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CHAPTER 1: FIGHTING INSURANCE FRAUD

Introduction

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

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

How Big Is the Problem?

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

Another problem with measuring insurance fraud relates, frankly, to the sometimes conflicting ways in which insurance carriers and the public define the crime. Consider, for example, the differences between cases of what is sometimes called "hard fraud" and instances of what is sometimes called "soft fraud." In hard fraud, the primary motive is to enrich oneself via insurance money, such as by staging an auto accident or setting insured property on fire. In soft fraud, however, people may have suffered a legitimate loss or purchased insurance for legitimate reasons and only later given in to the opportunistic temptation of lying to an insurance company. Depending on how broadly, the term is used, examples of soft fraud might include lying about the value of personal belongings destroyed in an accidental fire, exaggerating the amount of damage to a vehicle in an auto accident, intentionally misrepresenting the ZIP code where a car is principally garaged in order to save a few dollars on auto insurance or not disclosing tobacco use to a life insurance agent.

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

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

with this mindset might believe that estimates of fraud should only include instances of hard fraud.

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

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

Consequences of Insurance Fraud

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

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

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

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

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

- An Indiana man caused a natural gas explosion in his home for the insurance money but damaged approximately 80 neighboring properties, killed two of his neighbors and injured roughly a dozen others in the process. Security cameras recorded one of the victims pleading for help from emergency workers as he died.

- A Virginia doctor allegedly lied to several of his patients, claiming they had skin cancer, just so he could perform unnecessary procedures on them and bill their insurance companies.
- A Florida eye doctor needlessly stuck needles into patients' eyes and performed botched laser surgeries in a scam that bilked insurers out of more than $130 million.
- A pet store owner committed arson for insurance money while leaving nearly 30 dogs in their cages.
- A Michigan spinal surgeon performed negligent and unnecessary surgery on several patients, leaving some of them with permanent injury and disfigurement, while collecting more than $30 million from medical insurers.
- A Minnesota father beat his son to death and hurled him into a nearby river in an attempt to obtain a $50,000 death benefit from a life insurance company.
- Physicians in Illinois preyed on the homeless community, drug addicts and the elderly, bribing them with food, money and cigarettes to complain of heart ailments and ultimately undergo pointless heart catheterizations, angioplasties and expensive tests.

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

Public Perceptions of Insurance Fraud

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

- The number of "moralists," who have no tolerance for insurance fraud and view it as a punishable offense, dropped from 30 percent to 26 percent.
- The number of "realists," who have a low tolerance for insurance fraud but say they understand why it might be committed, remained consistent at 21 percent.
- The number of "conformists," who don't really care about insurance fraud and assume nearly everyone does it, ticked up from 25 percent to 26 percent.
- Perhaps most discouragingly, the number of "critics," who believe insurance fraud is justified, rose from 20 percent to 26 percent.

No matter the age of the data, the two main reasons why a sizable portion of the population will either support or at least ignore insurance fraud don't seem to change. First, compared to other crimes, insurance fraud is viewed as relatively harmless, impacting an impersonal corporate entity rather than hurting everyday people. Second, too many consumers see

insurance companies as villains, particularly when the cost of insurance goes up and/or when an insurance claim is not handled to the policyholder's satisfaction.

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

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

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

Government Responses to Fraud

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

Insurer Responses to Fraud

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

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

But for those cases in which fraud seems too big, too obvious or too important to ignore, carriers continue to add to their arsenal in the battle against crime. It's not uncommon for an insurer to maintain an anonymous hotline via which suspected dishonesty can be reported for further investigation. Many companies take fraud prevention seriously as part of their sales training and emphasize the ways in which even one insurance agent can

spot major warning signs. Evolving technology, too, has sometimes been an insurance company's indispensable ally in opposition to fraud, with GPS devices, social media networks and even heartbeat-measuring tools all validating suspicions about claims that couldn't have been investigated effectively in previous decades.

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

Special Investigation Units

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

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

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

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

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

Social Media Tools

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

Simple examples of fraud detection via social media include cases in which people receiving disability insurance payments post public photos of themselves rock climbing, skydiving or engaging in other physically strenuous activities. In another scenario, thrill-seeking drivers who engage in drag racing or intentional car crashes will sometimes post videos of these events in an attempt to gain fame with their online communities but will forget that those same incriminating videos might be publicly viewable by an auto claims adjuster. In one of the more amusing cases of a social media gaffe, as reported by the

San Gabriel Valley Tribune, a woman who received insurance assistance after a supposedly serious back injury faced fraud allegations when she posted a video of herself hurling a heavy, several-gallon bucket of ice water onto a colleague in an attempt to raise awareness for Lou Gehrig's Disease.

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

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

Fraud Analytics in Insurance

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

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

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

Producers and Antifraud Efforts

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

By emphasizing the possibility of insurance fraud during every stage of a transaction, and by enlisting producers and underwriters in the fight against consumers' deceptions, insurance companies become more likely to stop illegal behavior. Meanwhile, this broad

approach to attacking fraud can show the public that a distaste for insurance fraud—not a resistance to paying legitimate claims—is the motivating factor behind a carrier's sometimes tough actions.

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

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

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

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

- The applicant comes to you for insurance advice in an unconventional way. For example, if your entire business is built around referrals and centered on clients who reside within a certain geographic range, should you be suspicious when someone from a faraway community wants to do business with you and has no connections to any of your existing or former clients?
- The applicant demands that coverage be issued as soon as possible.
- The applicant insists on paying all premiums upfront and in cash, no matter the amount.
- The applicant provides a strange mailing address (such as a PO box in another state) or a suspicious phone number that no one ever seems to answer.
- The applicant has no special insurance training but somehow clearly understands how insurance claims are processed. This might seem like an even bigger red flag if the applicant expresses concern about how a particular carrier processes claims compared to competitors and if the person has already accumulated a spotty loss history.
- The applicant's previous loss history (if known) seems disproportionately weighted toward suspicious claims, such as multiple fires at different properties or multiple children with life insurance all dying at early ages.
- The applicant seems abnormally concerned about issues other than the coverage itself, such as any "free-look" or cancellation opportunities or whether the

transaction will require reporting to the IRS or some other regulatory body. Like insisting on cash-paid premiums, such behavior might be a sign of attempted money laundering.

- The applicant is unreasonably combative when asked for basic information.
- The applicant openly admits to experiencing major financial difficulties.

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

Examples and Red Flags of Insurance Fraud

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

Property Insurance Fraud

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

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

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

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

Fraud by Property Owners

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

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

- A claim involves personal property that had been added very recently to the owner's insurance policy.
- A claim involves a major loss that would not be covered in full if not for recent increases in the policy limits.
- A claim involves a structure that was on the verge of being lost by the owner, such as a home facing foreclosure or a commercial building nearing condemnation.

- A claim involves expensive items that have mysteriously disappeared. (This red flag helps explain why most insurance companies either don't cover certain items when they simply can't be found or at least why certain items—such as jewelry—might only be covered against this risk for a limited amount or for an extra charge.)

Arson

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

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

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

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

Fraud by Contractors

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

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

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

Although some carriers have derided the existence of assignment of benefits clauses, these provisions in insurance policies aren't entirely without value. In legitimate instances, they can help an insured person receive services from a third party even if the insured

person can't pay upfront for the work. The clauses, when not abused, can also sometimes result in smoother claims processing, since the service providers typically have more experience dealing with insurance claims than the average consumer. In fact, assignment of benefits is a common and often encouraged practice in health insurance, where patients sign forms at a medical office so that their doctors can bill insurance companies directly rather than forcing the patient to fill out and send complicated paperwork on their own.

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

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

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

Auto Insurance Fraud

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

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

- A driver suffers legitimate damage in an accident but bills an insurer for repairs of pre-existing damage unrelated to the accident.
- A driver lies about where a vehicle is principally garaged. (With auto insurance premiums influenced heavily by ZIP codes, the distance of a few miles can make a significant difference in the cost of coverage. In general, urban areas with more traffic or instances of auto theft tend to correspond with higher insurance rates than rural areas.)
- A driver fails to disclose whether a personal automobile is also used for business.
- A driver fails to disclose the amount and identities of others who have regular access to the insured vehicle.
- A driver intentionally underestimates how frequently a car is driven.
- An uninsured driver suffers property damage in an accident, buys insurance quickly and then claims that the accident occurred after the policy had been issued. (This attempt at fraud is known as "crash and buy.")

- A driver reports a vehicle stolen even though it has actually been dismantled and sold for parts.
- A driver's account of an accident is in conflict with data available to the insurance company (such as weather reports on days when an accident is alleged to have been caused by slippery roads, or data from insurer-installed devices that monitor an insured driver's speed and other behind-the-wheel activities).
- An accident occurs very soon after coverage is issued.
- The location where a vehicle will allegedly be garaged does not match the driver's mailing address, vehicle identification number or public records.
- A driver asks if coverage can be backdated so it can go into effect retroactively.
- The number of drivers insured under a policy is in conflict with what the driver has told an insurance professional about the size of his or her household.

Staged Auto Accidents

For a long time, insurance fraud was thought of as something an individual committed alone or with a few close confidants. But today, it almost seems as though those were the innocent good old days, back when individuals committed fraud but thought it best not to get too many strangers directly involved in their scams. Modern auto insurance fraud is often an example of organized crime and utilizes many participants.

Auto insurance fraud rings tend to be most common in states with no-fault auto insurance laws. The rings can be extremely complex. In some instances, these operations have included drivers, passengers, witnesses, tow-truck operators, repair shops, doctors, lawyers and police officers in their schemes. Each of these participants takes a cut of the billions of dollars that insurers allegedly lose each year because of phony claims.

Organized auto insurance fraud is more than just a serious problem for insurance companies that want to keep their money out of crooks' hands. Perhaps more than any other kind of insurance fraud committed on the consumer's end, auto insurance fraud deserves the attention of all people; those with insurance and those without, those who drive and those who ride in the passenger's seat. Rather than a seemingly victimless crime, this range of deceptions often hurts the innocents among us.

To better understand why, let's look at an example of how an auto insurance fraud ring functions.

Rob is part of an auto insurance fraud ring and is one of two passengers, plus a driver, in an inexpensive car. As they ride down some of the roads in an area where reasonably high speed limits are permitted but where twists and turns make driving a bit more challenging, Rob and the other passenger are watching for certain kinds of drivers. The less witnesses, the better, so they ideally want to find someone who is traveling alone.

