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ETHICAL SELLING AND FRAUD PREVENTION

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CHAPTER 1: THE IMPORTANCE OF ETHICAL SALES

Since ancient times, humans have looked carefully at ethics and have tried to determine what should or shouldn't be done in given situations. Our personal set of ethics is shaped by cultural influences as well as by the family members, peers and teachers who interact with us during our formative years. But as we grow older and more independent, the process of developing our ethics becomes increasingly a matter of personal responsibility. Without an authority figure looking over our shoulder and threatening to punish us for bad behavior, the choice to follow our internal code of ethics belongs to us. And without trustworthy elders at our disposal, we may need to think very carefully about how the black-and-white basics of good ethics (honesty, respect, compassion, etc.) fit into a world with so many gray areas.

Consistently applying solid ethics to our business can sometimes seem like a challenge. This is particularly true if we frame our understanding of ethics in a traditional way that has seemingly no room for self-interest. As idealistic as that view of ethics might be, it's probably best to admit that it isn't realistic. Though we may truly enjoy our jobs and aim to treat people fairly, it's probably safe to say that most of us do our work for the self-interested purpose of making money. In a world where money is practically necessary for survival, perhaps our business ethics should be focused not on the total elimination of self-interest, but on carefully monitoring that self-interest so that it doesn't harm the public.

Good ethics doesn't prevent you from having a profitable insurance career. In fact, adherence to a set of fair, well-meaning principles might contribute to your longevity in the business. Good ethics build strong relationships with consumers. Strong relationships, in turn, increase the chances of valued referrals.

Practicing good ethics can also keep those relationships strong when honest mistakes are made. Consider, for example, a scenario in which an insurance broker who specializes in commercial lines gives an otherwise excellent sales presentation to a long-time client but fails to adequately explain the intricacies of a major policy exclusion. After an accident at the client's place of business, the client is surprised to learn that the resulting loss will not be covered by insurance. Although the client is unhappy with the outcome, the broker has been helping to insure the business for many years and has otherwise proven to be very honest, knowledgeable, and service-oriented. The client and the broker have a conversation, in which the broker expresses regret and compassion. Had this been a different broker, the client might have filed complaints with a regulator, threatened to sue or at least severed their relationship. But since the broker built up so much good will over the years by acting with supreme professionalism, the relationship is allowed to continue.

Good ethics, of course, don't guarantee happy endings like this one. But along with other facets of risk management, they can certainly reduce the likelihood of compliance problems and consumer complaints.

Right and Wrong in Insurance

Admittedly, even the world's best ethics curriculum is unlikely to stop a highly unethical person from committing harmful acts. However, studying ethics has the potential to help generally ethical people apply their well-intended principles in new ways. Throughout the remainder of this course, we'll make the reasonable assumption that you, the reader, are in that second group of people. You probably don't need someone to tell you the basics

of right and wrong, but you might benefit from remembering what "doing the right thing" might mean in a number of seemingly ordinary business scenarios.

In order to demonstrate this point, let's take a few moments to consider two kinds of actions. First, make a brief list in your mind of what an ethical insurance sales professional SHOULD do when representing carriers or consumers. Then, take the opposite approach and think of a few actions that an ethical insurance sales professional definitely SHOULD NOT do.

Without thinking too hard about it, your two mental lists might look something like these:

An Ethical Insurance Sales Professional Should:

- Respect confidentiality.
- Give necessary disclosures regarding costs and exclusions.
- Listen carefully to the needs of consumers.
- Provide honest and well-informed explanations to people's questions.
- Treat people fairly.
- Behave with integrity.

An Ethical Insurance Sales Professional Should Not:

- Make decisions for the consumer.
- Base product recommendations mainly on the amount of commission being received.
- Advertise and summarize products in ways that are deceptive.
- Make sales through the use of unnecessary fear.

Applying What You Already Believe

Coming up with those basic lists isn't difficult. Recognizing how those basics can be brought to life, on the other hand, requires deeper contemplation. So, let's analyze a few of the listed items a bit more thoroughly.

Respecting Confidentiality

Respecting confidentiality in insurance doesn't just mean that you aren't using people's information for selfish reasons or engaging in gossip. It also means that you are careful not to slip up and disclose private facts about people in seemingly harmless situations.

Suppose your client, Mary Jones, is interested in a life insurance policy with a rider that allows some of the death benefit to be used prematurely in order to pay for long-term care services. However, Mary has some health conditions that might jeopardize her eligibility for the rider. Your co-worker does more long-term care business than you and is well-versed in the underwriting criteria of various insurance providers, so you leave him a voicemail, asking for advice. Your co-worker returns your call while you are waiting to check-in at a crowded continuing education class. Since this is important business for you, you take the call while waiting in line and explain Mary's situation by providing her full name and the names of her medical conditions. Your co-worker agrees to review your notes about Mary, which are at your office, and hangs up.

You feel good about sharing Mary's information with a competent and respected colleague in order to get her what she needs. But did you respect her privacy as much

as possible? Even if no one at the class is likely to know Mary or care about her medical issues, it was probably not a good idea to mention her specifics (especially her full name) in a public place. If nothing else, being careful to avoid disclosing personal information like this can be good practice for those situations in which accidental disclosure could be more harmful.

Providing Informed Explanations

Because your clients are unlikely to do so, you should remain informed by carefully reading the policies that you sell. This ensures that you will know the important facts that are likely to be important in the person's decision-making process, and it might even increase your chances of avoiding a regulatory complaint.

It may even be appropriate to provide unsolicited explanations of the insurance-buying process besides product selection and price. For example, you might consider explaining what happens after an application is submitted, how long approval might take and what kinds of issues might force a delay in the issuance of coverage. By knowing the intricacies of how a particular insurer processes and evaluates applicants' data, you can set reasonable expectations that will keep the applicant satisfied.

Treating People Fairly

A famous statement known as the "Golden Rule" instructs us to treat others as we would want to be treated. To an extent, this rule can be used to explain why we should consider offering the same level of service to all of our customers, but the realities of business might make this application at least partially impractical.

Put yourself in the position of a busy commercial insurance salesperson. You sell comprehensive property and casualty solutions to very large companies that mean a lot to your business's bottom line. You also have a few small businesses within your clientele that result in smaller returns. Both types of clients could use some time-consuming assistance from you as they navigate through their insurance options, but you only have so many hours in your day. So, does treating people fairly mean treating them equally?

Even well-meaning professionals are likely to admit that some clients are more valuable to them than others. Still, that doesn't mean that the seemingly less important clients should be ignored. In these situations, it might be helpful to step back from the situation and categorize the service-related requests made by each party. Are there requests that should be addressed as soon as possible, even if the client isn't as integral to your business's success as everyone else? If there are requests that aren't as pressing, can the work be either passed along to another qualified person or scheduled for another reasonable time? At the very least, the client should be contacted and informed that his or her concerns will eventually be addressed.

Avoiding Fear

Insurance professionals need to carefully monitor their presentations so that they don't engage in unnecessary scare tactics. But since the fear of loss is at the core of any insurance transaction, the line between what's a scare tactic and what's simply a form of wise risk management is debatable.

Saying something like, "You should consider life insurance in order to protect your family" appears harmless enough. But what if the statement becomes more specific and graphic? A slight modification like "You should consider life insurance in case something happens to you" adds a little more fear but might seem acceptable to many agents. A

step further like “You should consider life insurance because your father died young” is riskier, not only because of fear but because it plays on the person’s painful, personal memories and could offend the listener. In cases like this, the graphic details of a worst-case scenario are often already swirling around a prospect’s mind and, therefore, don’t need to be said.

Relationships With Carriers and Consumers

Regardless of whether they act as agents (and are generally considered to be representatives of the insurance company) or as brokers (and are generally considered to be representing the consumer), all insurance professionals owe certain duties to insurers and the buying public. Without balancing those responsibilities, your working relationships with either side will undergo a great deal of strain. If you only look out for the interest of the insurance company at the expense of the consumer, very few buyers will want to know you. Conversely, if you conceal information from an insurance carrier in the hope of helping an applicant, your book of business will eventually be highly scrutinized by skeptical underwriters.

