrier alleged that Betsy’s credit history and the distance of her home from a fire station (which was understated) had not been disclosed by the agent. If further alleged that if that facts had been disclosed, the carrier would not have written the risk. It did not bring up the aspect of the house being a log cabin.

Had the carrier prevailed after pushing the issue of concealment concerning the dwelling being a log home, it could have been awarded $775,000—which would have included interest from the time of claim payment to the insured. But because of a question of fact regarding a discussion between the agent and the carrier before the risk was written, it did not push. The agent says she disclosed the credit history to an underwriter over the phone and was given a green light to write the risk. The underwriter denies doing so.
The case was settled with the agent’s E & O carrier reimbursing the carrier for the amount of its payment to Betsy: $532,117.

**Claim #2 Lesson:** Clearly, the agent should not have concealed information. She should also have documented her conversation with the underwriter concerning Betsy’s credit history. Even with documentation concerning that fact, however, it is hard to imagine the carrier would not have prevailed in light of the agent’s failure to fully disclose information to the carrier.

**Claim #3:** This is a loss where the agent issued a construction bond without an application, premium payment, signed indemnity agreement, or authority, and bound the bond carrier. The carrier paid over $930,000 and sought to recover that amount plus attorney fees from either the agent or the bonded construction company. It appears collection from the construction firm would have been very difficult, as would any collection effort against the individual owner. The agent’s E & O carrier had some arguments regarding damages, since the carrier appeared not have exerted any control over the construction costs once they stepped in to finish the job. The claim by the carrier was settled for $510,000.

**Claim #3 Lesson:** If the agent had secured a signed application, premium, and a signed indemnity agreement or authority, it is unlikely the carrier would have had a cause of action against the agent.

**PROPERTY & CASUALTY—UMBRELLA LIABILITY**

**Claim #1:** This is a loss where it is alleged the agent allowed a layer of excess coverage to lapse for a large trucking firm, resulting in a gap in coverage above the primary layers. A trucking loss occurred during the period when a gap in coverage existed, and a party in another vehicle was rendered a quadriplegic. The situation that gave rise to the gap in coverage was initiated by Carrier X, who demanded more premium in order to maintain the excess coverage in force. The trucking firm sued the carrier because of the demand for additional premium. The carrier settled with the trucking firm and paid them $65,000,000.

The agent’s E & O carrier defended a suit brought by the trucking firm. There were issues dealing with the specifics of the $65,000,000 settlement as it relates to the gap in coverage, alleged to be somewhere between $5,000,000 and $7,000,000 million as it relates to the underlying loss. The E & O carrier’s counsel believed that the E & O carrier would be able to obtain a set-off for the negligence of the trucking firm’s former counsel in not addressing the gap in coverage when they settled the case with Carrier X.

After the Court had ruled that the agent’s E & O carrier could not argue the negligence of that law firm in the trial, the E & O carrier appealed to that state’s Supreme Court. The Supreme Court refused to hear the case. With its primary defense gone, the E & O carrier’s reserves were increased and the case subsequently settled for $5,150,000.

**Claim # 1 Lesson:** Had the agent documented the lapse of the underlying excess layer, it
Whenever umbrella liability coverage is in place, it is essential for agents to document all policy changes, cancellations, and other transactions that may affect the umbrella coverage.

**Claim #2:** The loss stems from a claim that the agency did not place umbrella coverage for a client until after a loss involving one of the client's trucks. The accident resulted in a claim against the client by a man who lost eyesight in both eyes. The agent had testified that the client wanted $5,000,000 in total coverage and that he was able to place only $2,000,000 of primary umbrella coverage and continued to work on placing the $3,000,000 of additional coverage.

The agent stated he received a quote from a carrier for the additional $3,000,000 but the client rejected the coverage because of price. Receipt of a key fax transmission between the agent and the client (where the status of the coverage search was relayed to the client) had been disputed and, while there are phone records to show a call was made, the agency did not keep the fax activity report to prove the fax was sent. Discovery of a copy of a page of the disputed fax was found in the client's bank's records and led the agent’s E & O carrier to believe they had the better argument, since there is no way the fax page could have found its way to the bank unless the client had forwarded it.

The suit against the client was settled with the blind claimant receiving $2,000,000 from the primary policy and taking an assignment from the client to pursue the agency in return for his not prosecuting the claim any further against the client. Several years later, counsel won on a motion dismissing the case based on the fact that the client was not damaged. The ruling was overturned on appeal and the suit against the agent was reinstituted. Following a failed mediation attempt, the agent’s E & O carrier learned that the agent had lied under oath when he testified that he had never had his license revoked. In fact, it had been revoked several years prior to the deposition. The perjury hurt the agent’s credibility. The agent’s E & O carrier re-engaged the mediator and the case was settled for $1,275,000.

**Claim #2 Lesson:** Had the agent documented the insured’s declination of the $3,000,000 proposal because of price, it is unlikely the case would have proceeded. It is understandable that the agent might have been embarrassed about a previous revocation of his license, but admitting the truth certainly couldn’t have hurt him as badly as perjuring himself did.

**Claim #3:** This is a case where it is alleged the agent failed to add a subsidiary company to an umbrella for the parent company, the agent’s client. It is also alleged the agent failed to answer a renewal application for the umbrella carrier correctly since the renewal application indicated there were no subsidiaries. The renewal application was not signed by the client.

The client paid over $4,000,000 to settle a products claim and recouped $1,500,000 from a primary carrier, along with a payment from the umbrella carrier who settled with the
client by paying only $500,000 on a $3,000,000 policy. The exposure to the agent’s E & O policy was $2,500,00.