They look at license plates as well, hoping to spot a tourist who would not want to waste time and money to challenge an insurance matter in a faraway state court. Or perhaps they decide to racially profile a victim. A seemingly foreign-born person who might be an undocumented immigrant and worried about being reported to authorities would be a good target because he or she might be less likely to call police or more easily intimidated into going along with whatever story Rob and his friends concoct.

After what seems like an hour, they finally settle on a car they can all agree on, a car driven by a man who has no idea he is about to become a victim of a fraud.

Rob's driver follows the man and is eventually able to move in front of the other vehicle. Keeping an eye on the distance between the two cars and adjusting his speed for the preferable amount of impact, Rob's driver slams on the breaks, and Rob holds his breath for a split second to brace himself for the forceful push that occurs when the two cars meet.

Rob's fellow passenger is all set with his fake vomit, ready to moan, groan and rub his stomach at the very second when the innocent driver approaches. Meanwhile, Rob tries to focus on what to say about his back, not wanting to overdo it. (That might call for x-rays and other unbiased medical tests that could expose the fraud.) But Rob wants the innocent driver to believe he is dealing with enough soreness and pain to warrant a few grimaces and mumbles, especially when turning his neck a certain way.

The innocent driver would normally be cursing at Rob and his friends, but his heart softens as Rob says he feels a little dizzy. Rob and the other members of the ring apologize to the innocent driver all at the same time, competing with one another so much that all he can really make out is something about an animal jumping in front of the car and the word "sorry" again and again.

After swapping driver information, one of the co-conspirators tells the victim they have already been on the phone with the police to report the accident. Sometimes when doing these jobs, that is indeed what is happening. But on other occasions, the companion is actually phoning an off-duty police officer who is in on the scheme.

After the accident is squared away, Rob and his gang visit a personal injury attorney who will fight for assorted reimbursements from any applicable insurance companies and who gets all of them an appointment with the same doctor. The doctor's office is as basic as they come, with no modern equipment in sight or any other visibly sick patients waiting for their own appointments. The doctor's practice, Rob knows, is only a front for these insurance scams and, come to think of it, so is the body shop that estimated the allegedly major damage on Rob's already beat-up jalopy.

If those mechanics knew how little they were making from these scams compared to the big cuts that the lawyer and doctor take home, they would probably threaten to expose the whole operation. But on second thought, there is no need to hold a grudge against the doctor. After all, she's the one who testifies to insurance companies and courts about Rob's phony back problems, headaches and other nagging soft-tissue ailments that are difficult to disprove. She and the lawyer are the ones with enough power and persistence to get the insurance companies to pay the claims.

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

Rob might think about those two cases of organized auto insurance fraud gone wrong and feel sad for a moment or two, but this feeling would likely go away when he is reminded of the insurance checks that will soon be provided to him. From Rob's point of view, there's no need to feel guilty, no need to be sad. Nobody died from what took place … not today anyway.

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

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

Organized Crime and Real Accidents

Sometimes an accident is not staged in any way, but doctors, lawyers and their associates work with victims to build a fraudulent case after the fact. Many small, local newspapers summarize accident reports in each issue, and any persistent reporter can usually obtain a copy of a police report or at least get a glance at one for note-taking purposes. For a fee, people called “ringers” or “steerers” might impersonate someone from the press or take advantage of a source at a police station or an insurance company and gather the names of people involved in recent car accidents.

This person might then contact accident victims and, if they have not yet contacted their insurance company, the ringer will suggest they wait until a particular doctor examines them. If the ringer has reason to believe an insurer already knows about the accident, he or she might tell victims that their insurer insists they see a specific doctor.

At that point, the ringer moves out of the picture, having not necessarily committed any claims fraud, and allows the lawyers and doctors to handle the rest of the situation. Maybe these scams work because the doctor and lawyer actually convince the patient that he or she suffers from certain after-effects from the accident. Maybe there are legal, physical or financial threats involved. Or maybe the accident victims recognize an insurance scam when they see one and are perfectly willing to become players in the master plan if doing so might net them a few bucks.

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

- Databases show that the same people tend to be involved in multiple accidents, often playing different roles. (For example, the driver in one accident was a witness in a second accident and a passenger in a third.)
- Evidence suggests that someone involved in the accident was reluctant to notify police and file a report.
- The amount of alleged physical injury seems disproportionate to the amount of physical damage to the vehicles.
- An alleged accident victim receives an abnormally high amount of treatment from one medical provider and is never referred to a specialist.
- The number of passengers in the alleged accident was significantly higher than the car’s capacity. (Extra passengers might’ve been stuffed into the car to allow for more claims of physical injury.)
- Injuries sustained by victims are “soft-tissue” injuries—such as back pain or whiplash—that can’t easily be proven or disproven by x-rays, body scans or other standard medical tests.

- Alleged accident victims are frequently utilizing a medical clinic with connections to their attorney.
- Alleged accident victims frequently report being struck by a hit-and-run driver or a vehicle that "came from out of nowhere."

Fraud by Body Shops

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

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

Workers Compensation and Disability Insurance Fraud

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

Fraud by Workers

If a workers compensation claim doesn't seem to make sense, it is more than likely that some kind of investigative team will be called in to handle the situation. Sometimes insurance companies employ their own teams, and sometimes employers or insurance companies outsource the work to private investigators.

All witnesses to an accident should be interviewed as soon as possible so that their recollections can either confirm or contradict the injured person's story. If an employer can only provide vague reports of an incident, the investigator's job becomes tougher, and an accusation of fraud could unfortunately boil down to nothing more than one person's word against another's.

An employee's status with a company can hint at the truth surrounding an accident. If an organization has announced layoffs, a person who believes he or she will soon be one of those laid off might panic and turn to workers compensation fraud.

Coworkers are important sources of information in these situations because they might have been the audience for an injured person's thoughts. Or, in a more optimistic outcome, they might be able to assure doubters that the person was a dedicated employee who would probably not engage in serious deceit. Temporary employees and new hires who make workers compensation claims often arouse some suspicion because their coworkers have not known them long enough to vouch for their character.

Accidents involving no witnesses are obvious causes for concern. This is especially the case when they occur on Monday mornings, since some workers might try to make their employer responsible for injuries actually suffered during free time on weekends. These employees will seem even less credible if they have reputations around the office as athletes, physical risk-takers or avid outdoorsmen.

Once the worker is out of the office, investigative teams can observe the person from afar. If the employee has a second job, a team might visit the second workplace to see if the injured person shows up for duty. Sometimes teams catch an allegedly disabled person moving heavy furniture, playing an aggressive game of softball or taking part in other strenuous activities that seem to contradict an injury claim.

When these significant discoveries are made, they may lead to a claim being denied, thereby saving the insurer and employer money. In some cases, however, these seemingly defenseless exhibitions of physical strength are not clean-cut examples of people getting caught in a lie. Some injured parties have successfully argued that an investigator merely observed them on one of their better days or did not take note of the many hours they spent recovering from the heavy lifting or the softball game. As weak as those lines of defense may seem, most professional fraud investigators attempt to strengthen their cases against supposed insurance cheaters by documenting a pattern of suspicious activity before challenging a claim.

Red flags also fly when people injure themselves at work despite having a reasonably safe job. Though freak accidents do occur, an employer or an insurer might wonder, for example, why a receptionist or clerical employee has filed for workers compensation benefits twice in the past three years.

Fraud by Employers

When business owners commit insurance fraud with respect to workers compensation, their goal is usually to reduce their insurance premiums and tax-related responsibilities. Through a method called “misclassification,” businesses might lie about their number of employees—as opposed to independent contractors—or aim to convince an insurance company that some of their workers with high-risk jobs are actually doing low-risk tasks. For example, a construction company might claim its roofers are actually engaged in general carpentry, or a manufacturer might declare that its warehouse employees are clerical workers. Some entities will even go so far as to establish shell companies abroad to make it appear as though they have significantly fewer employees on their books. While lowering their workers compensation premiums, many of these schemes also aim to reduce a business’s payroll tax liability.

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

Life Insurance Fraud

Despite occupying a juicy spot at the center of crime novels and a few classic films, life insurance fraud—at least compared to fraud in the health, property and casualty sectors of the industry—is thankfully rare. Rather than sensational cases in which beneficiaries

murder their loved ones for a death benefit, most cases of major life insurance fraud involve faked deaths, often by policyholders in dire financial straits. A husband, for example, might purchase several small term life insurance policies from several companies, list his wife as the beneficiary and then have his surviving spouse claim that he died in a third-world country where autopsies are uncommon or where falsified death certificates can be obtained easily on the black market. Unethical opportunists even took advantage of national sympathies and falsely claimed to have died in the terrorist attacks of 9/11.

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

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

Health Insurance Fraud

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

- **Billing for medical services never actually performed:** Sometimes this will be done through "upcoding," in which a provider will provide one type of cheaper medical care but bill an insurer for a more expensive procedure. In other scenarios, a medical provider will have performed no care at all but will be able to use a patient's insurance information through threats or intimidation. For example, some providers have taken advantage of opioid addiction in the United States by recruiting addicts, dangling medication in front of them in exchange for their health insurance information and threatening to cut off their drugs if they don't cooperate.
- **Performing unnecessary procedures:** In another example of abuse related to drug addiction, at least a few doctors have performed painful yet totally unnecessary surgeries on patients in exchange for medication.
- **Misrepresenting an elective medical procedure as medically necessary:** For instance, perhaps sympathetic to a patient's concerns about large medical bills, a plastic surgeon might claim that someone who wants a nose job for cosmetic reasons is actually suffering from a deviated septum.

- **Unbundling various medical charges that should ordinarily be combined into one:** Rather than billing a flat rate for a common annual checkup, a doctor might bill one amount for checking a patient's vital signs, another amount for making a visual observation of the patient, another amount for answering a patient's basic medical question, etc.
- **Employing unqualified (and perhaps unlicensed) medical staff to treat patients and billing the insurer under the doctor's name:** In an effort to spot this activity, insurance databases should be capable of flagging scenarios in which the volume of provided medical care stretches the limits of mathematical credibility. For instance, doctors have been caught claiming to have seen patients for more than 24 hours per day.