What Would You Do?

The conflicts that arise out of these dueling obligations are sometimes present during the application process. For instance, a disability insurance salesperson might be fully aware that an applicant has a potentially debilitating health condition, but the application provided by the carrier might be worded in a way that doesn’t directly ask about this significant risk. At this point, the salesperson has a decision to make: Should the potentially problematic condition be disclosed to someone at the insurance company, or should the professional follow the exact wording of the application and only provide the requested information?

As challenging as this proposed dilemma might seem, doing research about various companies can often make the issue irrelevant. If you familiarize yourself with an insurer’s views on various risks before approaching applicants, you might be more aware of which risk factors are really important to the company and which ones will have no impact on the pricing or availability of the company’s products.

Handling Premiums

Both the consumer and the insurer rely on the salesperson to make sure that initial premiums are transferred to the appropriate party. Unethical handling of funds, such as putting premiums in an agency’s general operating account, is a serious offense and has become one of the most strongly prosecuted insurance crimes. Although this form of wrongdoing is relatively uncommon in the life and health lines of insurance, it should be a major concern at most independent property and casualty agencies. Unlike most life and health agents, independent property and casualty agents often receive checks that are made out to the agency rather than to the issuing insurance company.

In order to ensure proper compliance, insurance professionals who collect and make premium deposits should carefully review state rules regarding premium fund trust accounts. Important information about proper handling of money might also appear in the agency contract between you and the insurance carrier.

Building Relationships With the Public

Let’s put relationships with insurers aside for a moment and focus on relationships with consumers. As you undoubtedly know, a lot of people outside of your profession have a negative opinion of the insurance industry. There are many possible reasons for that,

and a lot of those reasons are out of your control. But keep in mind that some people's negative perceptions of you are based on consumers' bad experiences with other insurance representatives. If you practice good ethics, you may be able to overcome some of the lingering negativity. Conversely, if you don't practice good ethics, you might make matters more difficult for the next insurance professional who deals with that person.

In order to ensure that your relationships with consumers remain strong, it is important to solicit and openly accept feedback from the public. By asking for feedback, you might be able to determine whether your explanations to a consumer were actually understood. If you are humble and willing to accept criticism, feedback might also alert you to mistakes you are making and help you correct problems before they get out of hand.

Avoiding Complaints

Failing to acknowledge and address problems with consumers could lead you down a path toward unwanted lawsuits in civil or criminal court. If valid complaints are filed with your state's insurance department, you also risk losing your license and having to pay major fines.

Due in large part to internet technology, it has become increasingly easy for dissatisfied insurance buyers to file complaints against licensees. Instead of requiring paper-based complaints that can easily get lost amid the shuffling of documents at government offices, most states offer easy access to complaint forms at their insurance department's website. Since unsubstantiated complaints can still force a licensee to lose time and energy by submitting documentation and attending hearings, any hint of unethical conduct should be avoided whenever possible.

Examples of what to avoid are provided in the next several sections of this course.

Material Misrepresentations

Salespersons need to be careful to avoid material misrepresentations. A material misrepresentation is any false or misleading statement that is likely to influence someone's decision. Material misrepresentations might be made intentionally in order to influence a buyer, or they might be made accidentally by a licensee who is not being careful with his or her language.

Examples of material misrepresentations include misrepresenting the financial condition of an insurance company or misrepresenting the terms, conditions, benefits or exclusions of an insurance product. Insignificant mistakes, such as a spelling error that has no impact on the meaning of the word, are not material misrepresentations.

Misrepresentations can result from what is said and also by what is left unsaid. A misrepresentation that occurs because of what someone fails to mention is called an "omission." Omission is a problem if it involves something that, if known, would influence someone's decision.

Intimidation

Intimidation occurs when someone is forced to do something, such as purchase insurance, under the threat of harm. While you might never even think of engaging in intimidation in order to sell insurance, you should be on the lookout for this unacceptable behavior when meeting with the public. For example, when meeting with elderly clients and their families, watch out for hints of elder abuse from relatives who might not have the elderly person's best interests in mind.

If you sense that a family member is forcing an elderly person to purchase an insurance product (such as life insurance, long-term care insurance or an annuity), you should strongly consider divorcing yourself from the transaction. Contracts, including insurance products, are generally not enforceable if the purchaser enters into them against his or her will.

Lowballing

The term "lowballing" is often used in situations where insurance salespersons intentionally misrepresent the cost of an insurance product in order to steal business from potential competitors. It is also used on occasion to describe a claims-handling situation in which the settlement offered by the insurance company is lower than what should be offered under the policy. In either case, lowballing is sure to provoke anger from a trusting policyholder.

Defamation, Libel and Slander

Defamation occurs when someone makes a false statement that harms the reputation of someone else. In times of heated competition, insurance professionals must be careful to avoid inappropriate comments about other licensees or other insurance businesses. If statements about competing entities are harmful and false, charges of libel (written defamation) or slander (spoken defamation) might result. Due to the wide reach of the Internet, insurance professionals should be extra careful when making unflattering comments online.

Concerns about defamation can be managed by emphasizing the strengths of your own products and your own skills and by avoiding any unnecessary mentions of competitors.

Marketing and Terminology

When advertising insurance in the media or in an oral presentation, sales professionals should clearly identify the product being sold. An insurance product such as cash-value life insurance should be identified as such and not disguised in terms like "family savings plan" or "emergency account."

Advertisements must emphasize products that are actually available and shouldn't involve "baiting and switching." In a bait and switch, desirable deals are offered in order to initiate contact from a consumer. Upon inquiring about the seemingly great deal, the person is told that it isn't available anymore but that there are other products available to suit his or her needs. Unlike an insurance licensee, the average person tends to know little about insurance and might be incapable of recognizing certain offers as "too good to be true."

Twisting and Churning

"Twisting" or "churning" occurs when one insurance policy is replaced by another even though there is no clear benefit to the policyholder. Although these two terms are often used interchangeably, twisting generally refers to instances in which there is an unnecessary switch in insurance companies. Churning, on the other hand, generally involves exchanging policies that are issued by the same insurer.

Policy exchanges, in and of themselves, aren't necessarily unethical. There might be clear differences in coverage that make a new policy a better fit for a buyer. Alternatively, a new policy might provide less coverage but cost significantly less than what the buyer is currently paying. However, agents should document the reason for exchanges and provide adequate disclosure of the potential consequences to the purchaser. For example, buyers should be made aware of any surrender charges or new

exclusionary periods that might result from the swap. Also, the policy being replaced should remain in force until the new policy has gone into effect.

Tips for Ethical Insurance Professionals

We've addressed unethical behavior and some of the consequences for consumers. But let's assume you're a very ethical person and that you always try to treat people well. What are some precautions you can take to avoid making a mistake or being accused of wrongdoing? The next few sections contain some simple pointers for you.

Analyzing Needs

To keep the consumer satisfied, you'll want to ensure that the products presented to a potential purchaser are suitable. When you meet with a new customer, you should conduct a needs analysis in order to determine the suitability of specific products. To perform a proper needs analysis, you must ask several questions and listen carefully to the answers.

Helpful questions might include:

- What are your needs and goals?
- What kinds of property do you currently own?
- What do you do for a living?
- Do you own your own business?
- Do you have a family?

In spite of the important information that can be learned from those questions, you should consider alerting the consumer that the answers won't have an impact on their eligibility for insurance (as long as that's the case). Depending on the kind of insurance and the state where you do business, certain factors (such as marital status) cannot be used to charge someone more or to limit a product's availability.