The agent’s E & O carrier had some very good liability arguments, since the client paid the claims itself and waited three years to report the loss to the agent. The area of vulnerability for the agent is his failure to divulge issue. Before the carrier settled with the client, it had filed a declaratory judgment action against the client claiming both late notice and rescission (failure to advise of subsidiary, which increased the risk). The rescission count falls squarely on the agent’s shoulders. The E & O carrier believed the main reason the carrier balked was the voluntary payment issue. It had had won a summary judgment and the case was dismissed.

Afterward, however, the Appellate Court reversed and placed the matter back on the trial calendar. The agent and his fellow employees will make poor witnesses. In addition, the E & O carrier’s expert is in failing health and his effectiveness at trial will be in question. The E & O case was subsequently settled for $1,500,000.

Claim #3 Lesson: Failure on the part of an agent to secure the client’s signature on an application, either new business and renewal, almost always has a negative outcome for the agent. Mistakes and oversights, such as not adding the subsidiary, cannot always be prevented—failing to obtain applicant signatures can be prevented.

LIFE/HEALTH INSURANCE

Claim #1: This is a case where the agent sold an annuity to a client and told him that after making premium payments of $90,000 year for 5 years, he would have no further premium obligations. The agent did not understand what he was selling. The predicted level of investment income for the carrier issuing the annuity did not pan out. After 5 years, the client was told he would have to continue annual premium payments of $27,000 to keep the policy in force.

The client then cashed in the policy at a loss and claimed he would not have retired from his business (he owned an insurance agency) had he known he would have to continue making payments. The client also received 50% of the commissions from the sale of the annuity. He testified he did not understand annuities and he had no life license. Counsel believed the provable damages were in the $90,000 - $100,000 range. The client was unreasonable and never lowered his demand of $750,000. The agent’s E & O carrier had offered a settlement of $80,000. In view of the impasse in negotiations, the E & O carrier agreed to enter into binding arbitration. The arbitrator basically "split the baby" and awarded $384,000.

Claim #1 Lesson – When selling an annuity—or any kind of policy, do not make representations concerning future premium obligations unless you are positive no future premium payments are due under any circumstances.

Claim #2: The long-time client worked with the agent for all his insurance needs. The client requested that the agent obtain "Key-Man" life insurance for the benefit of the
client, who had several key employees. The policy would pay the client if any one of the key people died.

The insured secured coverage through a carrier and sent the carrier an initial premium payment. The address given to the carrier on the application by the agent was the street address for the client company. All previous policies and dealings with this client listed a post office box address—and not a street address—and all previous correspondence had been addressed to the post office box. The premium check forwarded to the carrier was addressed to the post office box. In addition, the application listed the client’s phone number.

The carrier began sending bills to the street address, which appeared on the application, and bills were returned to the carrier from the post office as undeliverable. The key-man life policy was cancelled without the agent or the client knowing—because the cancellation notice was mailed to the street address. A key employee died after the policy was cancelled. Had the policy been in force, it would have paid $2,000,000.

Suit was filed against the agent and the carrier. Counsel, following discovery, opined the settlement value of the agency at $250,000. While there were some arguments in favor of the agency, the main problem involved the incorrect address given to the carrier by the agent on the application. The carrier settled for $750,000 and the agency settled for $150,000.

Claim #2 Lesson – Be extremely careful when completing applications: they are the foundation upon which coverage and agent liability is based.

Claim #3: This is a case where the insured bound a life carrier to an annuity contract where the wrong premium was calculated by the agent. It was originally believed that the proposal software provided to the agent was but the facts showed the agent improperly entered information into the software.

The carrier was obligated to the premium schedule established at policy inception. Damages sustained by the carrier are in the $300,000 to $500,000 range. The E & O carrier eventually settled for $384,000.

Claim #3 Lesson: Agent education and training is an essential aspect of an agent’s level of knowledge and proficiency. Failure on the part of an agent to properly process proposals and other calculations leaves him legally liable in the event he makes a mistake.

Claim #4: The agent and a sub-agent were involved in the sale of group health coverage to a trucking firm. The agent and sub-agent were aware that the truckers used by the trucking firm were independent contractors. The health policy only covered employees, not independent contractors. The trucking firm, and one of its trucker’s who generated $500,000 in medical bills before dying, were under the mistaken impression the independent contractor/truckers were covered by the policy. When the health carrier
learned that the trucker was not an employee, it denied the $500,000 in expenses.

Both the agent and the sub-agent shared liability. The case settled for $310,000 and the agent’s E&O carrier’s share of the claim on behalf of the agency was $155,000.

*Claim #4 Lesson:* Concealing information, or failing to disclose material facts, is binding upon an agent.

**PROPERTY & CASUALTY—CLAIMS-MADE POLICIES**

*Claim #1:* An agent switched claims-made carriers for a saw manufacturer. The original claims-made policy had retroactive date of three years prior to policy inception, while the new policy had a retroactive date of one year prior to policy inception. The agent mistakenly thought a one-year retroactive date was better than a three-year retroactive date and never discussed with the client the option of purchasing an Extended Reporting Period, or “tail,” from the prior carrier.

The client was sued by a man (during the new policy term) who was severely injured while using a saw, rendering his dominant arm useless. The saw was manufactured two years prior to the new policy’s inception date. The new carrier disclaimed coverage because the wrongful act date was prior to the one-year retroactive date. The old carrier denied coverage because the claim was not made within the policy term. The client sued the agent. The claim against the agent was settled for $335,000.

*Claim #1 Lesson:* An agent should never assume he knows what a policy provision means. In this circumstance, the agent should have discussed asked the new carrier for a retroactive date that went back further than one year. Since the previous policy’s retroactive date was three years before policy inception, and no lapse in coverage had taken place, it is likely the new carrier would have complied with the agent’s request. If the new carrier did not comply with the request, the agent should have offered the client the opportunity to purchase an Extended Reporting Period, or tail, from the original carrier.