Although patients cannot be expected to understand the complexities of medical billing, the insurance industry encourages them to look carefully at any medical billing statements and report any obvious irregularities. Even if a patient shares none of the cost for a fraudulent claim, cases of medical identity theft can create errors in a victim's medical records, such as incorrect blood types, bogus prescription histories and more. When relied upon in an emergency, those compromised records can put a patient's health at risk.

Conclusion

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

Producer training is key to making any progress on the issue. If the industry wants to reach its customers and convince them that insurance fraud is a problem worth tackling, agents and brokers might be some its best messengers.

CHAPTER 2: REVIEWING TERM LIFE INSURANCE

Introduction

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

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

With a careful blend of patience and expertise, life insurance professionals can guide consumers toward the right answers to those questions.

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

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

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

Term Life Insurance vs. Permanent Life Insurance

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

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

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

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

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

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

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

Who Needs Term Life Insurance?

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

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

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

- The person has a spouse who will need financial assistance regardless of when the insured person dies.
- The person has a special-needs child who is likely to require financial support throughout his or her lifetime.
- The person is not disciplined enough to save money on his or her own.
- The person is interested in building a policy's cash value in order to pay for an eventual major expense, such as a child's college education.

- The person has a permanent need for life insurance and is likely to be able to afford it over an extended period of time.
- The person is in a high tax bracket or is likely to die with a sizable and complicated estate.
- The person doesn't like the idea of buying term life insurance, surviving the term and never getting any financial benefit from a policy.
- Regardless of the reason, the person foresees wanting life insurance during his or her senior years.

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

Level Term Insurance

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

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

Decreasing Term Insurance

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

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

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

Where to Buy Term Insurance

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

In addition to being sold by insurance agents who specialize in life insurance, term life products are also commonly available from banks, professional associations and financial planners. As will be further noted in the next section, it's also a popular group benefit at many workplaces. Permanent life insurance is less likely to be sold through these additional channels because the products are more complex and require a lot more comparing and contrasting in order to pick or recommend the right type. (Whole life, universal life and variable life are only three of the many forms of permanent life insurance that might require careful study and consideration.)

Group Term Life Insurance

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

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

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

Term Lengths

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

One-year term insurance, known as "annual renewable term," was fairly common several decades ago and suited consumers whose need for life insurance was very temporary, but the cost of issuing policies that lasted for such a short time wasn't always favorable

for insurance companies. In today's market, longer terms, such as 5, 10 or 20 years, are far more likely.

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

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

Pricing and Premiums

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

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

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

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

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

Renewability

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

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

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

Reentry Term

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

Conversion Options

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

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

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

Of course, because permanent life insurance lasts longer and provides more features than term life insurance, conversion will require payments of higher premiums. Premiums after the conversion might be based on either the age at which the insured person originally

bought term life insurance, known as the person's "issue age." Alternatively, the post-conversion cost might be calculated on the basis of the person's "attained age" at the point of the conversion.

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

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

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

Term/Permanent Life Insurance Combinations

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

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

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

Consider this basic example:

- A family purchases a family income policy with a 20-year term built into it. If the insured parent dies in year 19 of the term, the surviving parent will receive monthly payments for the remaining year of the term plus the face amount of the policy's permanent life insurance component. If the insured parent dies after the 20-year

term, the surviving parent will receive the face amount of the policy's permanent life insurance component but won't receive a monthly income.

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

Consider this basic example:

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

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

Optional Riders

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

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

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

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

Conclusion

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

CHAPTER 3: REVIEWING PROPERTY AND CASUALTY INSURANCE

Introduction

Loss is a factor of everyday life, and most people handle small everyday losses on their own. But when there is a potential of an unmanageable loss, individuals and businesses look for other sources to be protected from financial ruin.

One such source is insurance. Insurance transfers the risk of an uncertainty of a loss from an individual to an insurer. Property and casualty insurers accept risks related to loss or damage to buildings and possessions, as well as risks related to liability.

The insurance company accepts risk from its customers and charges a fee or "premium" based on the likelihood and severity of a loss. More specifically, the insurance company will consider at least the following factors:

- **The certainty of the loss:** For example, is a home sitting on a mountainside where landslides are an everyday occurrence, or is the home sitting in a subdivision of leveled land where there is no potential of landslide? Is a home situated in a flood plain, or is it far away from this potentially hazardous type of area?
- **The management and reduction of the risk of loss:** For example, proper training of an employee using a blowtorch or other high-risk machinery would curtail loss frequency and will generally be viewed favorably by an insurance company. The same could be said about installing a sprinkler system in a home, office, or factory since it would curtail the severity of possible fire damage.

Premium Basics

An insurance contract transfers the risk from an individual, a business, or a group of individuals to an insurance company in exchange for a premium. The premiums of many individuals are 'pooled" by the insurance company to create the funds necessary to pay for losses.

In pricing their premiums and determining how much risk they will absorb, insurance companies use statistics showing how many potential losses can occur within a numerical quantity of people. The higher the quantity of people used in establishing the statistics, the more accurate the prediction will be.

Is It Insurable?

Before an individual, entity or piece of property can be insured, several factors must be considered. One major consideration is the presence of insurable interest.

In property and casualty insurance, insurable interest is defined as any actual, lawful and substantial economic interest in the safety or preservation of the subject of the insurance from loss or destruction or financial damage or impairment. Someone who lacks insurable interest in something cannot insure it.

Other considerations related to insurability include:

- The potential for loss, or at least the timing of loss, must be unpredictable.
- The potential loss must be able to be assigned a financial value.
- The presence of the "spread of risk" must be available. (Spread of risk is defined as the insurer's ability to spread insured risks over a large geographical area.

Without spread of risk, a single disaster could put an insurance company out of business.)

- The risk must be pure and not speculative. ("Pure risk" is defined as a risk in which there is no chance of gain, whereas a "speculative risk" is defined as a risk that can result in either a loss or gain. Since investing in the stock market could result in a loss or gain, it is considered a speculative risk and is generally not insurable.)

Perils and Hazards

In discussing property and casualty insurance, the terms "peril" and "hazard" need to be defined. A peril is the cause of the loss. A hazard is anything that increases the potential of the loss.

There are three different types of hazards:

- A "physical hazard" arises from the condition, occupancy or use of the property itself, such as a slippery or broken-down staircase.
- A "morale hazard" arises through unintentional carelessness or irresponsible actions, such as a belief that front doors don't need to be locked because a neighborhood is considered "safe."
- A "moral hazard" arises when an individual is tempted to create a loss for the purpose of collecting the insurance money and commits fraud.

The Insurance Contract

The insurance company and the owner of an insurance policy have a contractual relationship.

A contract is a legal agreement between two competent parties that promises certain performances in exchange for a certain consideration. When an insurance company agrees to compensate the insured for certain losses in exchange for a premium, both parties have entered into a contract.

In order for a contract to be valid, it must have certain elements, and an insurance contract is no exception. The elements of a contract include the following:

- **Competent parties:** In order for an individual to be judged competent, that individual must be of legal age, not considered mentally incapacitated and not under the influence of alcohol or other drugs.
- **Legal purpose:** Any contract entered into for an illegal purpose (such as a contract to steal property) is not valid.
- **Agreement by the parties:** The parties must come to a mutual agreement that is beneficial to both parties.
- **Offer and acceptance:** When an individual or entity submits an application for insurance, this is considered an offer. Acceptance occurs when the insurer accepts a premium.
- **Consideration:** Consideration is provided to the insurance company by the insured when the insured pays the premium. Consideration on the part of the insurer occurs when the insurer promises to pay certain losses under certain conditions.

Concept of Indemnification

A special characteristic of an insurance contract is a feature called “indemnification.”

Indemnification is a guarantee by the insurer that when a loss occurs, the insured will be restored to the approximate financial condition he or she was in before the loss, not better and not worse. With this in mind, it is often said that insurance is meant to make the policyholder “whole” after a loss.

Contracts Within a Contract

Insurance policies are complex documents that are actually several different types of contracts built into one. For example, most insurance contracts can be correctly described in all of the following ways:

- **Aleatory contract:** An insurance contract is aleatory because it depends on a loss occurring before the insured receives monetary compensation. If no loss occurs, the insurer generally provides no benefits.
- **Adhesion contract:** Insurance contracts are contracts of adhesion because one party draws up the contract (the insurer) and the other party (the insured) agrees to the terms and conditions. It is very rare for the insured to have much say in the specific wording of the contract. Because of this, if a dispute arises due to ambiguous language in the policy, the courts often apply a doctrine of reasonable expectations and generally rule on behalf of the insured.
- **Unilateral contract:** An insurance contract is unilateral because one side (the insurer) must perform or potentially be subject to court action, whereas the other side (the insured) can opt not to perform and generally won’t be subject to court action. If the insured opts not to perform the obligation to pay premiums, the insurer’s main option—rather than taking the insured to court—is to cancel the contract.
- **Good faith contract:** An insurance contract is a contract of good faith because both parties rely on the truthfulness and integrity of each other. An insurance company must act in good faith and pay a claim as long as the premium is paid, subject to the terms and conditions of the insurance policy. Making the insured complete unreasonable tasks in order to get a legitimate claim paid can result in regulatory fines or a lawsuit.
- **Conditional contract:** An insurance contract is conditional because it relies on certain stipulations outlined in the contract that each party must perform. Many insurance policies outline the duties, obligations, and definition of terms and roles in five separate sections. Those segments are:
    - **Declarations:** In property insurance, the declarations page typically includes the name of the insured, the address, the amount of coverage, a description of the property, and the cost of the policy.
    - **Insuring Agreement:** The insuring agreement outlines what is covered by the policy.
    - **Conditions:** The conditions section outlines the responsibilities and obligations of both parties.
    - **Exclusions:** The exclusions section describes which losses are not covered by the policy.

- **Definitions:** The definitions section spells out what different words mean in relation to the policy.

Property and Casualty Endorsements

In property and casualty insurance, endorsements change and modify the original policy in some way. In life and health insurance, the term “rider” is typically used instead of “endorsement.”

Types of Insurance Companies

Depending on the prospective purchaser and the type of desired coverage, insurance might be obtained from any of the following entities:

- Stock companies.
- Mutual companies.
- Reciprocals.
- Lloyd’s associations.
- Fraternal benefit societies.
- Risk-retention groups.
- Government.