The needs analysis is important because no two people are exactly alike. Even in a broader context, what you'd sell to a senior citizen is probably going to be different from what you'd sell to an 18-year-old. Similarly, what you'd sell to the 18-year-old is probably going to be different from what you'd sell to a 40-year old.

If you're working with a senior citizen, the main insurance concerns might be estate planning and paying for health care. An 18-year old might need renters insurance if he or she has an apartment. Auto insurance would be needed, too, if the person has a car.

At 40, there might be a bunch of things that are needed because 40-year olds are more likely to have dependents. Life, disability and homeowners insurance are all legitimate possibilities. So is extra liability insurance if the person has significant assets or has a pool or a trampoline in the backyard. The 40-year-old might also have a business, which opens up the door to a variety of commercial products. The list of possibilities could go on and on.

Assisting Elderly Customers

You'll want to use special care when working with clients who are elderly or disabled because sometimes (not always) there can be a communication problem. The person might not be able to hear you or speak clearly. In situations like this, you might find it helpful to have one of the person's trusted family members in the room. But even then, you'll want to get a sense that the family member isn't the one making the decisions.

Remember what we said earlier about coercion and intimidation. Unfortunately, some caregivers don't always have people's best interests at heart.

Maintaining Documentation

No matter who you meet with or speak to, it's important to take and keep good notes. Taking detailed notes about all of your interactions with the public can decrease the likelihood of disagreements regarding what was said or not said in conversation or what kinds of financial advice were or were not provided. If you and an angry consumer continue to dispute the facts of a particular meeting or conversation, your notes can help defend you in the event of a regulatory complaint.

However, good note-taking shouldn't be an activity that is done only on occasion. In order to aid your credibility and for your notes to serve as an adequate piece of evidence, you may need to show that you take detailed notes in all similar circumstances.

The notes you take during client interactions should be contemporaneous rather than after the fact. The quicker you are to document something, the better chance you'll have at remembering all of the important details.

Some agents keep handwritten notes in client files. Others keep a continuous record in a computer software program. In either case, some sales professionals find it helpful to send an email to clients containing a summary of a conversation's key points. In addition to the summary, the email might ask the recipient, "Do you agree that this is what we discussed?" The client can then respond and clarify points where necessary.

In order to maintain a clear picture of your relationship with clients, and to protect yourself, here are some documents that you might keep in an organized, readily accessible fashion:

- Copies of completed applications.
- Copies of any written correspondence with clients.
- Copies of any written correspondence with insurance carriers.
- Notes from meetings.
- Notes from phone calls.
- Notes regarding all attempts to contact clients (for example, a note that you left a voice mail regarding an upcoming policy renewal).
- Notes regarding the timing of various mailings to clients or prospects.

A Note-Taking Case Study

In order to underline the importance of notes, let's go through an extended scenario, which was developed with the help of a former securities regulator. At the end of our story, you should also be able to see how consumer complaints of practically any kind can complicate matters for licensees.

Our story begins with a concerned daughter who has gone through her elderly mother's paperwork. After noting some suspicious documents, she discovers that her mother recently cancelled a decades-old life insurance policy and bought a new one. Since the annual premiums were the same for both policies, the daughter is unsure why the replacement took place. After talking with her mother, she convinces herself that a slick life insurance agent tricked her mother into switching insurance for no good reason.

The daughter contacts her state's insurance department and is told to send copies of any relevant documentation to the local regulators. With her mother's consent, she sends copies of the new policy and the cancelled policy, along with notes that the daughter took when the old policy was issued.

Upon receiving the documentation from the daughter, state regulators are able to identify the agent who sold the new life insurance policy and note that the agent has already had two similar complaints filed against him. Concerned that the latest complaint might represent a pattern, state regulators assign an investigator to the case.

At this point, the assigned investigator is concerned not only about the actions of the agent who sold a policy to the mother but also about the overall business practices at the agent's place of employment. In order to determine whether there is misconduct at the agency level, or perhaps a failure to supervise, the investigator writes to the agency's compliance officer and demands that all of the agency's records be readied for a visit. Because of the complaints against this one agent, ALL of the business's records (those related to the specific agent and those unrelated to him) will be subjected to scrutiny.

In response to the request by the investigator, managers at the agency start covering their tracks. They identify records proving that all agents have undergone ethics training, and they reprimand the agent in writing. Unfortunately for the agent, the agency managers are more concerned about protecting themselves than about protecting him.

Meanwhile, the daughter has hired legal counsel and has announced that she and her mother plan to sue the agent for damages. Since his managers don't seem willing to support him, the agent decides to hire his own attorney . Luckily for him, the agent has made a habit of keeping detailed notes during all of his client interactions and of all company meetings. Through those notes, he is able to show not only that replacing the life insurance policy had a tangible benefit for the mother but also that his managers emphasized the money-making potential of life insurance replacements to all agents in the organization. Based on the various headaches caused by the entire experience and lack of support, the agent determines that he will be happier working someplace else.

We could take this scenario even further, but the story's two key points should already be clear to you:

- Regulatory complaints, even those in which no wrongdoing actually occurred, can be a big problem and should be avoided when possible.
- Maintaining detailed notes is an essential element of risk management for insurance professionals.

Keeping Yourself Informed

The evolution of the insurance industry doesn't stop once you pass your licensing exams. In order to serve the public well and remain on good terms with insurance regulators, sales professionals must take some initiative and keep up with what's happening around them.

While employees at large insurers might receive comprehensive training and frequent regulatory updates from a compliance department, licensees who work either alone or at small agencies must work a bit harder to remain up to date. Let's look at a few simple tasks that can help you keep up with important changes.

Looking Online

As part of keeping up with changes in state requirements, you might consider checking the website of your state's insurance department on a regular basis. Most departments will post important updates online, and some have completely stopped sending important news by regular mail. State websites are also likely to contain links to relevant insurance laws and administrative rules.

Regular Reading

Trade publications can help inactive licensees keep track of important trends in the insurance community. Many respected insurance publications offer free online newsletters that are delivered on a monthly, weekly or even daily basis. Others might be included as part of your membership in an insurance trade organization.

Reviewing Company Guidelines

Active licensees should periodically review any company handbooks or agency agreements that they receive as part of their employment with various agencies and insurance carriers. In many cases, the licensee will be representing an insurance company as part of a transaction and must conduct business in a manner prescribed by the company. It's possible that a company handbook or agency contract will put restrictions on a licensee's conduct that are more strict than local laws or state rules.

If you are in a supervisory position and do not have a handbook, you might want to consider creating one. Having sets of procedures all in writing and all in one place can make it easier for your subordinates to respond to problems. Of course, you will want to ensure that workers who receive the handbook actually read it.

Privacy Protection

As part of being a trusted insurance expert, you are likely to learn some very private facts about the people who do business with you. Whether they are about finances, health problems or planned business endeavors, we all have things about ourselves that we wouldn't want everyone to know. So even if you aren't required by law to keep something private, always try to be empathetic. Above all else, consider obtaining the client's written permission and signature before releasing any potentially sensitive information.

As in most things, privacy in the insurance business isn't absolute. You probably don't have to think very hard in order to come up with cases in which sharing someone's information is necessary to completing a legitimate business task. For example, a licensee might need to make copies or share the original version of a completed insurance application with an underwriting department. In general, this is considered an ethically acceptable practice as long as reasonable precautions are observed. (Even when sharing is necessary, information should not be left out in the open where it can be viewed for unnecessary purposes.) Similarly, most licensees are unlikely to have problems with sharing information when it is requested by a regulator or essential to their legal defense in a court of law.

Still, due to the amount of personal and financial information that they collect, insurance professionals should take reasonable steps to combat Identity theft. If identifying information about a client falls into the wrong hands, tremendous harm (including but not limited to the opening of fraudulent credit accounts) can be accomplished. Even theft that is quickly detected can take a great deal of time and effort to correct.