*Claim #2:* This case involves the agent’s client, an engineering firm. The agent switched carriers from a policy that had no retroactive date to a policy that had a seven-year retroactive date. The engineering firm had designed a silo that collapsed and the agent was aware of the collapse, which occurred 8 years after the silo had been worked on by the client. During the term of the old claims-made policy, the client conferred with the agent and they decided that, because no claim had been made at that time, not to report the potential loss to the old carrier.

When a claim was made during the term with the new carrier, the loss was reported and the carrier denied coverage because the wrongful act occurred before the seven-year retroactive date. The client paid $300,000 to settle the claim against them and subsequently sued the agent, alleging that since the agent knew about the silo collapse he should have reported the loss as a potential claim to the old carrier during that policy term OR have obtained an earlier retroactive date with the new carrier. The case against the
agent was settled for $135,000.

Claim #2 Lesson: Virtually all liability policies include a provision that known claims occurring prior to the policy period will not be covered. In this instance, it appears that both the client and the agent took a chance in not reporting the loss. The client’s gamble paid off because he was able to successfully sue the agent. The agent’s gamble did not pay off. It is never a good idea for an agent to lie or conceal information.

PROPERTY & CASUALTY—CLIENT REQUESTS TO REDUCE COVERAGE

Claim #1: The owner of a large six-building apartment complex requested a reduction in coverage. Business was slow and he approached the agent and asked that two of the buildings be removed from coverage on the Commercial Property policy to save premium. The buildings were removed from the policy. The policy was subsequently replaced by another carrier and only four buildings were listed. In that particular state, there is no duty for a client to read and examine a policy.

After the replacement policy was written, the client, without telling the agent, decided to rent the two vacant buildings to victims of Hurricane Katrina--at government-subsidized rents. A fire occurred and the two buildings were destroyed.

While the agent’s file contained a copy of the request to the previous carrier to remove the buildings, there was nothing in the agent’s file documenting the discussions with the client nor did the agent have the client’s written authorization to remove coverage. The client stated he had not wanted the buildings removed from the original policy and sued the agent to recover damages. The damage to the two buildings was valued at approximately $1,000,000. Faced with a scenario where the agent and the client were diametrically opposed in their testimony, and the agent’s lack of documentation, the case was eventually settled for $500,000.

Claim #1 Lesson: Always document conversations with clients and always obtain written authorizations from clients when reducing or canceling coverage.

Claim #2: A restaurant owner asked his agent to reduce the contents coverage mid-term from $275,000 to $150,000. The carrier lowered the limits as requested by the agent and issued a refund check, which the client cashed. The policy renewed.

Following a total loss to the building, the carrier paid the $150,000 limit for contents. The client claimed he did not read the renewal policy and said he thought the refund check was issued because he’d removed a car from a personal auto policy. He claimed he never asked for a reduction in contents coverage and sued the agent.

Following a trial in the matter, the jury chose to believe the client, and awarded $125,000 plus interest and attorney fees.
Claim #2 Lesson: Had the agent obtained a written authorization from the client to reduce coverage, the client would not have had a cause of action.

PROPERTY & CASUALTY COVERAGE—BUILDER’S RISK

Claim #1: A property owner who purchased an expensive home was having major renovations done to it before it was to be occupied. A Builder’s Risk policy was written by the agent and, subsequently, a loss arose from a fire. Following the blaze, the Builder’s Risk carrier only paid for the work that had been completed up to the date of the loss, plus materials that were on-site and that were to be part of the structure. The policy did not cover any damage to the existing structure because there was no policy in place for the existing structure.

The client, a long time customer of the agency, claimed $1,800,000 in damages to the existing structure and sued the agent. The agent admitted at his deposition he thought Builder’s Risk also covered the existing structure. Because the policy language clearly excluded coverage for the existing structure, and coverage would have been available by endorsement, the agent’s E & O carrier paid $700,000 to settle the claim against the agent.

Claim #1 Lesson: An agent should read the policies he writes and understand the exiting coverages, exclusions, and available coverages. Consumers have a right to expect that their agent understands the policies he writes.

Claim #2: A former school and gymnasium was being renovated and converted into apartments. The work was to be performed in two stages: demolition, followed by renovations. Builder’s Risk coverage, secured by the contractor, was in place. When the agent and the client (the owner of the premises) spoke, the client gave the agent a rough estimate as to when the work would be completed. Both had an understanding that when the work was completed, a property policy covering the apartment complex would be secured.

At the end of the demolition phase, the owner/client secured additional financing to complete the project and asked for proof of insurance from the agent. The agent misunderstood the communication, thinking the entire project was completed. Knowing Builder’s Risk would not protect the client for an occupied building, the agent secured a Commercial Property policy for what were actually gutted, unoccupied buildings. The agent already knew the estimated time frame for the project completion and should have realized that the project was not anywhere near complete. However, the property carrier wrote the policy requested by the agent and within weeks the buildings were destroyed by fire.

The Builder’s Risk policy only covered materials and tools that were on the site, since no real renovations had begun. The property carrier attempted to deny the claim because the buildings were unoccupied, but was eventually forced to pay $2,600,000. In turn, the property carrier sued the agent, claiming the agent wrongfully bound them to a policy for a risk that the agent knew, or should have known, wasn’t eligible for coverage.
Following a trial against the agent, a verdict in excess of $2,000,000 million was rendered and paid.

Claim #2 Lesson: Had the agent understood the workings of a Builder’s Risk policy, and had he inspected the property, this claim could have been avoided.

PROPERTY & CASUALTY—WORKERS’ COMPENSATION

Claim #1: This case involves an agent’s client who was working in his home state and three surrounding states. When the client’s previous carrier “non-renewed” the Worker’s Compensation policy, the agent obtained coverage from a different carrier. The previous policy had an “All States” endorsement attached, while the new policy only covered Workers’ Compensation coverage for two of the three states.