Stock companies are structured by the sale of stock to individuals who become stockholders in the company. The goal of the company is to make a profit and return dividends to its stockholders. Stockholders can be either insured parties or simply investors in the venture.

Mutual insurance companies are owned by all the insureds, and profits are returned either in the form of dividends or a reduction in future premiums.

A reciprocal is made up of members who agree to share the insurance responsibilities with all the other members of the unincorporated group. All members insure each other and share in the losses. A reciprocal is often managed by an attorney who handles all the business of the reciprocal.

A Lloyd’s association is structured as a voluntary association of individuals, or groups of individuals, who agree to share in insurance contracts. Each “syndicate” or individual is individually responsible for the amounts of insurance it writes.

Fraternal benefit societies are structured as incorporated societies or orders without capital stock. Business is conducted solely for the benefit of its members and their beneficiaries. They operate on a not-for-profit basis. Fraternal organizations offer insurance that is available only to their members.

A risk-retention group is an insurance company formed by several organizations to cover those organizations’ loss exposures. It is often exempt from most state laws that apply to insurance companies.

Government insurance programs are often available to provide coverage that is not normally available through private insurance companies. Examples of this are flood insurance and high-risk auto insurance programs.

Types of Property and Casualty Coverages

Property insurance generally insures personal property, homes and buildings. Common examples of property insurance are listed below:

- **Dwelling insurance:** This insurance might be purchased by the owner of a non-owner-occupied rental property.
- **Homeowners insurance:** This insurance might be purchased by the owner of a home.
- **Commercial property insurance:** This insurance might be purchased by a business to protect its own property and that of its customers.
- **Inland marine insurance:** This insurance might be purchased to insure property that is commonly in transit, either by road or waterway.
- **Ocean marine insurance:** This insurance might be purchased to insure vessels and cargo that travel on the oceans.

Casualty insurance normally covers the liability risk that we face as a result of our actions toward others. Included in this category are the following types of insurance, among others:

- Aviation insurance.
- Auto insurance.
- Crime insurance.
- Workers compensation insurance.
- Surety bonds.

Regulating the Property/Casualty Field

The insurance industry as a whole is regulated by various entities. In addition, some entities don't directly regulate insurance but have significant influence on those that do. Some of the agencies or organizations that have the most influence on the property and casualty industry include:

- State departments of insurance.
- Federal regulatory bodies.
- National Association of Insurance Commissioners (NAIC).
- A.M. Best Company.
- Standard and Poor's.

Each state has an insurance department that is charged with regulating the insurance industry within that particular state. The administrators of their departments are called "directors," "superintendents" or "commissioners" of insurance.

These administrators, on a voluntary basis, become members of a national organization called the National Association of Insurance Commissioners (NAIC). This organization meets at established intervals to exchange information. Through their recommendations and decisions, the nation's insurance laws reach a certain level of uniformity. Although not binding on any state, their recommendations often become law and are employed in individual states.

A.M. Best Company and Standard and Poor's each publish ratings of insurance companies, evaluating the financial position of these companies. Consumers looking to choose an insurance carrier are often encouraged to check with these ratings services because a low-rated company might not have as much financial health to pay claims as a high-rated company.

When a state reviews the ability of an insurance company to do business in its area, a company is authorized either as an "admitted" insurer or a "non-admitted" insurer. An admitted insurer is fully authorized to conduct business in that state, whereas a non-admitted or non-authorized insurer is only permitted to do business under certain special circumstances, such as when coverage is not available from an admitted carrier.

Each state's insurance department plays a vital role in the areas of:

- Regulation of agents.
- Ratification of forms.
- Ratification of rates.

Regulating the Agent

With minor exceptions, insurance agents must be licensed and regulated by the state. It is generally illegal for an individual to sell insurance without being licensed.

Agents must complete an established amount of pre-licensing education before they can be administered an exam for their initial licensing. The successful completion of this exam and proper processing of their application will permit agents to become licensed to sell insurance.

In addition to initial licensing, all states have enacted laws that require an agent to complete a prescribed amount of continuing education hours of study in order to renew their licenses at each renewal interval.

Ratification of Forms

Policy forms (such as a company's standard insurance policy) and endorsement forms used by insurers in most states must be approved by the states. Several methods are used to achieve this goal, with the appropriate method often depending on the type of insurance being sold and the state where insurance transactions are occurring. These methods include:

- **Prior approval:** In this method, all forms must be submitted to the state for approval prior to the use of the forms.
- **File and use:** In this method, a company can start using the forms as soon as they have been filed with the state but might need to stop using them if the state later decides not to approve them.
- **Use and file:** In this method, an insurance company can use the forms in advance as long as the forms are eventually filed with the state within a specified period of initial usage.
- **Mandatory forms:** In this method, all insurers in a particular market must use a special state-approved policy form.
- **Open competition:** In this method, companies can use forms that are competitive to the market place, as long as they are non-discriminatory.

Ratification of Rates

Much like the use of forms, rates for insurance have certain controls imposed upon them before they can become official and charged to customers. Again, the manner in which rates are regulated and approved will likely depend on the type of insurance and the state where it's being sold. Approaches to rate approvals are listed below:

- **Prior approval:** In prior approval states, all rates must be approved by the state before an insurance company can begin using them.
- **File and use:** In file and use states, insurance companies may begin using rates as soon as they are filed with the state. Eventually, the state can either approve or disapprove the rates.
- **Use and file:** In use and file states, insurers may begin to use rates but must eventually file those rates with the state within a specified period of time.
- **Open competition:** In open competition states, insurance companies are free to set rates in accordance with the market place as long as they meet the requirements of adequacy and nondiscrimination. In establishing rates by this method, an insurance company must calculate rates that will be adequate to cover:
    - The cost of losses that will have to be paid.
    - The cost of conducting business.
    - A margin of profit.
- **Mandatory rates:** In these states, the rates are set by the state, and the insurance company must adhere to them.

Enforcement of Insurance Regulations

Failure to comply with state regulations can result in any of the following consequences:

- Fines.
- License suspension for the agent.
- License revocation for the agent.
- Suspension of a company's authority to do business.
- Revocation of a company's authority to do business.

The Application For Insurance

The insured's offer of insurance is made through the application form. The accuracy of the information on the application form is critical to the acceptance of the insured. Both the agent and applicant must be totally truthful and thorough in providing the requested information. The information provided in the application will help the underwriter determine whether to accept the risk as well as what rate to charge for the requested insurance.

The Binder

Once the application form has been completed, the property and casualty agent may have the authority to issue a "binder." A binder is a statement, usually in writing, that the insured has immediate protection for a specified period of time. A binder is not a guarantee that a policy will be issued but is merely a temporary coverage until the application has been investigated and reviewed.

Binders tend to be fairly unique to the property and casualty field of insurance and are not commonly used in the life insurance or health insurance fields. In those areas of the insurance business, a more restrictive document known as a "conditional receipt" will often be provided in place of a binder.

Since binders can force an insurer to pay for losses that occur even while an applicant is still being evaluated, agents should understand their level of binding authority and should only issue these documents with care.

Evaluating and Investigating the Application

The evaluating and investigating of the facts of an application are done by an underwriter. In addition to the application, underwriters turn to other sources for information. Included in these sources are:

- The company's own claim files.
- Previous insurers of the applicant.
- Inspection services.
- Insurance industry bureaus.

If an applicant is denied as a result of information provided by an outside credit reporting firm, the applicant, by requirement of the federal Fair Credit Reporting Act, must be notified in writing and must be given the opportunity to receive a copy of the derogatory information from the reporting agency.

An underwriter also has an obligation to protect the insurer against adverse selection. Adverse selection is defined as the tendency of insureds with a greater-than-average risk of loss to purchase insurance.

Rating the Policy

There are at least three basic ways of rating a policy:

- Judgment rating.
- Manual rating.
- Merit rating.

The judgment method of rating establishes premiums based on a careful evaluation of each individual risk without the use of manuals or tables.

The manual rating method uses rates based on collected statistics. The rates, which apply per unit of insurance, are published in manuals.

The merit rating method determines premiums by starting with a manual rate and then modifying it to reflect the risk's unique characteristics.

Proof Of Insurance

Once a policy has been accepted, a consumer might ask for and receive a "certificate of insurance." The certificate carries a general summary of the coverage of the policy and is often provided by the consumer to third parties who want confirmation of the consumer's insured status. For example, a building contractor might ask a subcontractor to provide a certificate of insurance before allowing the subcontractor to complete any work on a construction project. Similarly, a home improvement business might provide certificates of

insurance to its customers as reassurance that the company is properly covered for property damage, workers compensation and other liability risks.

Cancellation of the Policy

Once a policy has been issued, a company can cancel it only under the specified conditions of the policy. Three of these conditions are:

- Misrepresentation.
- Concealment.
- Fraud.

“Misrepresentation” is a written or verbal misstatement of facts involved in the contract on which the insurer has relied in order to issue the specified coverage. Misrepresentation can be either intentional or unintentional. If misrepresentation involves a material fact, the insurer might have solid legal standing to cancel the policy.

“Concealment” is the withholding of facts involved in the contract on which the insurer relies. In this case, the person engaging in concealment doesn’t outwardly lie but fails to disclose important information.

In general, “fraud” is a deliberate misrepresentation that causes harm.

Other important terms in property and casualty insurance are listed below:

- Waiver.
- Estoppel.
- Policy period.
- Unearned premium.
- Short-rate basis.
- Pro-rata basis.
- Flat-cancellation basis.

A “waiver” is the intentional relinquishment of a known right.

“Estoppel” is the principle that states that if one party intentionally or unintentionally creates the impression that a certain fact exists, and an innocent party relies on that impression and is injured as a result, the guilty party may be legally prohibited from asserting that the fact does not exist.

The “policy period” is the date and time specified in the declarations page, showing when coverage begins and ends.

“Unearned premium” is any premium not yet “used up” and that will be returned if the policy is canceled.

“Short-rate basis” is a method of calculating a premium refund for unused premium wherein the company not only keeps the premium for insurance already used, but also keeps an allowance for expenses, such as issuing the policy.

“Pro-rated basis” is a way of computing a premium refund when the insurance company cancels the policy and returns all unused premiums without deduction for any costs.

“Flat cancellation” refers to a policy being canceled by either party on its effective date.

The History of Fire Insurance

Fires are an alarming cause of financial insecurity. The destruction of property values and the loss of human life can be a traumatic experience to families and businesses alike.