With prevention of identity theft in mind, consider all the items that you carry around with you, such as a briefcase. Do you know what's contained in those items and where they are at all times? If the paper or electronic documents that you carry around were to ever to be lost or stolen, what might the consequences be for your clients? Obviously, proper privacy protection involves safeguarding physical forms of information and isn't just about improper oral disclosures.

Privacy Risk Management

Some rules and laws contain extensive requirements for sharing and storing personal information. Before going into greater detail about federal privacy laws, here are some simple actions that might help preserve people's privacy:

- Keep sensitive information locked or password-protected, and only give keys or passwords to responsible professionals who truly need the information.
- Maintain clear, documented procedures for maintaining clients' privacy in the workplace.
- Periodically review privacy procedures and update them as necessary.
- Restrict online activities so that all Web-based business is conducted through secure connections.
- Obtain written consent prior to disclosing anyone's personal information.

The Gramm-Leach-Bliley Act

One privacy-related law to be aware of is the Gramm-Leach-Bliley Act (GLBA). The GLBA was intended mainly as a deregulation measure that made it easier for banks, insurance companies and other financial institutions to become intertwined and consolidate. When companies become affiliated with one another, the likelihood of information sharing is high. So, the law also called for some privacy measures. Those measures include the following kinds of requirements:

- Safeguard requirements.
- Privacy notice requirements.
- Opt-out requirements.

Many financial institutions follow GLBA rules that have been established by the Federal Trade Commission. But slightly different rules for insurance entities have been set by some state insurance departments. Due to the potential for variances in state requirements, you should conduct some legal research or speak with a qualified expert if GLBA compliance is part of your job. Depending on a company's procedures, GLBA-related tasks might be handled internally by the company or by the individual agent.

GLBA Safeguard Rules

As part of the Gramm-Leach-Bliley rules, insurers generally need to have written safeguards in place to protect their customers' information. Information must be safeguarded if it is "non-public personal financial information."

The requirements for implementing safeguards aren't particularly specific, maybe because the kinds of security risks are going to be different from person to person and company to company. But the safeguards should reasonably protect confidentiality and minimize security breaches. Basic examples of safeguards might include keeping paper files in locked cabinets and keeping data files password-protected.

When creating safeguards, companies need to consider the kinds of privacy or security risks that are likely to arise in their business and the best ways to address them. Workers at insurance companies should receive adequate training regarding how to keep information safeguarded.

Businesses also need to reevaluate their risks and their safeguards from time to time as their situations change. For example, a company that formerly worked with a significant amount of paper documents might need to reevaluate its safeguards as it moves toward greater use of electronic records.

GLBA Privacy/Opt-Out Notices

In addition to putting safeguards in place, insurance companies need to give people written privacy notices. A notice needs to say what information the company collects, what information the company gives out, and who receives the shared information. The notice must contain an opportunity for the person to opt out of having some of his or her information shared. In general, consumers can opt out of having their information shared with third parties who aren't affiliated with the insurance company.

The Health Insurance Portability and Accountability Act (HIPAA)

Along with making group health coverage easier to obtain for people with serious medical problems, the Health Insurance Portability and Accountability Act is one of the most significant federal laws pertaining to privacy. It dictates how our medical information can be shared and how people who have our information must protect it.

Licensees who are involved with health insurance obviously need to be aware of HIPAA so that they don't break the law. The rest of us probably don't need to worry about HIPAA from a compliance standpoint, but the law should still be important to us. After all, we all go to doctors, most of us have health insurance, and we presumably all would prefer that our health information be kept as private as possible.

Knowing about HIPAA can be tremendously important in an emergency. If there's a medical emergency involving someone who isn't your spouse, some medical providers won't share important information with you because they don't understand the law. Or in another example, let's assume you're helping an elderly family member pay medical bills and you need information from a doctor or an insurance company. In these kinds of scenarios, it's helpful to know what your rights really are.

Protected Information

Specific HIPAA-related rules about keeping health information confidential are contained in the Department of Health and Human Services' extensive "Privacy Rule." However, the rule doesn't apply to all kinds of health information. In general, in order for information to be protected and covered by the rule, ALL three of the following conditions must be met:

- The information was created by or given to a health care provider, health plan, health care clearinghouse or employer.
- The information relates to a person's medical condition, care provided to the person, or payment of care for the person.
- The information identifies the person or could reasonably be used to identify the person.

The last point about identification is very important. Your medical information isn't required to be protected under HIPAA if there's no reasonable way that it can used to identify you. In other words, a doctor saying something, like "I once treated a patient for tuberculosis" or an insurance company saying, "We've paid claims amounting to $20 million this year" might not be violating the law, but saying, "I once treated Jane Smith for tuberculosis," or "The policyholder at 123 Main Street has made a $5,000 claim" would almost certainly be a problem.

Keep in mind, though, that we're speaking in generalities here. HIPAA is a very complicated law, and the specifics of a given situation are integral to a proper compliance solution. If you are responsible for handling people's health information and have a concern, talk to an attorney or compliance officer who knows your situation and knows the rules. (Additional information about HIPAA compliance can be found in some of our other self-study courses.)

Keeping all of that in mind, here are some examples of information that are generally protected through HIPAA:

- Information discussed with a doctor or nurse.
- Information in medical files.
- Information about medical bills.
- Information about health insurance claims.
- Non-medical information (name, address, etc.) if it can reasonably be used to identify someone and uncover something about the person's health.

Note that it doesn't matter when the information was first given to a health provider or health plan. Even information that was provided prior to HIPAA's passage is protected. Information that people give about their relatives is protected, too (such as family medical histories that are shared with doctors).

The Agent's Role As "Business Associate"

HIPAA compliance is mainly a concern for health insurance companies, health care clearinghouses and health care providers, the three of which are collectively known as "covered entities." However, the Privacy Rule also needs to be followed by "business associates." Business associates are third parties who receive protected information on behalf of (or in order to perform services for) health care providers, health plans or health care clearinghouses. They aren't employees of covered entities, but they still do business for them or with them.

Some examples of business associates under the Privacy Rule are as follows:

- Lawyers and accountants for covered entities.
- Health insurance agents and brokers.
- Third-party administrators for health plans.

If you are a business associate, the covered entity that you're doing business with is required to have you sign a "business associate agreement." The agreement will state what you can and can't do with protected health information. The agreement can't allow you to do things under the Privacy Rule that a covered entity can't do. It can also put additional restrictions on the kinds of information you can receive and how you can

share it. In other words, the agreement must be at least as strict as the Privacy Rule, but it can be stricter, too.

If a covered entity believes that a business associate is violating people's privacy (or if a business associate feels this way about an insurer), it must inform the potential violator and try to fix the problem. If the problem can't be fixed, the relationship must be terminated. If the relationship between a covered entity and a business associate ends, the business associate needs to return any health information, destroy it, or agree to keep it private. Circumstances and the format of the information will help determine the best of those three options.

CHAPTER 2: CONSUMER FRAUD

We've spent a lot of time talking about bad things that some people in the insurance business might do. But of course, consumers are sometimes unethical, too. Many examples of their unethical behavior involve some degree of fraud committed against an insurance company.

Defining "Fraud"

When we use the word "fraud" in this course, we mean a form of deception committed against others for personal gain that is usually financial in nature. From an insurance standpoint, fraud that is financial in nature doesn't necessarily mean that the person is trying to illegally take money directly from the insurance company (such as by padding a claim or by faking a loss). It can also mean trying to save money from the beginning by lying on an application and thereby getting a better rate.

Within the context of this course, fraud doesn't include innocent mistakes, such as forgetting to mention a doctor's visit for a minor medical condition or being off by a few pounds when asked about your weight. Instead, our definition of fraud is focused on material representation. The untruth should be something that was intentional and also had an impact on the price of the insurance, the person's eligibility for the insurance, or the amount of money received from the insurance company.