The agent incorrectly assumed that employees used for work in the third state were hired in the home state of the client. An employee who was hired in the third (uncovered) state was severely injured on the job and filed a Workers’ Compensation claim under the client’s policy, which was then denied by the carrier because no coverage had been purchased for that state. A general contractor who had hired the client to perform work in the uncovered state, and who was obligated to provide Worker’s Compensation coverage if a sub-contractor did not provide it, paid the Workers’ Compensation claim. In turn, the general contractor sued the agency’s client for the expenses related to providing coverage. The agency’s client then sued the agency.

Because the agency replaced a policy with an “All States” endorsement with a policy that only covered two states, and the agent failed to explain this change to the client, the claim against the agent was settled for $275,000.

Claim #1 Lesson: Once again, it is apparent that an agent should understand the coverage he writes. He should also compare replacement policies with the prior policies to verify that no gaps in coverage, or differences in coverage, exist.

Claim #2: A client supplied farm workers to farms in two states and had two different addresses, one in each state. The agent assumed that all workers the client supplied to various farms were hired in one state and only procured coverage for that state. A foreign national working in the second state lost a leg in a farm accident. The Workers’ Compensation carrier denied coverage because the injury did not occur in the covered state. Moreover, it appeared that the injured employee was not hired in the covered state. The worker sued his employer directly because the Workers’ Compensation defense could not be used. A verdict of almost $4,000,000 was rendered against the agency’s client. The client, in exchange for a partial release, assigned his rights to sue the agent to the injured party. The claim against the agent was eventually settled for $550,000.

Claim #2 Lesson: An agent who knows the scope of his client’s operations through regular communications with the client, such as asking questions instead of assuming, can avoid claims scenarios such as this one.
Claim #3: The agent failed to replace non-renewed Worker’s Compensation coverage for its client, whose employee suffered fatal injuries in a motor vehicle accident. The agent had worked through a broker to secure the Workers’ Compensation coverage and was under the impression coverage had been bound by the broker and was in place. The broker informed the insured after the auto accident that coverage had not been bound; furthermore, the broker said that an e-mail had been sent to the agent, informing him that coverage had been declined by the prospective carrier. The agent denied receiving the e-mail. The loss presents an exposure of $400,000 to $500,000 in Workers’ Compensation benefits due to the estate of the deceased worker. The agent’s E & O carrier believed liability should be shared between the carrier, the broker, and the agent. The case is still pending.

Claim #3 Lesson: Workers’ compensation coverage can seldom be bound by an agent. Assuming coverage is in place because an order for coverage was made is a risky action for an agent to take. It is likely that the court will not find against the carrier and the broker if they can document their coverage denial to the agent.

Claim #4: The agency’s client, a very larger contractor, had relied on the agency for 25 years to calculate Workers’ Compensation rates for them so they could pass the cost of their self-insured Workers’ Compensation program to their customers in bids tendered for various construction jobs. The agent in the agency who normally performed the rate calculations for the contractor was out on disability and another agent performed the task in his place. Unfortunately, the replacement rater miscalculated the rates, which resulted in a $2,600,000 shortfall that was not discovered for a year. The case was settled at mediation $1,975,000.

Claim #4 Lesson: Here is another example of an agent either doing a job that he is not trained/equipped to do failing to secure backup to confirm that an error was not made.

PROPERTY & CASUALTY—REPLACING POLICIES

Claim #1: This case involves an agent who obtain Business Personal Property of Others coverage when replacing a Commercial Package Policy. The client, a contract packager of beauty products, naturally possessed products manufactured elsewhere. A theft occurred and a claim was submitted. The new carrier provided very limited coverage for items in the client’s care, custody, or control, whereas the prior policy provided full coverage for this type of loss. Using an offset for the limited amount paid by the new carrier, the claim against the agency settled for $120,000.

Claim #1 Lesson: Had the agent been familiar with the differing coverages provided by the two policies, this loss could have been avoided. Reading policy forms and endorsements is required aspect of the job for an agent.

Claim #2: Another E&O claim that should never have happened involved a long-standing commercial customer who owned several buildings near a river. The prior Commercial Multi-Peril policy provided flood coverage for all of the buildings, up to 50% of blanket limits. The new policy, which contained a limitation on flood coverage,
paid only in excess of any coverage provided by NFIP for each of the buildings. In essence, the new policy would pay only after incurring $500,000 in damages for each building. Two buildings were damaged when the river overflowed, with $269,000 in damage to one structure and damages totaling $369,000 to the other structure. Because the loss for each building was less than $500,000, the carrier denied payment. The claim against the agency eventually settled for $575,000.

Claim #2 Lesson: Again, reading policies and policy provisions is required of the agent—not the client.

PROPERTY & CASUALTY—TIMELY PLACEMENT OF COVERAGE

Claim #1: A case that was recently settled on behalf of an agency involved a client who experienced a gap in coverage due to agency error. The client, a maintenance company, was non-renewed by the Commercial General Liability carrier following the agent’s failure to provide requested information. Upon receipt of a non-renewal notice—which was received well in advance of the policy expiration date—the agent contacted the carrier, hoping to renew the policy by supplying the necessary information. Despite the agent’s efforts, the carrier would not renew the policy.

Nine long months elapsed before replacement coverage was secured. Unfortunately, a loss occurred during the gap in coverage and a pregnant woman, who fell in a building maintained by the client, miscarried. Between the legal defense and settlement fees, the total cost to resolve the claim against the agent amounted to nearly $500,000.

Claim #1 Lesson: When faced with non-renewal notices, regardless of the reason they are issued, an agent should not guarantee the client that coverage can be obtained. If the client is unable to secure coverage, he should advise the client in writing, thus giving the client the opportunity to secure coverage elsewhere.