The first fire insurance company in the United States was established in 1734 and was called the Friendly Society for the Mutual Insurance of Houses Against Fire. By 1740, this firm was out of business as a result of a fire in Charleston, South Carolina, that wiped out most of the area.

After the disastrous fire of 1740, several other fire companies were formed. These insurers used a risk classification method basing rates on the construction materials used in the building of the dwelling. Thus, a building constructed of brick had a more favorable risk rating than one made of wood.

Fire insurance companies in early America sometimes operated on a subscription basis. Subscribers would pay fire-fighting companies in advance and receive a metallic logo in return that would be installed outside their building. If a protected property had a fire, the appropriate fire-fighting company was notified. And once the fire mark was identified, the fire was fought.

During the early years of fire insurance, insurers drafted their own policies, and the contracts lacked uniformity. The contracts were lengthy and restrictive, and numerous moral hazard clauses and other restrictive provisions were inserted in the contracts, which permitted insurers to deny claims.

Furthermore, insurance policies were written to cover a single peril. If an insured needed additional coverage, such as for wind damage or some other peril, it was written as a separate policy. Often, these additional perils were not even covered by the same company.

In 1873, Massachusetts became the first state to adopt a standard policy for the writing of fire insurance. New York passed a similar law in 1886. The standard fire policy was later revised in 1918 and later in 1943 and became the basis for fire insurance policy language in many other parts of the country.

Two major advantages result from a standard policy, such as the one crafted in New York all those years ago. First, loss-adjustment problems are lessened, since the possibility of two contracts with different policy provisions is reduced. Second, there are fewer legal difficulties, since the courts have interpreted the words, phrases and provisions of the standard contract repeatedly, and their meaning is known more precisely.

Despite being replaced by other standard policy forms in subsequent decades, the standard fire policy from New York remains an important historical document. Many basic property insurance concepts were first legally defined in it. For example, the principles of indemnity, insurable interest, actual cash value and pro-rated sharing of losses can all be traced back to the New York document.

Although the standard fire policy offered basic protection, many insurers argued that a policy offering broader coverage would benefit the industry as well as the public. In particular, product that covered both property and liability in one policy would be much more desirable.

Insurance companies felt that they would benefit from a combined fire and liability policy in the following ways:

- Decreased adverse selection against the company.

- Reduction in overall administrative and underwriting costs.
- Increased policy retention.

In the late 1940s, insurers were permitted by insurance regulators to combine property and casualty perils into one policy. Many formats and combinations of coverage sprung out from this deregulation. Eventually, most property and casualty insurers settled on offering a standard package policy that is known generally today as “homeowners insurance.”

Although insurance companies selling homeowners insurance are not necessarily required to sell the exact same policy with the exact same wording as their competitors, most at least base their homeowners policy forms on language crafted by a private company called the “Insurance Services Office” (ISO). Language from the ISO is then commonly amended, often by adding an endorsement to the standard policy, to suit a carrier’s or customer’s specific goals or needs.

Homeowners insurance is a package policy that combines two or more separate contracts into one policy. The current homeowners insurance format typically incorporates the standard fire policy with other coverages, including comprehensive personal liability insurance, additional living expense coverage, replacement-cost coverage on the dwelling and medical expense coverage for people other than the homeowner and family.

As mentioned previously, most but not all homeowners insurance policies follow a framework created by the ISO, with occasional endorsements or amendments added at the company’s discretion. There are several ISO homeowners forms, each designed for a different audience and intended to cover slightly different losses. The ISO’s standard policies have names that feature the letters “HO” followed by a number. In theory, a person could purchase an HO-1, HO-2, HO-3, HO-4, HO-5, HO-6, HO-7 or HO-8 policy.

Let’s briefly review those common forms now.

HO-1

An HO-1 policy insures the dwelling and other structures and also covers the insured's personal property. An HO-1 policy is a named-perils policy, meaning it only insures against perils that are specifically mentioned in the coverage form. This is in contrast to other types of homeowners insurance, which might cover the dwelling against all perils except those that are specifically excluded in the policy. The HO-1 is not widely used at the present time and has even been withdrawn from use entirely in many states.

An insurance policy modeled after the ISO’s HO-1 form insures the homeowner against property losses caused by the following perils:

- Fire.
- Lightning.
- Wind.
- Hail.
- Explosion.
- Riot and civil commotion.
- Aircraft.
- Vehicles.

- Smoke.
- Vandalism and malicious mischief.
- Theft.
- Volcanic eruptions.

HO-2

The HO-2 policy form is sometimes referred to as the “broad form.” This policy insures the homeowner against property losses caused by many common perils. In addition to covering losses brought on by all the perils mentioned in the HO-1 form, the HO-2 form reimburses the insured for losses related to the following:

- Falling objects.
- Weight of ice, snow or sleet.
- Accidental discharge of water or steam.
- Accidental overflow of water or steam.
- Freezing.
- Sudden and accidental tearing, cracking, burning or bulging of heating, air conditioning, water or steam systems.
- Sudden and accidental discharge from artificially generated electrical current.

HO-3

The HO-3 policy form is sometimes referred to as the “special form.” It is generally considered the standard version of modern homeowners insurance.

Unlike previously mentioned homeowners forms, the HO-3 form covers the insured dwelling and detached structures (detached garages, sheds, etc.) on an “all-risk” basis. This means a loss will be covered by the policy unless the insurance contract specifically excludes it.

When explaining the positive features within HO-3 policies, insurance producers sometimes forget to mention that the all-risk coverage applies only to the dwelling and detached structures. By contrast and by default, HO-3 policies cover personal property on a “named-peril” basis, just like HO-1 policies and HO-2 policies. This means a loss pertaining to personal property will only be covered if it has been caused by a peril specifically mentioned as a covered peril in the insurance contract. With respect to personal property, the covered perils in an HO-3 policy are basically the same as those in an HO-2 policy.

HO-4

The HO-4 policy form is used to insure renters and their belongings. The HO-4 policy form insures personal property against the same perils named in the HO-2 form. But the typical renters insurance policy is different from other homeowners policies in several respects.

The most significant difference between HO-4 policies and the other forms we’ve previously discussed is that the HO-4 policy’s main emphasis is on contents coverage rather than on dwelling coverage. This makes sense because the responsibility of maintaining the building and fixing structural problems usually belongs to the landlord rather than the tenant. Like all other standard homeowners forms, it also often provides

personal liability protection if the policyholder is accused of causing property damage or bodily injury.

HO-5

The HO-5 policy form gives the insured all-risk coverage for both the dwelling and personal property. As good as that may sound, HO-5 policies can be very expensive.

If a person prefers all-risk coverage for both the dwelling and its contents, the insurer will probably not even bother selling the person an HO-5 policy. Instead, the all-risk coverage for personal property will simply be added onto an HO-3 policy for an additional cost.

HO-6

Condominiums and townhouses are covered by a "master policy," which is purchased by an elected association on behalf of all residents at the complex. The master policy will cover damages to a building's exterior, as well as common areas such as basements and hallways. The extent to which the master policy insures each individual unit is left up to the association.

The portions of each unit that are not insured by the master policy will be disclosed in the association's bylaws or in similar documents. At the very least, the policy ought to cover the unit's walls, ceiling and floors.

Those parts of the unit that aren't covered by the master policy are the individual owner's responsibility. Of course, each individual owner is also responsible for obtaining his or her own insurance for personal property and personal liability.

To address the concerns of condo dwellers and townhouse owners, insurance companies sell policies based on the HO-6 form, also known as the "unit-owners" form. The unit-owners form features named-peril coverage for the insured's personal property and a little bit of named-peril coverage for the unit itself. The named perils in an HO-6 policy are the same as those in an HO-2 policy.

HO-7

HO-7 policies are meant to insure mobile homes, which can also be covered by adding endorsements to other homeowners forms.

HO-8

The HO-8 policy form is sometimes known as the "modified" form. It is not used in all states and is typically used to cover older homes in urban areas when the dwelling's market value is considerably lower than its replacement cost.

In many ways, the coverage available through an HO-8 policy is identical to the coverage in an HO-1 policy. However, in a very important difference, HO-8 policies cover the dwelling only up to its actual cash value. Unlike the HO-2, HO-3 and HO-5 forms, they do not insure the dwelling up to its replacement cost.

In general, actual cash value is the property's replacement cost minus depreciation. A few states have multiple definitions of "actual cash value" with regard to dwellings. In California, for example, actual cash value generally means replacement cost minus depreciation. But if a dwelling in that state is covered for actual cash value and is completely destroyed, the owner might receive the dwelling's fair market value or the policy's dollar limit, whichever is less.

Liability Insurance Fundamentals

Liability losses are losses incurred by individuals as a result of their actions toward other people or their property. When an individual is required to make financial restitution to other people for causing or contributing to those people's losses, a liability loss has occurred.

In the civil legal system, when an individual violates the rights of another, that individual has committed what is known as a "tort." A tort can either be intentional or unintentional. Liability insurance provides coverage for unintentional torts. In general, insurance cannot be used to protect someone when he or she commits intentionally harmful acts.

Negligence is a key factor in determining liability. In order for a person to be liable to another, that individual must have been negligent. "Negligence" is defined as the lack of reasonable care that is required to protect others from the unreasonable chance of harm.

In order to establish negligence, several factors must often be present:

- **There must be a legal duty owed to someone:** Legal duty owed is that obligation that we all have toward one another to reasonably protect one another's rights and property. Within that duty, there are several levels of accountability depending on the relationship and conditions. For example, a person invited to our home is owed the highest degree of care. An individual performing a service in our home is owed a lower degree of care. And a trespasser is owed the lowest degree of care.
- **A breach of a legal duty owed to someone must occur:** Breach of legal duty occurs when it is established that standard care was not taken and that lack of precaution caused harm to another individual or the person's property.
- **The allegedly negligent person must be involved in the proximate cause for the loss:** The proximate cause is the action that occurred that resulted in the harm or damage. The action must be continuous and unbroken. If the action is broken by an intervening action, this new action becomes the proximate cause.
- **There must be damages:** If no harm came to an individual or the person's property, there was no negligence and therefore there can be no claim.

Contributory Negligence

When both parties contribute to negligence, "contributory negligence" exists. The degree to which each party contributed is taken into account in arriving at a payment, or perhaps a non-payment, of damages.