Although it might seem silly at first to dissect our definition of fraud so carefully, it is important to note that other people might use a different definition that is looser or more strict. As we'll soon see, differences in definitions of fraud can create a disconnect between insurance professionals and the public. This disconnect, when not acknowledged, often prevents fraud from being controlled.

What's the Problem With Fraud?

If left unaddressed, insurance fraud can produce a number of problems. Perhaps most significantly, money lost by insurers because of fraud tends to trickle down to the consumer in the form of higher premiums and in the form of coverage that is either insufficient or harder for everyone to find. Like any other business suffering losses, insurance companies might not be able to provide adequate products and still remain solvent.

There are even seemingly unintended consequences for the perpetrator of fraud. This is particularly true in cases where fraud involves a bogus or inflated insurance claim. Even if the person isn't caught, being compensated for fake or exaggerated losses will still make the person a bigger insurance risk. Future insurance might therefore be less affordable for the person or harder to find.

Sadly, fraudulent schemes can also cause physical harm or even death to innocent people if the criminal's plan goes wrong. Staged auto accidents, for example, might injure innocent drivers or pedestrians. Fires started for insurance money can easily spread to neighboring properties belonging to innocent victims.

To one extent or another, fraud affects all of us. In order to do our small part in spotting it, we need to know how it happens. Still, taking just one course about fraud during your career is unlikely to be adequate because skilled crooks know how to adapt. Once one type of scheme is exposed, they look for a new hole in the system and try to exploit it. If you truly want to play a part in stopping fraud, your attention to the issue must follow you through the years.

How Big Is the Problem?

The truth is, we don't really know how much insurance fraud actually takes place. The only time we learn about a case of fraud is when people get sloppy and are caught. So, who knows how many people are successful?

Still, a few industry groups have put together some numbers. The Coalition Against Insurance Fraud, which deals mainly with the property and casualty side of our industry, says $80 billion of insurance fraud occurs each year. Meanwhile the National Health Care Anti-Fraud Association says about $60 billion of just health care fraud takes place annually.

To put these numbers into perspective, insured losses amounted to $26 billion from Hurricane Andrew, $38 billion from the 9/11 attacks and $45 billion from Hurricane Katrina. Those of you who were in the property and casualty business at those times are probably well aware of the impact that those events had on insurers. If the estimated fraud figures from the aforementioned trade associations are accurate, we are essentially experiencing catastrophic losses every year just because of selfishness and lies.

Why Fraud Occurs

Fraud committed by consumers might be something that was always intentional (such as a policy that is purchased as part of a money laundering scheme). But it can also be something that a legitimate insurance applicant gets involved in later. For example, a driver might buy auto insurance because she really wants it and then decide years later to intentionally damage her vehicle while feeling some kind of financial pressure. Financial pressures might arise from high bills, a high amount of debt, personal financial losses or unexpected financial emergencies.

Some people are led toward fraud because they need to fund their vices. Vices include addictions to alcohol or other drugs, gambling or even extramarital affairs. If someone has an out-of-control lifestyle, he or she might turn to fraud to support it.

If fraud is being perpetrated by an insurance insider, work-related pressures might be part of the motivation. An agent or an insurance employee might feel underappreciated, underpaid or generally dissatisfied with a work situation. Concerns about job security might also cause employees to panic and do the wrong thing.

Feelings of entitlement aren't limited to insurance insiders. In fact, a consumer might have similar feelings and believe that fraud is one way to get back at an insurer that has continued to raise premiums even though the policyholder has made prompt payments without any losses. Similarly, a claimant who has a bad experience when trying to reach an insurance settlement might engage in fraud as a way to get even.

Finally, people might commit fraud under the assumption that what they're doing really isn't fraud at all. In an earlier portion of this course, we emphasized the need to clearly define fraud. In reality, consumers have a different definition of fraud than insurers.

To average consumers, fraud sounds like such a big thing, something that involves hundreds of thousands of dollars or more. With this mindset, padding a small property insurance claim or lying about where a car is garaged in order to get a slightly better rate doesn't seem so bad to them. Even if they agree that lying is wrong, they often don't think that all lying is fraud. Of course, people in the insurance business tend to feel differently.

Why Consumers Tolerate Fraud

In a survey conducted by the Coalition Against Insurance Fraud, less than a third of respondents said there is absolutely no excuse for insurance fraud. Everyone else said fraud was either justified in some cases or something that didn't bother them.

Those might seem like shocking statistics, but it's important for us to analyze the possible reasons behind them. Perhaps the low concern regarding insurance fraud is due to the fact that financial fraud isn't violent or graphic. It's usually not as scary to people as burglaries or murders. And like many other kinds of white-collar criminality, it often seems very impersonal. Even though it amounts to theft, the average person doesn't feel like they're losing anything from it. Although the insurance company being victimized is certainly losing money, that company doesn't have a face and, therefore, doesn't receive much sympathy.

Through those statistics, we might determine that the public doesn't expect the fight against insurance fraud to be a priority for law enforcement. If that's true, it might relate to what psychologist Abraham Maslow termed the "hierarchy of needs." Within the context of insurance fraud, Maslow's theory might say that if you live in a community that can be physically dangerous, your first priority is for law enforcement to keep you and your family physically safe. Until we are confident that our world is physically safe, we might not put as much pressure on government to prosecute other kinds of crimes, including financial ones. With financial scandals populating the news over the past few years, it's possible that the public is becoming more aware and less tolerant of white-collar crime. But only time will tell if this is really true.

A more likely reason why people tolerate fraud—let's be honest—is that they have a negative opinion of insurance companies. Similar to the public's favorable relationship with their own Congressional representative and their decidedly negative opinion of Congress, consumers usually like their insurance agent but don't like insurance companies.

Try to recall some of the rhetoric surrounding health care reform and the passage of the Affordable Care Act. Regardless of whether someone was supportive of the law or against it, attacking the alleged greed of insurance companies became a populist pastime. Indeed, for many Americans, cheating insurers out of money is almost like cheating on your income taxes. It may be a crime, but many people do it without too many feelings of guilt.

The Agent's Role in Fraud Prevention

Regardless of their fairness or the reasons for them, society's views on insurance fraud won't change overnight. In the meantime, insurance professionals need to deal with the frauds that might already be occurring under their noses. Insurance agents and brokers, along with insurance carriers, must accept some of that responsibility.

It's easy to say that stopping fraud is someone else's job and leave it for a claims department, a special investigative unit or a claims-tracking software program. But is that an ethical approach to the problem?

We mentioned earlier how an agent or broker can owe ethical duties to both the insurer and the insured. No matter if you're representing the insurance company or the consumer in a transaction, you have an ethical obligation to bring parties together only in good faith. If you suspect that one of those parties is trying to deceive the other, you probably aren't doing your duty.

Relying on others to catch and stop fraud also tends to be impractical and inefficient. In most cases, the agent or broker has the closest insurance-related relationship with the consumer. The relative closeness of that relationship means that, out of everyone at an insurance company, the agent or broker is often the best judge of a consumer's character. The agent or broker might notice suspicious behavior that other insurance representatives might miss. Conversely, behavior that would otherwise seem suspicious might be excusable if the agent or broker can vouch strongly for the suspect's good intentions.

Despite the important role that sales professionals play in the fraud-fighting process, solutions to the problem shouldn't rest entirely on their shoulders. Insurance licensees are not police officers, and negative consequences can arise if they overstep their boundaries. If, for instance, an agent discourages a consumer from filing what turns out to be a legitimate claim, the resulting strain in the relationship might be irreparable.

Basic Kinds of Insurance Fraud

We can divide the kinds of insurance fraud into three broad categories:

- Application fraud (for example, a consumer who lies about tobacco use, how much he or she drives, or where he or she typically stores a vehicle).
- Claims fraud (in other words, lying about a loss).
- Producer/insider fraud (committed by agents, claims adjusters, marketers, company executives or others in the insurance field).

Since application fraud is perhaps the kind that is most likely to be detected by an agent or broker, let's summarize some of its warning signs.