Claim #2: A case involved a mere three-day gap in coverage where a liquor liability carrier non-renewed a client. Despite the fact that the agency sent an application from another carrier to the client, there were conflicting stories as to whether the completed application ever reached the managing general agent. Mixed signals between the agent and the client resulted in a three-day gap in coverage, during which time one of the client’s intoxicated patrons struck and killed a pedestrian—a young mother of three.

The client and another bar/restaurant were sued. The other restaurant settled, as did the auto carrier, leaving the agency’s client as the sole defendant. The agent’s E & O carrier provided the client’s defense and eventually settled the claim for $200,000.

Claim #2 Lesson: Clear documentation by the agent to the client should be provided in situations where failure of the agent to receive information from the client might result in a gap in coverage. Had the agent advised the client in writing that his failure to submit an application within a certain time frame would result in a gap in coverage, it is unlikely the agent would been found responsible.
NO SIGNED APPLICATIONS

Claim #1: A large manufacturer with an asbestos exposure, carrying $100,000,000 in coverage (a primary layer of $1,000,000 and multiple excess layers of varying size), endured claims in the 1980's from plaintiffs who were exposed to asbestos. The primary coverage was exhausted quickly, so the excess layers kicked in. While the claims were being investigated, several carriers in the excess layers balked on payment, claiming that when they wrote the risk, they were not informed of the asbestos exposure. The client retaliated by filing a suit against the excess carriers, which were eventually settled. Unfortunately, several carriers paid only 75% of their limits, which left the client faced with a $13,000,000 gap between claims to be paid and available coverage. The agent denied culpability, saying the information he submitted to the carrier was provided by the insured. However, the client sued the agent, and only after protracted and very expensive litigation was the claim against the agent settled—for a considerable sum.

Claim #2: Claiming false information was provided on the policy application, a carrier sued an agent after paying a claim in which a restaurant was destroyed by fire. It turned out that there was more to the insured restaurant than the carrier knew. It was, in fact, a nightclub that employed exotic dancers. Once again, the agent maintained that the information submitted to the carrier was provided by the client. Even though the lawsuit was eventually settled, it was very costly.

Claim #1 and #2 Lessons: Legally, a client can’t be bound by statements made on an application he didn’t sign. An agent is always risking an E & O claim when writing coverage without a signed application.

PROPERTY & CASUALTY—PERSONAL AUTO

Claim #1: The personal lines carrier for the agency’s client learned that the client’s car was being used for commercial purposes and decided to non-renew the policy. A copy of the non-renewal notice was sent to both the client and the agency. The client later claimed he never received the notice. Sometime after the notice was sent, the agent sent certificates of insurance to the client indicating coverage was in force. The client stated that he felt he had coverage because the certificates indicated he did. The client was involved in an accident that caused damage to another car. The carrier disclaimed and the client sued the agency. The case settled against the agent for $3,500.

Claim #1 Lesson: An agent should never issue certificates of insurance or auto ID cards without verifying coverage is in place. Completing such forms from memory, or based on a previously issued form, can result in the agent being responsible for coverage.

Claim #2: This is a loss where a client, Joe, claimed his agent should have made sure he had higher liability limits on his auto policy. Joe's vehicles had limits of 25,000/50,000 and one of his vehicles was involved in an accident where the driver of the other car was killed. Joe was considered to be liable for the death. The deceased was a 23-year-old married man with a child. His claim was worth $1,500,000 to $2,000,000. The estate had refused to accept the policy limits in settlement and was pursuing Joe’s assets, which
were considerable. He owned a ranch and possessed natural gas contracts for the use of his land. While on its face, this appears to be a defensible claim, Joe has a drinking problem and a case can be made that the agent, in view of his client's considerable wealth, should have insisted he have higher limits. The agent claims he suggested to Joe that he increase his limits, but did not document his suggestions. Joe does not remember the agent discussing his limits. The case against the agent settled for $325,000.

Claim #2 Lesson: It is quite possible the agent discussed with Joe the fact that he should increase his limits. However, at the time of the discussion, it was likely that price—or some other factor—was more important to Joe. After the conversation, the details escaped Joe, which often happens when an agent discusses a subject about which a client is not interested. Had the agent documented the conversation or, better yet, sent a letter to Joe offering him higher limits along with pricing, this claim may have been avoided.

WHAT TO DO IN THE EVENT OF AN E & O CLAIM

Now that it has become quite clear how an agent can get himself into trouble and how to avoid getting into trouble, what happens when an agent finds himself sued anyway? Many agents do not have access to the policy that provides their professional liability coverage, aka E & O policy, so how does an agent know what to do?

The first thing to bear in mind is that nearly all professional liability policies require the agent to report all known losses in writing “as soon as practicable.” Many policies also contain requirements that involve submitting notification of a loss within 60 or 90 days of either becoming aware of circumstances that might lead to a loss or the policy expiration date. Failure to prove prompt notice as required may preclude coverage.

Providing salient details of the circumstances giving rise to the claim is essential. According to Curtis Pearsall, former Vice-President of Utica National, “When your agency is involved in an E & O claim, the defense counsel that is assigned to represent you will ask for various pieces of documentation. In addition, there is also a very good chance that depositions of key agency personnel will be taken. It is fair to say that the defense of your agency and the success of trying to absolve your agency of any wrongdoing will largely hinge on the customer file, whether paper or electronic.” The more documentation an agent can provide to his E & O carrier, the more likely the carrier will be able to defend the agent.

Most professional liability policies contain a provision that requires the agent to refrain from admitting liability and to refrain from negotiating payment. An admission of liability by the agent, or an offer of settlement or payment, may jeopardize coverage.