Liability and Statutes of Limitations

A "statute of limitations" requires that a suit must be filed within a specified period of time in order to be valid under the law. If this period of time has passed, the harmed party might not be able to make a successful claim against the negligent party.

Conclusion

Property and casualty insurance is a broad field that offers a wide variety of risk-related products and services to the public. With the right insurance solutions in place, consumers can successfully transfer risks related to damage to their property as well as various risks associated with liability.

CHAPTER 4: UNDERSTANDING INSURANCE REGULATION

Introduction

The history of insurance regulation has its roots in 17th century England. The controversial and highly contested route of its development has resulted in a regulatory structure that is uniquely different than that found in other industries. There is no question, however, that the activities of American insurance companies are highly regulated, and few other businesses are guided by the strict controls and guidelines found in this industry.

To illustrate, an insurance company cannot establish operations without specific and regulated levels of operating funds. Other businesses do not have these start-of-business requirements. Similarly, insurance products generally must be sold by licensed agents or brokers only, while other businesses may market their goods and services through whatever means they elect to use. The insurance industry must have its rates approved by the state in which it is operating, while other businesses are free to set their own prices and rates. Finally, regulations require insurance companies to maintain certain levels of funding (reserves) for the protection of their consumers.

Generally, in most other industries, the state regulatory focus becomes secondary to federal regulation as an industry matures, but the insurance industry in the United States has moved away from a centralized federal regulatory structure, and the concentration of regulation has been passed to state governments.

Although the states exerted little control over insurance businesses prior to the Civil War, several states established statutes requiring charters for the insurers selling products within their boundaries. These charters and their provisions restricted insurance company activities and offerings, specified reserves and established parameters regarding investments.

In some states, chartering bodies directed insurance companies to make their financial standings public, while others required insurers to publish annual reports. Companies in Massachusetts were mandated to make these reports public as early as 1818. Other states soon followed this lead, asking for annual reports from state-based insurance companies and requiring insurers outside the state to make statements of their financial condition available. Other than these parameters, the insurance businesses of the time were allowed to operate as they chose.

While these chartering mechanisms provided regulatory guidelines for the industry, little was available in the way of enforcing them. The states were adept at issuing charters and often appointed various departments to tax their earnings from premiums, but the administrators assigned to regulate insurance businesses in certain states were not always effective in policing the industry in regard to legislation.

As a result, some companies made poor investment decisions and squandered their funds. Others simply went bankrupt. Still others used deceptive and unfair policy provisions. This rollercoaster track record made it obvious that some type of regulation was necessary for the protection of the public. It also indicated a need for regulation to balance business activities and sustain the industry.

In an effort to more efficiently empower state regulatory offices, New Hampshire was the first state to establish a three-seat insurance commission in 1851. The board was later reorganized to include a single commissioner in 1869. Other states followed, and today, the state insurance commission continues to exercise substantial influence within the insurance industry.

In 1855, the state of Massachusetts established the first department of insurance and, in 1858, appointed mathematics professor Elizur Wright as insurance commissioner. Wright would later be credited as the person who contributed most to the future of insurance supervision, due to his concept of regulation for the purpose of insurer solvency.

Shortly after New Hampshire created the first insurance commission, the U.S. House of Representatives proposed a bill to establish a national bureau of insurance as an adjunct of the Treasury Department. Two years later, the Senate passed a similar bill. Both were defeated, however. The reason for the failure of the two bills, it was speculated, was because the country was not yet ready to embrace the idea of federal control of the insurance industry.

In the early 1900s, the effectiveness of the regulation of the insurance industry was studied by two separate committees. The New York legislature appointed a committee—The Armstrong Commission—for the purpose of studying the life insurance industry in 1905. The committee reported finding several areas of abuse regarding financial reporting and other wrongdoings resulting from the lack of effective regulation.

In 1910, the New York legislature appointed the Merritt Committee to investigate non-life insurance lines. This committee reported that price competition would result in rate wars that would be devastating to the industry. It noted that insurers that had only marginal operations would be forced to offer coverage at a slightly lower rate and that those insurers with stronger operations would respond to these decreases by lowering their rates. Eventually, this would create a problem for the marginal insurers, which would result in bankruptcies. This study reported that cartel insurance pricing was acceptable for the public good as well as for the good of the industry.

Congress passed the McCarran-Ferguson Act in 1945 to declare that states should regulate the business of insurance and to affirm that the continued regulation of the insurance industry by the states was in the public's best interest.

The Financial Services Modernization Act of 1999, also called Gramm-Leach-Bliley, established a comprehensive framework to permit affiliations among banks, securities firms and insurance companies. Gramm-Leach-Bliley once again acknowledged that states should regulate the business of insurance. However, Congress also called for state reform to allow insurance companies to compete more effectively in the newly integrated financial service marketplace.

In most states, the insurance department is part of the executive branch of state government, and it is under the direction of the insurance commissioner. In a few instances, this is an elective position. However, in other states, the governor appoints the commissioner. The commissioner's main duty is to administer the insurance laws of the state along with the assistance of staff members.

The Role of the State Legislatures

State legislatures set broad policy for the regulation of insurance. They establish and oversee state insurance departments, regularly review and revise state insurance laws and approve regulatory budgets. State insurance departments employ tens of thousands of regulatory personnel. Increases in staff and enhanced automation allow regulators to substantially boost the quality and intensity of their financial oversight of insurers and expand consumer protection activities.

National Association of Insurance Commissioners (NAIC)

The National Association of Insurance Commissioners (NAIC) serves as a vehicle for individual state regulators to coordinate their activities and share resources. The NAIC functions as an advisory body and service provider for state insurance departments. State insurance regulators use the NAIC to pool scarce resources, discuss issues of common concern and align their oversight of the industry. Each state, however, ultimately determines which actions it will take.

The NAIC was developed to coordinate the activities of the individual state insurance departments. Founded by George W. Miller, the second superintendent of insurance for the state of New York, the early goals of the NAIC were of uniformity across examination practices, annual reporting statements and laws.

The first meeting of the body was in 1871 and included all of the insurance commissioners of the various states. It became a voluntary organization, and through the guidance of the NAIC, the state departments began to avoid the confusion of uncoordinated operations.

Today, the NAIC meets regularly, with regional meetings scheduled between meetings of the entire NAIC body. Various committees from the organization work throughout the year on specific topics. Much of the committee work is focused on standardization procedures and formats, but others have developed information included on policies and policy statements.

As a body, the group is committed to the development of legislative recommendations. Once the need for a new law is identified, a specific committee studies the situation and makes a recommendation to the larger group. If the group can pass the measure, it is submitted to the legislatures of the states involved in the form of a model bill for discussion. Although some states eventually reject some of these legislative proposals, the process has resulted in a growing uniformity of the industry's regulation throughout the country.

The NAIC continues to study the problems and changes within the industry. Task forces use advisory committees made up of insurers and the public-at-large to investigate issues and ideas to improve the industry as a whole. In the 1980s, for example, an NAIC task force gave primary attention to the use of gender and marital status as classification factors used in automobile insurance ratings and comprehensive health insurance coverage. They also looked at the question of state vs. federal insurance regulation and ways to detect insurer insolvency before it actually occurred.

The Purpose and Structure of Insurance Regulation

The fundamental reason for government regulation of insurance is to protect consumers. State systems are accessible and accountable to the public and sensitive to local social and economic conditions. Insurance regulation is structured around several key functions, including company licensing, producer licensing, product regulation, market conduct, financial regulation and consumer services.

Why Regulate?

The insurance industry is "affected with a public interest." This concept was initially developed by the British jurist Lord Matthew Hale in 1676. The U.S. Supreme Court used Hale's concept as a basis for writing its own decisions and determined that the insurance industry was deemed "affected with a public interest" because of its role in many other business and industry activities.

Two hundred years later, in the case of Munn v. Illinois, the Supreme Court further determined that insurance companies were businesses affected by the public interest. In its ruling, the court recognized the states' right to regulate "properties" affected with the public interest, but protected these "properties" or businesses by further stating that the courts, not the legislature, would be responsible for determining "reasonableness."

Munn v. Illinois became a landmark ruling because it specified that property was "clothed with a public interest when used in a manner to make it of public consequence and affects the community at large." However, no specific consequences were delineated in the ruling, and in its final form, the public interest concept became a dynamic one that would vary with court opinions down through the years.

The case of Paul v. Virginia in 1869 determined the legal basis for state regulation of the insurance industry. Samuel Paul was a Virginia insurance agent for several New York fire insurance companies. In Virginia at that time, insurance agents representing out-of-state companies were required to provide certain information to the state controller's office. Paul had not met these requirements. The result of his noncompliance was a $50 fine. When Paul appealed the fine, he argued that the insurance business was commerce, and in his case, interstate commerce. The U.S. Constitution, by his interpretation, controlled interstate commerce, and according to Paul, Virginia had no right to enforce its insurance-related requirements on agents.

The Supreme Court rejected Paul's argument, ruling that selling insurance policies was not commerce, but personal contracts—not merchandise that was being shipped from one state to another. In their ruling on Paul v. Virginia, the Supreme Court upheld the Virginia laws and ruled that insurance companies were not to be regulated by the federal government but by the states. Paul ultimately lost his fight and had to pay the $50 fine, but the case determined the right of the state governments to regulate insurance companies, a ruling that was held intact for the next 75 years.

In part, the ruling stated:

- *... issuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the insured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. They are not subjects of trade or barter offered in the market as something having an existence and value independent of the parties to them. They are not commodities to be shipped or forwarded from one state to another and then put up for sale. They are like other personal contracts between parties that are completed by their signature and the transfer of consideration. Such contracts are not interstate transactions, though the parties may be domiciled in different states. The policies do not take effect—are not executed contracts—until delivered by the agent in Virginia. They are, then, local transactions, and are governed by the local law. They do not constitute a part of the commerce between the states any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York whilst in Virginia would constitute a portion of such commerce.*

In the early 1900s, it was proposed that certain aspects of the insurance industry be placed under federal regulation. However, the U.S. Congress was advised to refrain from passing such legislation on the basis that Paul v. Virginia and other cases had determined that the federal government had no documented authority over the industry. It was not until 1944 that the Supreme Court reversed its Paul v. Virginia decision and ruled in the South-Eastern Underwriters Association case that the insurance industry was indeed commerce.