Red Flags of Application Fraud

Some warning signs of potential fraud can pop up very early in a person's relationship with their insurance company. Something might seem strange on their application, or something they say might seem suspicious.

Red flags (or warning signs) of potential application fraud are listed below:

- The applicant seems nervous and fidgety.
- The applicant has a suspicious phone number or voicemail greeting.
- The applicant provides a suspicious identification card or has no identification.
- The applicant insists on buying more insurance than necessary.
- The applicant wants to pay large premiums in cash.
- The applicant has a suspicious credit history or a criminal background.
- The applicant becomes agitated when asked for necessary information.
- The applicant demands that a policy be issued as soon as possible.

Realize, of course, that the appearance of a red flag doesn't always mean that fraud is taking place. There might be several red flags, and your gut and brain will tell you that nothing bad is probably happening. Or there might only be one odd thing going on, and your gut might tell you that something's wrong. As you gain experience working with consumers, your judgment in these matters is likely to improve.

Fraud in Specific Lines of Insurance

Now that you've familiarized yourself with the basics of fraud, let's go over common fraud schemes involving specific kinds of insurance.

Property Insurance Fraud Examples

A lot of the examples of property insurance fraud relate to claims. There are cases where the policyholder lies and hasn't suffered any real loss at all. For example, the owner of an expensive piece of jewelry might insure the item, sell it, and then claim that it was stolen in order to collect some insurance money.

There are also cases in which a legitimate loss has occurred but the loss has been exaggerated to the point where fraud is involved. After a real burglary, for instance, a victimized homeowner might claim to have lost items that he or she never actually owned. Although homeowners insurance policies have relatively strict limits regarding coverage of valuable items like jewelry, furs or stamp collections, lying about individually inexpensive items can be easy, especially when no photos or receipts are required.

Arson, which occurs when buildings are purposely set on fire, is sometimes committed by the owners of failing businesses. As was mentioned earlier, this can be a particularly detestable type of fraud because uncontrollable flames can easily damage other people's property and put innocent lives in danger.

After a natural disaster, insurers and homeowners should be on the lookout for unethical contractors who are intent on claiming some insurance money. Going from damaged house to damaged house, these contractors might offer to evaluate the damage to an owner's roof and worsen the damage on purpose (without telling the owner) in order to bill the insurer for an even larger repair.

Auto Insurance Fraud Examples

Fraud committed on an auto insurance application might entail lying about a vehicle's regular location. Due to concerns about theft and traffic congestion, most auto insurers in the United States will base pricing to an extent on where the vehicle is usually located. A driver might lie about his or her address or might even lie about where the vehicle is normally parked. In order to save a few dollars, the owner might claim that a car is kept in a locked garage as opposed to out on the street.

Some people buy auto insurance legitimately at first but turn to fraud when they can't afford the car anymore. For a fee, third parties might be willing to stage a theft or destroy a vehicle. Many times, the people who are paid will either take the car to another country and resell it or dismantle it and sell the parts. This scheme, known as a "give up," has been noticed during times of rising fuel prices, particularly in regard to gas-guzzling sport-utility vehicles.

As was the case with some property insurance schemes, fraudulent auto insurance claims might evolve from a legitimate loss. Suppose a driver gets into an accident and is covered for theft but not collision damage. In a manner similar to the "give up" scheme mentioned above, the damaged vehicle might be reported as stolen to the insurer and sold for parts. In order to lessen the frequency of this scam, auto insurers may want to be vigilant for alleged thefts that occur shortly after the filing of an accident report.

Sometimes, there's obviously damage to the vehicle but physical injury to the driver or the passenger is faked. This is more commonly an issue in states with no-fault auto insurance systems, but it can happen in other places, too, if some no-fault medical

insurance is included as part of the standard auto policy. “Soft-tissue” injuries, such as pain in the neck, back or various muscles can be especially difficult to disprove because the source of the discomfort doesn’t always show up on x-rays.

Often, the phony or exaggerated injuries after an accident have a medical provider who is part of an elaborate fraud ring. The doctor might have someone track down an accident victim and convince the victim either to go to the doctor’s clinic or to lie about his or her injuries. The provider will know how to deal with the insurance company, and when the doctor is compensated by the insurer, everyone involved in the fraud will share the money.

Sometimes the injuries are faked and so are the accidents. Two drivers might crash into each other on purpose, or one driver who intends on causing an accident might prey on an innocent motorist. In the latter case, a driver intending to cause an accident might move in front of a victim and then intentionally slam on the breaks. Alternatively, a partner might watch the victim, wait for the innocent driver to become distracted, and then have the other driver hit the victim from behind.

In addition to drivers and passengers, staged auto accidents can involve paid pedestrians who serve as witnesses. Alleged calls to the police may even produce an officer who is also part of the scam.

As you can see, these frauds are very complex and tend to need many participants in order to work properly. Insurance professionals with access to accident information might want to check if the same people tend to pop up in multiple accidents as drivers, passengers, pedestrians or other witnesses. The parties who engaged in one elaborate scheme might switch roles and attempt it again.

Unfortunately, the consequences of some staged accidents reach further than just the insurance companies. Alleged accidents don’t always go as planned, and innocent victims have been known to suffer serious injuries, or even death, because of them.

Workers Compensation Fraud Examples

When asked to visualize a case of workers compensation insurance fraud, most people will think of an unethical worker who fakes an injury in order to collect a check. But in fact, fraud in workers compensation, some experts say, is caused even more commonly by employers.

Workers Compensation Fraud By Employers

The cost of workers compensation insurance tends to be based (at least in part) on the three following factors, all of which might prompt a business owner to attempt fraud by providing false information to an insurer:

- The number of employees (as opposed to independent contractors) covered by the insurance.
- The job duties of the covered employees.
- The salary or wages of the covered employees.

Because workers compensation is generally only for employees, businesses intending to commit workers compensation fraud might claim that certain employees are actually independent contractors. Businesses that make innocent mistakes when declaring a person’s employment status should be made aware that the difference between an employee and a contractor isn’t always easy and usually involves the analysis of several

important factors. A worker is not an independent contractor just because he or she doesn't get benefits, works from home or has a flexible schedule. Even a written agreement that says the worker is an independent contractor can be irrelevant if the worker is treated otherwise as an employee.

Lying about a covered worker's job duties is especially a problem among businesses that specialize in physically strenuous projects. An agent selling workers compensation coverage to a construction business might become suspicious if a surprisingly large number of employees are supposedly in low-risk clerical positions. A more subtle variation on this type of fraud is a case in which an employee's true job duties are modified very slightly for the purposes of calculating insurance rates. For example, a construction company might claim that someone who spends most of his or her time as a roofer is actually engaged in the less-dangerous activity of general carpentry.

Workers Compensation Fraud By Employees

Our focus on fraud by employers doesn't mean that employees don't commit workers compensation fraud, too. Staged accidents, like the classic "slip-and-fall," are capable of occurring at the office. But some aspects of those injuries don't always match our perception of them.

For example, we tend to think of the employees who commit these crimes as lazy and that they're just relaxing at home and collecting their money. Often, though, a worker with multiple jobs will fake an injury at one workplace and still keep working someplace else.

Even if an employee has only one job, a case of workers compensation fraud might not be a case of alleged total disability. A claimant hoping to be compensated for a full-time job in exchange for part-time work might claim to be capable of still performing some work-related tasks but not others.

Detecting Workers Compensation Fraud

With fraud prevention in mind, here are some questions for employers and investigators to consider after a workplace accident:

- Were there any witnesses? (An accident might seem suspicious if there were no witnesses or if the employee's recollection and a witness's recollection don't match.)
- When did the accident occur? (Employees who injure themselves in recreational activities during the weekend might stage an accident shortly after returning to work.)
- What are the injured person's hobbies? (Is this someone who engages in extreme sports, rock climbing or other physically risky activities?)
- What is the person's status in the organization? (Special attention might be paid to incidents involving new employees or people whose job security is known to be at risk.)
- Do job duties make an accident unlikely? (Accidents can happen to everyone. But a receptionist whose primary duty involves answering the phone probably shouldn't be involved in several workplace accidents.)