Some other policy provisions include:

• Do not alter or destroy documents pertaining to the claim
• Do not alter procedures manuals without first consulting the E & O carrier
• Do not provide written or recorded statements to anyone other than a representative
of the E & O carrier
• Do not discuss the claim with anyone other than legal counsel or a representative of the E & O carrier
• Do not allow agent/agency records or documentation to be reviewed, copied, or taken without seeking advice from the E & O carrier
• Cooperate with the E & O carrier

RESOURCES LIST

Utica National Insurance Company – E & O Page
http://www.uticanational.com/NewEandOsite/EandOMainPage.asp

Safeco Insurance – Insurance Professional E & O

Rough Notes magazine – search for archived E & O articles
http://www.roughnotes.com/

International Risk Management Institute (IRMI)

Professional Insurance Agents (PIA) National E & O Program
http://www.pianet.com/PIAMainStreetStore/insuranceproducts/eando.htm

Independent Insurance Agents & Brokers of America – Big I Professional Liability
http://www.iiaba.net/na/default?ContentPreference=NA&ActiveTab=NA&ActiveState=MT
(click Member Resources on this Home Page, and then Big I Professional Liability)
CHAPTER 10 REVIEW QUESTIONS

1. The most commonly occurring lines of business involved in personal lines E & O claims include all of the following EXCEPT _____.
   [a] Flood
   [b] Auto
   [c] Ocean marine
   [d] Umbrella

2. Which of the following is one of the two biggest issues involving agent E & O claims and flood insurance?
   [a] Flood zones
   [b] Flood maps
   [c] Emergency program
   [d] Preferred policy

3. _____ was the leading reason E & O claims were paid in 1988 and is still the leading reason today.
   [a] Late claims reporting
   [b] Failure to document
   [c] False advertising
   [d] Answering hypothetical questions

4. Using a logo or other symbol that is protected by copyright or trademark without _____ is illegal.
   [a] Payment
   [b] The owner’s permission
   [c] The copyright or patent office’s permission
   [d] The insurance company’s permission

5. _____ is one of the most important elements of establishing and using a procedures manual.
   [a] Frequent use
   [b] Consistency
   [c] Updating
   [d] Insurance company approval
REVIEW QUESTION ANSWER KEY

CHAPTER 1

1. What state first enacted insurance regulation? (page 5, last pp)
   [a] Nevada
   [b] New Hampshire (appointed an insurance commissioner in 1851)
   [c] North Carolina
   [d] New York

2. What is the NAIC? (page 6, pp 2)
   [a] National Association of Insurance Companies
   [b] National Assurance Indemnity Corporation
   [c] Northern Alliance of Insurance Companies
   [d] National Association of Insurance Commissioners

3. The Fair Credit Reporting Act regulates _____. (page 9, pp 2)
   [a] Interstate commerce (is regulated by, among others, the Sherman Anti-Trust Act)
   [b] The collection, dissemination, and use of consumer information
   [c] Credit reporting agencies (is regulated by the GLBA)
   [d] Insurance credit scores (regulated by the states)

4. A variable annuity is both an annuity and a _____. (page 18, pp 4)
   [a] Contract
   [b] Policy
   [c] Security (a security assumes an investment risk and is regulated by the SEC)
   [d] Bond

5. Insurance fraud is a _____ in all but three states. (page 27, pp 5)
   [a] Crime (statistic of the Coalition Against Insurance Fraud)
   [b] Felony
   [c] Misdemeanor
   [d] Common occurrence
CHAPTER 2

1. An insurance producer owes responsibilities to all of the following parties EXCEPT _____. (page 32, pp 1)
   [a] Insurance company
   [b] Regulatory agencies
   [c] Consumers
   [d] Auto body repair shops (no regulatory requirements exist concerning the agent relationship with auto body repair shops)

2. Which of the following types of agent acts on behalf of several principals? (page 33, pp 2)
   [a] Broker (acts on behalf of the client)
   [b] **General Agent**
   [c] Surplus Lines Agent (holds a special license to sell insurance for non-admitted insurers)
   [d] Agent Cluster (is a group of individual agents and/or brokers)

3. Which of the following defines authority that is communicated in writing? (page 36, last pp)
   [a] Implied Authority (is generally communicated as a result of express authority)
   [b] Guaranteed Authority (doesn’t exist)
   [c] **Express Authority**
   [d] Presumption of Authority (doesn’t exist)

4. All of the following businesses fall under the definition of “financial institution,” per the GLBA EXCEPT_____. (page 42, last pp)
   [a] Insurance company
   [b] Insurance agency
   [c] Credit reporting agency
   [d] Hairdresser (does not collect nonpublic personal information, as insurance companies, agencies, and credit reporting agencies do)

5. An agent is required to conduct business in a location that _____. (page 51, pp 2)
   [a] Is in the agent’s home (not required and, in some cases, not permitted by the state or the company)
   [b] **Is easily accessible to the public (requirement of most agent/company contracts)**
   [c] Offers privacy (is a good idea, but is not spelled out in the contract)
   [d] Is in the same building as the insurance company (not required)
1. The term due diligence became popular as a result of _____. (page 59, next to last pp)
   [a] The U.S. Securities’ Act of 1933 (which was enacted after the Great Depression to provide information to the public and to prevent deception and fraud)
   [b] The Fair Credit Reporting Act (enacted in 1970)
   [c] The Gramm-Leach-Bliley Act (enacted in 1999)
   [d] The Sherman Act (enacted before the Depression)

2. Due diligence requires the agent to _____. (page 64, pp 3)
   [a] Guess when the insured isn’t sure of an answer to a question on an application (exhibits a lack of due diligence)
   [b] Sign an application when the insured isn’t available to do so (exhibits a lack of due diligence)
   [c] Obtain information directly from the client
   [d] Withhold information from the company if sharing it is not beneficial to the client (exhibits a lack of due diligence)

3. Efforts to bring transparency to agent compensation in New York led to a ban on ____ in New York and other states. (page 77, pp 2)
   [a] Agent/broker commissions (these are legal)
   [b] Contingent commissions (which are contingent upon certain factors, such as satisfactory loss ratios or production levels)
   [c] Bid-rigging schemes (have always been illegal)
   [d] Brokerage fees (these are legal)