In 1945, however, Congress passed the McCarran-Ferguson Act. This act stated that the states should continue to regulate the insurance industry because it was in the public interest, and it further specified that federal antitrust laws only apply to the insurance industry in instances where state regulation is not effective.

State Vs. Federal Regulations

Arguments surrounding the debate of state vs. federal regulations have continued for the better part of two centuries, with flames intensifying around controversies regarding state control and the regulation of issuance rates. During former President Jimmy Carter's term in office, a national regulatory commission was named for the purpose of reviewing the implications of antitrust laws, particularly the McCarran Act, which provides certain antitrust immunity for the insurance industry.

Which type of regulation is preferable: state or federal? This question, too, remains at the forefront of the ongoing debate. However, many experts believe that such a question does not embrace the complexity of the regulatory bodies. To them, the question is not which is better for regulation—state or federal—but what combination of these two entities would be most effective?

Potential Advantages of Federal Control

Between the rulings of Paul v. Virginia and the South-Eastern Underwriters Association case, hundreds of briefs have been filed against state regulation and in favor of the insurance industry being considered commerce. However, those who were in favor of federal control of the insurance industry took this stand because they believed a federal regulatory system would be less complex.

Even today, because of issues surrounding rate regulation, those favoring federal control continue to make their voices heard. Their reasons for favoring a move from state to federal regulatory control often are prompted by their frustration with state regulatory boards, but they also contend that federal regulation would be to the advantage of the entire industry. Some of their arguments include:

- Insurance is a product sold and used throughout the nation. Because of this national scope, it logically follows that the industry should be regulated by a federal body.
- Each state has its own laws and regulations regarding the insurance industry. By placing the insurance industry under federal regulation, insurers would be able to comply with a uniform system of regulation.
- Total federal control over the industry would avoid the "overlapping" regulations that often occur in the state/federal regulatory environment.
- Because the industry is currently regulated by 52 separate departments (50 states plus the District of Columbia and Puerto Rico), it seems logical to assume that these 52 departments are more costly to operate than one centralized federal department.

Potential Advantages of State Regulation

As with the backers of federal regulation, those favoring state regulation of the insurance industry have also advanced some specific arguments over the years. The following represents a sampling of these theories:

- State regulation is a familiar experience. There are less unknowns involved within the process. Many in the industry believe that it would be far more advantageous to examine current practices and build on the experience of existing regulatory measures than to begin with a totally unknown system.
- Because state offices would be more familiar with the local environment, many people believe it would be more effective to have the individual states rule on issues, as opposed to a centralized federal department of regulation.
- Currently, if a state missteps in its handling of certain problems, the surrounding states are not enveloped in the ripple effect that would occur if federal regulatory errors were made.

It is important to remember that the public interest must be of primary concern when evaluating the advantages and disadvantages of one regulatory system as opposed to another. The argument as to whether state or federal regulation is best continues to move from one side of the debate to the other. The debate will likely continue for several more decades.

Company Licensing

State laws require insurers and insurance-related businesses to be licensed before selling their products or services. All U.S. insurers are subject to regulation in their state of domicile and in the other states where they are licensed to sell insurance. Insurers that fail to comply with regulatory requirements are subject to license suspension or revocation, and states may exact fines for regulatory violations.

Producer Licensing

Insurance agents and brokers, also known as “producers, must be licensed to sell insurance and must comply with various state laws and regulations governing their activities. More than 2 million individuals are licensed to provide insurance services in the United States. State insurance departments oversee producer activities in order to protect insurance consumer interests in insurance transactions.

The states set continuing education standards to ensure that agents meet high professional standards. Producers who fail to comply with regulatory requirements are subject to fines and license suspension or revocation.

When producers operate in multiple jurisdictions, states must coordinate their efforts to track producers and prevent violations. Special databases are maintained by the NAIC to assist the states in this effort. The National Insurance Producer Registry (NIPR)—a non-profit affiliate of the NAIC—was established to develop and operate a national repository for producer licensing information.

Product Regulation

State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected.

For property and casualty insurance sold to individuals and families, about half of the states require insurers to file rates and to receive prior approval before they go into effect. With the common exception of workers compensation and medical malpractice insurance, property and casualty insurance sold to businesses is often subject to a competitive rating approach. Under such a system, regulators typically retain authority to disapprove rates if they find that competition is not working.

Premiums for life insurance and annuity products generally are subjected to less stringent regulatory approval, although regulators may seek to ensure that policy benefits are commensurate with the premiums charged. Many states subject health insurance rates to prior approval.

Simplifying Policy Language

Over the years, the insurance industry has become so complex that policies are often the subject of court interpretation. Because of these complexities, it is difficult for the average policyholder to understand even a basic policy, which allows for unscrupulous agents to write policies that may not be in the best interest of the insured. In some cases, even honest insurers may inadvertently include exclusions and special provisions that may be misleading or unfavorable to the policyholder.

Because of this situation, and because it is generally felt that most insurance policies are often difficult to understand, there has been a movement in place for several years to simplify policy formats. One rate advisory bureau filed a homeowners policy reducing the narrative by about 40 percent and increasing the size of the type used in the policy by 25 percent. More white space was also allowed between the lines. More readable policy guidelines have also been instituted for automobile, business, personal, life and health insurance policies.

To maintain a certain amount of control over the policies offered by various insurers, the state commissioner might need to approve policy forms. This makes it difficult for companies to either mislead or deceive the consumer with statements that contain highly technical terminology or ambiguous descriptions of coverage. For certain types of insurance coverage, including fire and workers compensation, a standard form is often required. Other coverages forbid the use of gimmickry in their forms and verbiage.

The commissioner, upon reviewing a new policy format, may overrule any type of wording in provisions that may be deceptive or misrepresent the "real" coverage. The unfortunate aspect of this particular type of regulation is that most state insurance departments have neither the funds nor the trained personnel to review every form that is used for insuring individuals in that state.

Financial Regulation

One of the primary goals of insurance regulation is that of preventing insurance companies from going into bankruptcy. To this end, controls have been established through government regulations unique to the insurance industry. These controls require insurance companies to maintain certain levels of operating capital, as well as specified reserves and surplus levels to underwrite "the future services" agreed upon in the policies issued by that company. The government requires insurance companies to meet these levels because of the far-reaching effects of an insurance company going bankrupt.

When any other business fails, the competition absorbs its customers and may adjust goods and prices to remain within the good graces of the public. In this scenario, both the competitor and the consumer benefit. When an insurance company fails, there are no similar beneficiaries.

Insurance premiums are based on what the insurer estimates the cost of future services will be. If the estimated costs of these services or losses are lower than the actual costs, the result is that rates are set too low and policies are underpriced. Several decades ago, the industry underestimated the impetus of rising rates in liability claims for property-

casualty policies. A few years later, this area of the industry experienced significant losses because of the underpricing.

Because the industry must estimate future trends and activities, there is always the possibility that rates may be inadequate to cover losses. This fact, when coupled with the far-reaching impact of insurance company failure, forms the logic of regulation to protect the industry from insolvency.

Financial regulation provides crucial safeguards for insurance consumers. Periodic financial examinations of insurance companies occur on a scheduled basis. State financial examiners investigate a company's accounting methods, procedures and financial statement presentation. These exams verify and validate what is presented in the company's annual statement to ascertain whether the company is in good financial standing.

When an examination of financial records shows an insurer to be financially impaired, the state insurance department can take control of the company. Aggressively working with financially troubled companies is a critical part of the regulator's role. In the event that the company must be liquidated or becomes insolvent, the states maintain a system of financial guaranty funds that cover a portion of consumers' personal losses.

Regulation of Admitted Assets

The solvency of an insurance company is measured by how much admitted assets surpass the company's liabilities. This measurement is taken by state regulators. Valuations for the company are highly regulated, which makes the insurance industry—once again—unique from most corporations.

In most situations, "admitted assets" are those assets held by the company that include legal portfolio investments. Admitted assets always include office buildings and real estate (some states also allow computer equipment), but do not include operational assets for the firm (such as automobiles, supplies, furniture and other capital expenditures, or secured or unsecured loans and advances to agents).

Market Regulation

Market regulation attempts to ensure fair and reasonable insurance prices, products and trade practices in order to protect consumers. With improved cooperation among states and uniform market conduct examinations, regulators hope to ensure continued consumer protections at the state level.

Market conduct examinations occur on a routine basis but also can be triggered by complaints against an insurer. These exams review agent licensing issues, complaints, types of products sold by the company, agent sales practices, proper rating, claims handling and other market-related aspects of an insurer's operation.

When violations are found, the insurance department makes recommendations to improve the company's operations and to bring the company into compliance with state law. In addition, a company may be subject to civil penalties or license suspension or revocation.

Regulation of Sales and Sales Activities

The purpose of regulating sales activities is, at first glance, to protect the consumer from unreliable services and disreputable agents. However, this type of regulation also serves to provide a balance of fair competition within the market environment. In this area of regulation, the states regulate how insurers obtain new policyholders, the ethical standards within the industry and the standards required of insurance sales agents.

Once a prospective agent or broker has passed a licensing examination and the license is issued, the agent or broker must continue learning about the field through continuing education requirements each year or every few years. This continuing education or training may often be taken individually or through the attendance at seminars.

Once a salesperson has been licensed, that individual's activities may also fall under regulation, particularly if those sales activities drift into the realm of misrepresentation. Most of the states have statutes that prohibit misrepresentation of the facts about a policy and its coverage. Some statutes also cover the parameters of the relationship between the insured and the insurer.

In the insurance industry, the term "twisting" refers to the misrepresentation of the facts by an agent in order to manipulate the policyholder into substituting one contract for another. Twisting also includes failure to include all the facts when policies are represented. Because of regulation against twisting, agents are discouraged from making recommendations that may include dropping one policy in favor of another.

Another sales activity that is regulated against is that of rebating—where an agent would refund part of the premium to the policyholder. In most states, anti-rebating regulations have been established for the purpose of protecting the public interest. However, a few states allow rebating and believe it can help rather than hinder competition in the marketplace.

Consumer Services

The states' single most significant challenge in insurance regulation is to be vigilant in the protection of consumers, especially in light of the changes taking place in the financial services marketplace. States have established toll-free hotlines, websites and special consumer services units to receive and handle complaints against insurers and agents.