In the past, catching an employee who is exaggerating a workplace injury might have required observation of the allegedly injured person in a seemingly private moment.

These days, the potential for workers compensation fraud can be detected by what employees post on social media networks such as Facebook or Instagram.

With younger generations moving into the workforce, it is increasingly common for employees to post items on the internet that could get them into trouble. From the standpoint of workers compensation fraud, this trend might include posts or photos in which the allegedly injured worker has clearly engaged in strenuous physical activity for recreational purposes.

Be aware, though, that if someone is caught doing some kind of strenuous activity, there is not always a clear case of fraud. When challenged about the legitimacy of their injuries, some workers have successfully argued that single pieces of possible proof, such as a single photograph or a single visual observation of the person engaging in sports, are misleading. In their defense, some have argued that the observed case of physical activity was a mistake and that their accuser failed to witness how the strenuous activity worsened the injury that prompted a workers compensation claim in the first place.

Health Insurance Fraud

It's certainly possible for health insurance fraud to be committed by a consumer who is acting alone. In the years prior to implementation of the Affordable Care Act, some applicants undoubtedly lied about their health history in order to secure affordable coverage. And even now, there are employees who will lie about who is or isn't a dependent so that non-eligible people can be covered through an employer's health plan.

But in general, medical insurance fraud is most successful and most prevalent among groups of people who know how our health care system and its payment structure actually work. In cases where the dollar amount of health insurance being committed is especially large, there is likely to be a medical provider involved.

In order to get paid, medical providers might commit health insurance fraud by falsifying the specifics of a diagnosis in order to ensure that a performed procedure is covered by a patient's insurance . Some physicians who engage in this practice might even view it as a compassionate act that benefits their patients.

Like most patients, doctors are likely to have their own potentially negative opinions of insurance companies, especially if they believe that seemingly necessary care is being limited or not paid for by a health plan. Even if patients are initially unaware of what their doctor is doing in order to receive payment, they are unlikely to address the situation unless it impacts their own finances. A billing statement from the insurer that lists procedures that differ from those actually performed is likely to go unnoticed by the patient as long as those procedures have no impact on the recipient's copayment or coinsurance amounts.

Some health care providers will commit insurance fraud by billing the insurer multiple times for a procedure that was only performed once. Similarly, a few have even forced patients to come in for multiple rounds of treatment instead of providing all necessary care in a single visit. In one case, a doctor was accused of stretching chemotherapy treatments into multiple sessions, not so the patient would improve, but because it meant he could bill the insurer multiple times.

In schemes known as "rent-a-patient," providers offer bribes to people who are willing to receive needless medical care, which is then billed to an insurer or a government health

plan. Patients who suffer from drug addiction are particularly susceptible to participation in these schemes because the ring-leading doctor is often the supplier of their medication.

Some bogus medical clinics exist in order to cheat insurers and patients. Imagine that you've just been injured in a car accident and are referred by an emergency-room physician to a local clinic. You go to the clinic but receive nothing more than a basic massage, which does hardly anything to relieve your pain. Still, the clinic bills your health insurance company for hundreds of dollars. Due to the lack of medical expertise on display at the clinic, you wonder whether the clinic is legitimate or if the referring physician sent you there as part of a complicated scam.

Indeed, some bogus clinics have been known to have relationships with licensed physicians. Others have been able to receive money from insurers by committing identity theft against innocent medical professionals.

In the past, the consequences of identity theft mainly involved the opening of fraudulent accounts with lenders or credit card companies. These days, however, a thief might also aim to use a victim's information in order to utilize the person's health insurance. If consumers are already in the habit of shredding or destroying financial documents, they might want to do the same for any insurance documents that are being thrown away, including any insurance cards.

Fake Insurers and Fake Insurance

Unfortunately, health insurance is also where we tend to find a lot of bogus entities posing as insurance companies and offering phony insurance to unsuspecting consumers. Scams involving fake insurance tend to be most successful in bad economic times because victims are likely to have less money are more likely to accept money-saving sales pitches that wouldn't ordinarily attract them.

Fake health insurance is also a common concern when new health insurance laws are passed and when changes to government health plans are implemented. For example, passage of the Affordable Care Act and the implementation of prescription drug coverage under Medicare Part D were followed by cases in which telemarketers or door-to-door salespeople falsely claimed to be from the government and tricked vulnerable people into buying fake health insurance policies.

In some cases, bogus insurance carriers have employed licensed agents, some of whom claim to have been blindsided by their company's illegal activities. Your state insurance department should have lists of licensed insurance companies, along with information about consumer complaints. If you are concerned about a company's legitimacy, here are some red flags that might be cause for concern:

- The company provides excellent service in the beginning of its relationship with policyholders but eventually becomes unresponsive to their requests.
- The company is headquartered at an offshore location, perhaps to avoid regulatory scrutiny.
- The company's name or logo is very similar to the name or logo of a well-known insurance company.
- The company offers large amounts of coverage at unrealistically low prices.
- The company advertises in a way that disguises its name or the kinds of products being sold.

Life Insurance Fraud Examples

In all honesty, life insurance fraud can be a thrilling topic of discussion. If that weren't true, this kind of fraud wouldn't frequently pop up in the plots of classic movies or crime novels. No one, of course, is advocating life insurance fraud, but there's something about death that at least grabs our attention.

Traditionally, life insurance policies have contained incontestability clauses that make it very difficult for insurers to question deaths occurring two years after the issue date. As a result, if a savvy criminal is looking to commit life insurance fraud, death won't happen soon after a policy has been purchased.

When deaths are faked, the beneficiary might need to work around the problem of not having a death certificate. In order to solve this problem, the beneficiary might recruit a funeral director who knows how to forge the relevant documents. In other cases, the beneficiary might allege that death occurred in a violent, third-world country where death certificates (or even autopsies) are uncommon or impractical.

Oddly enough, when a beneficiary fakes someone's death, the person who is alleged to have died might not even be aware of it. It's not unheard of, for example, for an insurance representative to visit an alleged widow at her home and to be greeted by her understandably confused husband. Sometimes the allegedly deceased husband or wife is so angered by the revelation that he or she agrees to testify against the conniving spouse in court.

Understanding Insurable Interest

Faked deaths without the person's knowledge are sometimes done by buying several small life insurance policies from different companies. Since the policies are small, the companies might be more willing to pay the death benefit, and they might also be more willing to issue the policy without obtaining clear consent from the other person and making sure that the purchaser has an insurable interest.

Under the legal theory of insurable interest, someone can only insure someone or something if the person or thing has value for the purchaser. In some cases, insurable interest must exist both at the time the insurance is purchased and at the time a claim for benefits is made. In the case of life insurance, insurable interest usually only needs to exist at the time of purchase. Note that the rules for insurable interest put limits on who can own the insurance policy. However, they generally do not limit who the owner can choose as the policy's beneficiary.

Despite the legal safeguards that might be in place to prevent a lack of insurable interest, the loose nature of those laws might require a life insurance agent to ponder whether a legal transaction is also an ethical one. Imagine yourself in front of a married couple who want to purchase a large life insurance policy on their child's life. The policy will list the parents as the beneficiary.

Although it may be legal for the parents to purchase the policy (under the assumption that a child's death can create expenses for them), would you feel comfortable being part of the transaction? Would the size of the death benefit or the features of the policy (for example, a plain term-life policy vs. a whole-life policy with the potential for cash values) make a difference to you? If you believe you would have some concerns about this sale, how would you address them? If these questions were posed to a roomful of insurance agents, it's possible that no two people would reply with exactly the same answers.