4. Annuity disclosures are required by all of the following, EXCEPT _____. (page 80, pp 3)
   [a] State regulatory agencies (to comply with state disclosure requirements)
   [b] Securities Exchange Commission (to comply with federal disclosure requirements)
   [c] FINRA (to comply with regulatory and industry requirements)
   [d] GLBA (the protection of information under this Act doesn’t apply specifically to annuities)

5. When annuities are also securities, the SEC requires certain disclosure documents to be provided to consumers, including _____. (page 82, pp 2)
   [a] Prospectuses (which contain specific financial information about the product being sold)
   [b] Contracts (the annuity is the contract)
   [c] Mutual funds (may or may not be an investment in the contract)
   [d] Rider (this is a contract endorsement the client purchases and is not required by the SEC)
CHAPTER 4

1. Ethical behavior is characterized by all the following values EXCEPT _____.
   (age 89, last pp)
   [a] Goodness
   [b] Morals
   [c] Scruples
   [d] Wealth (is not a philosophical value)

2. Meta-ethics focuses on how to define _____. (page 92, last pp)
   [a] What is morally right and morally wrong
   [b] What makes a man happy (normative ethics)
   [c] The justification of using force (military ethics)
   [d] Moral emotions (moral philosophy)

3. If a person knowingly makes a false statement on an application for the purpose of deceiving, he has made a _____. (page 105, pp 2)
   [a] Representation (this is a true statement)
   [b] Misrepresentation
   [c] Guarantee (this is a promise)
   [d] Warranty (this is a promise)

4. When a producer misrepresents policy terms, conditions, or benefits to induce a customer to buy a policy, he has committed the act of _____. (page 106, pp 3)
   [a] Rebating (involves commission sharing or illegal reduction of premiums)
   [b] Twisting
   [c] Commingling (involves combining personal and client funds)
   [d] Discrimination (involves rates, underwriting, and/or premiums)

5. Scams targeting seniors, who are attracted to seminars about estate planning and other similar topics, are called _____. (page 115, last pp)
   [a] Living Trust Mills
   [b] Estate Planning (this is a legitimate practice)
   [c] Military Sales Practices (this pertains to insurance sales on military installations)
   [d] Commingling of Funds (this is an illegal trade practice, regardless of the age of the client)
CHAPTER 5

1. A soft market is characterized by all of the following EXCEPT _____. (page 126, pp 3)
   [a] Low premiums
   [b] Reducing profits
   [c] **Tightened underwriting (this characterizes a hard market)**
   [d] Excess competition

2. One of the most contentious issues concerning auto insurance is ____. (page 130 pp 4)
   [a] **Uninsured Motorist Coverage**
   [b] Home-Based Businesses (pertains to homeowner insurance)
   [c] EPLI Coverage (this is employment practices liability insurance)
   [d] LTC Coverage (this is long-term care coverage)

3. All of the following are examples of EPLI claims EXCEPT ____. (page 143, pp 2)
   [a] An employee takes offense after hearing a joke told in the lunchroom and files a discrimination claim
   [b] The methods a supervisor used when firing an employee are at issue and the employee files a wrongful termination claim
   [c] **An employee is injured when a fellow employee hits him (this is a workers’ compensation claim)**
   [d] Charges of discrimination are filed by a person who wasn’t hired after interviewing for a position

4. ____ is the most frequently occurring natural disaster in the world. (page 149, pp 3)
   [a] Flood (per the CDC)
   [b] Earthquake
   [c] Mudslide
   [d] Hurricane

5. A certificate of insurance is ____. (page 153, pp 2)
   [a] A guarantee of coverage (this is a binder or a policy)
   [b] A temporary policy (this is a binder)
   [c] **A snapshot of coverage**
   [d] A policy endorsement (this is a particular form of coverage)
CHAPTER 6

1. What percentage of the American population was covered by some form of health insurance during calendar year 2007? (page 166, next to last pp)
   [a] 94%
   [b] 92%
   [c] 84% (According to the U.S. Census Bureau, Housing and Household Economic Statistics Division)
   [d] 82%

2. Which of the following is an element of a health savings account (HSA)? (page 168, pp 2)
   [a] It is a tax-exempt trust or custodial account
   [b] It is created for the purpose of paying for non-qualified medical expenses (it pays for qualified medical expenses)
   [c] It must be connected to a low-deductible health plan (it must be connected to a high-deductible medical plan)
   [d] It is not portable (it is portable)

3. Disability income policies require a certain amount of time to elapse before benefits are paid. This amount of time is ____. (page 178, pp 1)
   [a] A benefit period (this is the time during which benefits are paid)
   [b] A waiting period
   [c] A lifetime benefit period (this is a type of benefit period)
   [d] Waived on a long-term disability policy (not true)

4. Annuity suitability requirements were established to prevent individuals from ____. (page 184, pp 1)
   [a] Buying life insurance policies (not true)
   [b] Entering into contracts that are not appropriate
   [c] Buying annuity policies (they are used to help people buy the right annuity policies)
   [d] Entering into contracts that are illegal (annuity contracts are not illegal)

5. Agreements between private insurance companies, state governments, and residents for the purpose of purchasing private long-term care policies are called ____. (page 190, last pp)
   [a] Contracts
   [b] Partnerships (these agreements reward policyholders if they need Medicaid assistance with the cost of long-term care)
   [c] Annuities
   [d] Policies
CHAPTER 7

1. If an insurance agent takes a client’s electronic payment, what section of the GLBA governs the collection of that information? (page 212, pp 2)
   [a] Safeguards Rule (this governs the protection and security of information)
   [b] Financial Privacy Rule
   [c] PreTexting (this governs obtaining financial information under false pretenses)
   [d] Federal Trade Commission (the GLBA falls under regulation by the Federal Trade Commission)