Money Laundering

Of all the major kinds of insurance, life insurance has the closest link to money laundering. When people commit money laundering, their goal is to access illegally obtained or illegally used funds in a manner that eludes law enforcement. The following kinds of crimes are typically affiliated with some form of money laundering:

- Terrorism.
- Arms smuggling.
- Drug trafficking.
- Illegal fundraising.
- Tax evasion.

Most money laundering schemes go through the following three stages:

- Placement.
- Layering.
- Integration.

In the placement stage, illegally obtained funds are brought into the economy. This is often done by commingling and depositing clean money and the dirty money into the same account. In order to facilitate this process, criminals might operate a cash-heavy "front" business (such as a laundry service or restaurant) that is operated for the purpose of funneling money into various accounts. When the front business goes to a financial institution and makes a deposit, some of the deposit will be from the front business's legitimate activities, and some of it might be money obtained through illegal endeavors.

In the layering stage, criminals intentionally transfer money from place to place and from account to account so that the dirty money becomes more difficult to trace. It can mean moving money from one financial institution to another or from domestic accounts to foreign accounts and back again. The more complicated the maze, the more likely that the layering will be successful.

In the integration stage, the launderer attempts to withdraw the money. The withdrawn funds might be used to personally enrich the criminals or to fund additional illegal activities.

Life insurance companies can play an unintended role in a money laundering scheme because their products can be purchased in large lump sums and then surrendered for a cash value. In cases where a life insurance policy or annuity imposes a surrender charge, the size of the charge will have already been factored into the launder's cost of doing business.

Detecting Possible Money Laundering

Like other kinds of fraud, money laundering can sometimes be detected by professionals who pay attention to certain red flags. Although there might be a reasonable explanation for the appearance of a red flag, sound judgment and careful monitoring of the situation might be in order. Here are some potential red flags of money laundering:

- A cash-value product is surrendered soon after purchase.
- Ownership of a cash-value product is transferred without a reasonable explanation.

- An applicant expresses an unusual amount of concern about early surrender charges.
- Major loans are made against a cash-value product soon after purchase.

Money Laundering After 9/11

The issue of money laundering in insurance was brought up after the terrorist attacks of Sept. 11, 2001, as law enforcement tried to figure out how terrorist organizations like al-Qaeda obtained or disguised their funding. This concern prompted the introduction of anti-money-laundering requirements for insurers under the USA Patriot Act. In general, the requirements apply to companies that deal with permanent life insurance, annuities or other insurance products that can be converted easily to cash.

Insurers that are impacted by the law need to have an anti-money laundering program that trains employees about the risks of money laundering, the warning signs of money laundering and how to report suspicious activity. The extent of the training can vary from company to company and employee to employee and should be based on the amount of money laundering risks that the company or the employee is likely to encounter. The responsibility for putting the training program together and making sure the training has been done belongs to the insurer, not the individual agent. The company needs to appoint a compliance officer who will be responsible for the program. The program must be reevaluated from time to time to see if it matches the company's level of risk. Documents related to the program need to go to the U.S. Treasury Department upon request.

More information about anti-money laundering requirements can be found in some of our other self-study courses.

Viaticals and Life Settlements

Viatical settlements and life settlements relate to life insurance and have various ethics-related issues attached to them. A viatical settlement is a transaction in which an investor purchases a life insurance policy on the life of a terminally ill individual. In exchange for allowing the investor to purchase the policy and effectively become the policy's beneficiary, the terminally ill person can receive a significant amount of money that can be used as he or she sees fit. These settlements were originally intended to help AIDS patients who had purchased insurance when healthy but ultimately needed help with end-of-life expenses and other medical costs. As life expectancy among HIV-positive patients improved, the viatical market shifted toward policyholders with terminal cancer.

Life settlements are very similar to viatical settlements but involve policies on the life of a moderately impaired senior citizen rather than a terminally ill person. Because the original policy owner is in better health, the insured senior will receive less for his or her policy than a terminally ill person.

As you may have guessed, one of the ethics-related issues with viatical and life settlements relates to insurable interest. When investors buy someone's life insurance, they don't have a financial interest in having that person live longer. In fact, the return on their investment will be higher if the terminally ill person or senior citizen dies quickly. To some in the insurance business, the impact of an early death on an investor's return makes these transactions seem rather ghoulish. On the other hand, advocates of these arrangements claim that the settlements serve a noble purpose by helping needy people turn unwanted life insurance into a very flexible asset.

In addition to debates about their use, viatical and life settlements have not been immune to fraud. In their early days, these transactions received negative reputations in part because of dissatisfaction among investors. Unethical companies sometimes told prospects that their money would go toward the purchase of policies on terminally ill people when, in fact, their contributions went toward policies on people who were relatively healthy.

Clean-Sheeting and STOLI

Though they are closely related, the life insurance and settlement communities have had a very complicated, occasionally testy relationship. Part of the unease revolves around "clean-sheeting" and "stranger-originated life insurance" (sometimes referred to as "STOLI").

Clean-sheeting occurs when an uninsured sick person lies about his or her condition in order to purchase life insurance and then sell it to an investor. Depending on the circumstances, this kind of fraud might or might not be accomplished with the assistance of an insurance licensee.

In a stranger-originated life insurance transaction, an uninsured senior citizen is actively recruited by someone to purchase life insurance and sell it to investors. However, unlike a case of clean-sheeting, an applicant for stranger-originated life insurance only misrepresents the reason for purchasing the insurance. Health issues, on the other hand, are fully disclosed.

Since an applicant for stranger-originated life insurance doesn't lie about his or her health, it might be difficult to discern why life insurance companies dislike STOLI transactions. At least in part, these companies are concerned about the impact on lapse rates.

As part of calculating their potential profits, insurers bet that a certain number of policyholders will eventually cancel their insurance. When a life insurance cancellation occurs, the insurer is released from having to eventually pay a death benefit and can put those previously earmarked funds to another use. Stranger-originated life insurance complicates an insurer's estimates because the policy won't be cancelled even if the insured person no longer has a need for it. The money that was expected to be saved by virtue of a cancellation will need to remain available to pay the investor.

In response to concerns from life insurers, many states have instituted limits on stranger-originated life insurance. For example, some states don't allow someone to sell their life insurance to an investor within a certain number of years unless the person is undergoing financial or health-related hardships.

Finding a Balance

The fraud portion of this material has attempted to emphasize that some scams can be detected by relying on your instincts and observations. Of course, there are other ways to detect fraud as well. Computer programs can evaluate information on applications and alert underwriters to potential red flags. Industry databases can be accessed that link suspicious claimants who may have defrauded multiple companies.

As methods of detecting fraud increase, ethically minded insurance professionals might want to consider the tools available to their industry and monitor whether those techniques are appropriate. For instance, if fraud prevention requires some degree of spying—either in person or online—should limits still be in place in order to protect people's privacy? Or, as a philosopher might put it, "Do the ends justify the means?"

At the very least, insurance professionals who are in high-ranking roles at an insurance carrier may want to discuss fraud-prevention techniques with a qualified legal expert so that a solution to one problem doesn't create unwanted trouble.

CONCLUSION

Though people have the capacity to change, the odds are good that a person's sense of right and wrong will be cemented at an early age. Reading about ethics is unlikely to turn a bad person into a good person.

But that doesn't mean that our seemingly unchangeable principles can't be applied in new ways. Through greater self-awareness, we might come to see how our favored values of honesty, compassion and courage can be demonstrated in a wider variety of situations. In many cases, we don't need to learn new values in order to be more ethical. We merely need to remind ourselves more frequently of the values that are already important to us.

Awareness is also an important part of managing the consequences of someone else's bad behavior. If we remain alert to the potential for unethical conduct and know how it is commonly practiced, we will be more successful at preventing harmful outcomes.

Unethical conduct can occur within insurance businesses and within the ranks of consumers who interact with those businesses. If you want your profession to remain strong, you may need to address unethical behavior regardless of its source.

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