2. If an e-mail contains only _____ content, it is subject to all requirements of the CAN-SPAM Act. (page 213, pp 2)
   [a] Transactional content (exempt from most requirements of CAN-SPAM)
   [b] Relationship content (exempt from most requirements of CAN-SPAM)
   [c] Commercial content
   [d] Other content (exempt from most requirements of CAN-SPAM)

3. What kind of signature utilizes key cryptography to “sign” a message? (page 215, pp 2)
   [a] Electronic signature (this is a generic term encompassing all methods of affixing an electronic record)
   [b] Digital signature
   [c] Online signature (not an official term)
   [d] Scrivener signature (a signature that is hand-written)

4. The HITECH Act has expanded the required privacy and security protections for electronic technology information available under what Act? (page 219, pp 4)
   [a] GLBA (this Act concerns financial information)
   [b] HIPAA
   [c] FCRA (this Act concerns credit reporting)
   [d] ePHI (this is a type of information, not an Act)

5. With the enactment of HITECH, _____ are now officially required to comply with the Safety Rule. (page 221, next to last pp)
   [a] Insurance agents (insurance agents are not specifically named in the Act, although they may qualify as business associates)
   [b] EHRs (EHRs are electronic health records)
   [c] Health care providers (already subject to the Safety Rule)
   [d] Business associates
CHAPTER 8

1. A combined ratios is calculated by comparing an insurance company’s ratio of losses and expenses to the _____.
   [a] Premiums it collects in a particular year
   [b] Claims it pays in a particular year
   [c] Loss ratio
   [d] Reinsurance premiums it pays in a particular year

2. All of the following are among the four major categories of risk that must be calculated to arrive at a general risk based capital amount for an insurance company EXCEPT_____.
   [a] Asset Risk
   [b] Credit Risk
   [c] Speculative Risk (this is the definition of one of the two broad types of risk)
   [d] Off-Balance Sheet Risk

3. All of the following are among the top three rating services that rate the financial strength of insurance companies EXCEPT_____.
   [a] Standard & Poor’s
   [b] Lloyd’s of London (this is an insurance syndicate)
   [c] Moody’s Investors Services
   [d] A.M. Best Company

4. The members of the National Conference of Insurance Guaranty Funds and the National Organization of Life & Health Insurance Guaranty Associations include the guaranty associations in all 50 states and _____.
   [a] Puerto Rico
   [b] The District of Columbia
   [c] Puerto Rico and the District of Columbia
   [d] Puerto Rico and Canada (Canada is not part of the U.S.)

5. The object of securing reinsurance is for an insurance company to reduce its exposure to _____ by transferring some of its risk to another insurance company.
   [a] Underwriting risk
   [b] Loss
   [c] The economy
   [d] Catastrophes
CHAPTER 9

1. Market conduct examinations often result in fines for which of the following?
   (page 248, pp 3)
   [a] E & O claims (don’t affect compliance)
   [b] High loss ratios (don’t affect compliance)
   [c] Violations of insurance code (market conduct exams are conducted to verify compliance with insurance code)
   [d] Employment Practices claims (don’t affect compliance)

2. All of the following are among the top ten criticisms cited in market conduct exams of insurance companies EXCEPT _____. (page 249, pp 3)
   [a] Using unapproved or unfiled forms
   [b] Failure to acknowledge, pay, or deny claims within specified time frames
   [c] Failure to use unfiled rates (Using unfiled rates is a criticism)
   [d] Improper documentation of claims files

3. _____ developed its first handbook for market conduct examinations in the 1970s. (page 250, pp 4)
   [a] The SEC (SEC oversees securities, not insurance)
   [b] FINRA (FINRA oversees securities, not insurance)
   [c] The NAIC
   [d] Congress (the Federal government doesn’t regulate the insurance industry)

4. NCOIL’s Proposed Market Conduct Annual Statement Model Act would apply to admitted insurance companies writing more than ____ of direct written premium. (page 251, next to last pp)
   [a] $10,000
   [b] $100,000
   [c] $1,000,000
   [d] $10,000,000

5. Market Conduct exams review which of the following? (page 253, pp 2)
   [a] Producer and adjuster licensing (this is a pattern of market conduct behavior)
   [b] Reinsurance (not a pattern of market conduct behavior)
   [c] Combined ratios (not a pattern of market conduct behavior)
   [d] Market Conduct Annual Statements (not a pattern of market conduct behavior)
CHAPTER 10

1. The most commonly occurring lines of business involved in personal lines E & O claims include all of the following EXCEPT _____. (page 264, last pp)
   [a] Flood
   [b] Auto
   [c] Ocean marine (this is a commercial line of insurance)
   [d] Umbrella

2. Which of the following is one of the two biggest issues involving agent E & O claims and flood insurance? (page 268, pp 3)
   [a] Flood zones
   [b] Flood maps (were not mentioned in the text)
   [c] Emergency program (agents don’t choose the program)
   [d] Preferred policy (agents don’t choose the policy form)

3. ____ was the leading reason E & O claims were paid in 1988 and is still the leading reason today. (page 269, pp 3)
   [a] Late claims reporting
   [b] Failure to document
   [c] False advertising
   [d] Answering hypothetical questions

4. Using a logo or other symbol that is protected by copyright or trademark without ____ is illegal. (page 270, last pp)
   [a] Payment (not true)
   [b] The owner’s permission
   [c] The copyright or patent office’s permission (permission must be granted by the owner of the copyright or trademark)
   [d] The insurance company’s permission (permission must be granted by the owner of the copyright or trademark)

5. ____ is one of the most important elements of establishing and using a procedures manual. (page 271, last pp)
   [a] Frequent use (it should be used all the time)
   [b] Consistency
   [c] Upgrading (a good idea, but not a big contributing factor to E & O claims)
   [d] Insurance company approval (not necessary)