As needed, state insurance departments work together with policyholders and insurers to resolve disputes. In addition, many states sponsor educational seminars and provide consumer brochures on a variety of insurance topics. Some states publish rate comparison guides to help consumers get the best value when they purchase insurance.

Why Insurance Is Regulated

Government regulation of insurance companies and agents began in the states more than 100 years ago for one overriding reason—to protect consumers. State regulators' most important consumer protection is to assure that insurers remain solvent so they can meet their obligations to pay claims. States also supervise insurance sales and marketing practices and policy terms and conditions to ensure that consumers are treated fairly when they purchase insurance products and file claims.

Unlike most products, the purchaser of an insurance policy will not be able to fully determine the value of the product purchased until after a claim is presented—when it is too late to decide that a different insurer or a different product might make a better choice. All of these subjective aspects add up to one big certainty: Insurance products can generate consumer backlash and dissatisfaction that require a high level of regulatory resources and responsiveness.

Types of Insurance Companies

Before any life insurance company can sell insurance in any state, it must be licensed to sell insurance or, as it is called, "admitted" to that state. An insurer that is admitted to a

state is authorized to do business in that state. If an insurer is not admitted to a state, it is generally unauthorized to do business in that state.

Insurance companies can be organized in several ways; however, most are organized either as stock companies or as mutual companies.

Stock Companies

A stock company gets its name from its basic ownership characteristic. Its stockholders, people who have bought stock in the company, own a stock company. The stockholders may or may not also be policyowners. The sole function of the stockholders is to elect a board of directors who in turn will guide the operation of the company. If the company is successful financially, the stockholders will receive dividends, which are paid for each share of stock owned. A stock insurance company, like all other corporations, is in business to make a profit for the stockholders.

Mutual Companies

Unlike a stock company, which is owned by its stockholders, a mutual company doesn't have traditional stockholders. Control in a mutual company rests with the policyowners who 'mutually" own the company. The policyowners elect a board of directors, and any "profits" are returned as dividends to the policyowners in the form of reduced costs for insurance.

It should be mentioned here that dividends from a mutual company are not profits in the mercantile or commercial sense but rather the return of an "overcharge" of premium. For example, a mutual life insurance company might sell life insurance at one specific age for $20 per $1,000 of face amount. Once a dividend has been declared, each policyowner might then receive credit on the premium statement in the amount of $2 per $1,000. Thus, the resultant cost for the insurance is $18 per $1,000 of face amount.

While not true in every case, mutual insurance companies usually issue "participating" life insurance policies. The term participating means that if the company realizes a savings, these savings or "profits" are passed along to the policyowner in the form of policy dividends. Thus, the policyowner in a mutual insurance participates in any savings or "profits" enjoyed by the company.

Fraternal Benefit Societies

Another type of insurer with which you should be familiar is the fraternal benefit society, also known as a "fraternal." A fraternal insurer is a social and benevolent organization, which provides, among other services, insurance benefits for members. Membership in such an organization is often based on factors such as a person's nationality, religion, or occupation. But whatever the criteria for membership, keep in mind that fraternals have functions other than providing insurance.

Each state defines and provides for the regulation of fraternal benefit societies in its insurance laws. But although the exact definition of a fraternal may differ from state to state, an organization usually must have certain characteristics to qualify as a fraternal benefit society. First, the organization generally must exist only for the benefit of its members and of their beneficiaries and be non-profit. Second, it must be organized without capital stock.

A third characteristic is that the society usually must be organized on a lodge system. This means that the organization must have local lodges or chapters, which hold regular meetings to carry on the activities of the society.

Finally, the organization must have a representative form of government. There must be a governing body chosen by the members directly or by delegates in accordance with the organization's bylaws or constitution.

Government Insurance Programs

Government insurance programs have been created when private insurers would have been subjected to adverse selection or were incapable of meeting society's needs.

By its administration of various federal insurance programs, the U.S. government has become the largest insurer in the world. These various programs include Social Security, Medicare and the Railroad Retirement, Disability, and Unemployment programs.

Reciprocals

Reciprocals are groups of individuals (called "subscribers") who are insured under an arrangement where each subscriber is both an insured and an insurer. In other words, the other members of the group insure one another. However, the liability of each subscriber is limited.

The administrator of the reciprocal is an "attorney-in-fact." He or she is granted this power by the subscribers through a broad power of attorney and receives a percentage of the gross premiums paid by the subscribers. Other than this payment to the attorney-in-fact and administrative expenses, the cost to the reciprocal is limited to the amount of the losses that occur. Any unused premiums are returned to the subscribers.

Lloyd's of London

Lloyd's of London is a name familiar to many in the insurance industry. Perhaps the most interesting fact about Lloyd's of London is that it is not an insurer nor does it issue policies. Rather, Lloyd's of London is an association of members that write insurance for their own accounts. The New York Stock Exchange bears the same relationship to stock purchases as Lloyd's bears to the purchase of insurance. Though neither organization engages in trade, both provide facilities and rules that govern how its members will pursue trade. In addition, Lloyd's maintains worldwide underwriting information and a complete record of losses. It also aids in loss settlements and supervises salvage and repairs throughout the world

At Lloyd's, an insurance transaction begins when a proposal is placed before the underwriting members or their agents by a licensed broker. The broker prepares the policy and submits it to the Policy Signing Office, where the policy is examined. if the policy conforms to agreed-upon rules, it is submitted to the underwriters. Those underwriters who wish to participate in the policy affix their signatures, or "underwrite," the risk.

Financial Status of Insurers

Changing economic conditions and highly publicized failures of financial institutions (from savings and loan companies to insurance companies) have focused much attention on the financial status of private insurers. Independent rating services provide ratings that consumers can use to measure the status of a company and compare it to others. The two most popular rating services are A.M. Best Company and Standard and Poor's, each of which provide a letter grade based on an insurer's financial stability.

In most cases, insurance companies pay a fee to be rated by a rating service. Other rating services include Moody's Investors Service (measuring financial strength) and Duff and Phelps (measuring claims-paying ability and managerial soundness).

Purposes of Regulation

In all areas of the insurance industry, public confidence in the established system is essential to the maintenance and ultimate success of the business. If the public should lack confidence in the industry because of experiences with fraudulent and incompetent insurers, the system would eventually fail. This lack of confidence would occur if the insurer becomes unable to provide the coverage promised. In cases of insolvency, the consumer would not only forfeit the price of the policy, but also the expected reimbursement for loss of property, disabilities, medical expenses or the support of dependents.

To establish and maintain consumer confidence, certain regulatory goals have been developed to combat negative and unscrupulous business activities within the industry in order to prevent insurer insolvency, prevent fraud, assure reasonable pricing and increase the availability of insurance.

Prevention of Fraud

The prevention of fraud protects the consumer against being misled or misinformed by an insurer. As has often been pointed out by the industry, as well as public advocates, insurance policies are highly complex, technical documents that few laypeople actually understand. Without regulation, there would exist the possibility that, at some time, an unscrupulous insurer could include certain phraseology that would mislead the insured and save the insurer from paying a particular claim.

Another aspect of fraud awareness relates to companies' alleged financial solvency. To continually strengthen its consumer base, a company will advertise itself as a strong and reliable firm with well-invested funds. To provide the consumer with some protection against fraudulent claims of this type, states monitor a firm's operations to assure that no false claims may be made.

Regulation by Government Branches

The insurance industry is also subject to three distinct types of regulation executed by the three branches of the democratic form of government—legislative, judicial and executive. These three methods of regulation, plus the self-regulatory structures, oversee specific areas of operations within the industry and distribute regulatory powers between state and federal regulatory agencies. The following paragraphs will examine and explain the distinctions of each of the four categories.

Legislative Regulation

All insurers and their operations in the 50 states, the District of Columbia and Puerto Rico are governed by insurance laws and regulations. The states legislate these guidelines for matters such as agent licensure, methods of doing business, the availability of coverage and other aspects, and they have police power to enforce the rules protecting the health and welfare of the citizens of that state once those rules are approved.

Regarding insurance, the states do not leave the development of legislation totally to legislatures. In fact, associations of insurers and other individuals and groups are encouraged to develop model bills and submit them for legislative sponsorship.

Judicial Regulation

Through their interpretation of legislation and other questions, the judicial branch of each state plays a major role in the regulation of insurance. Although their involvement is often indirect in its nature, the courts are also employed to settle disputes between parties

involved in insurance contracts. The written ruling of the court for each case, therefore, becomes a part of the body of legislation regulating insurance.

Executive Regulation

As the insurance industry became more diversified and complex, it became obvious that the industry's regulation should be supervised by knowledgeable and experienced individuals. Each state has established an insurance department headed by a commissioner or an individual with a similar insurance-specific title. Commissioners make rules, called administrative law, to assure the successful operation of the industry within their state. However, these rules and these individuals are, in turn, accountable to review by the courts.

The duties of state insurance commissioners are broad and varied, but each state insurance department has certain basic duties. These include licensing of insurance companies and agents working within the state, monitoring the activities of licensed agents and screening these activities regarding good business practices. In some cases, the commissioner is required to impose certain penalties for unscrupulous behavior, such as the revocation of licensure or the closing of businesses that fail to meet regulatory requirements regarding reserves, capital and surplus.

Since 1818, when the Massachusetts insurance department required filing of the first annual financial reports, state commissioners have required the filing of annual statements; furthermore, they act as a depository for securities in states with laws governing securities and require an evaluation of corporate assets on a regular basis.

Commissioners also regulate trade practices and oversee and approve policy contracts. In their role as a regulators, the commissioners may also monitor rates to guard against discrimination. The state investigates complaints on all levels and maintains strict controls on any mail-order insurance activity in the state.

Self-Regulation

Despite the existence and power of government-level regulators, the insurance industry has continued to be a self-regulated industry to a certain degree. Through associations of insurers and agents, these self-regulatory groups have exerted some level of control through strict codes of ethical conduct and other cooperative agreements. These groups continue to function, generally out of the fear that more public regulation would impair the industry and its purposes.

Pricing of Insurance Rates

Although most insurance rates are the result of extremely complicated formulas, a simplified explanation is this: Insurance rates are a determination of a policyholder's percentage of responsibility for loss expenses. The premium to insure the property—usually home or automobile—is the rate per unit of coverage multiplied by the number of units purchased.

Here are some examples: Say you want to purchase a homeowners policy. A unit would be 100 square feet within the building. If you want to purchase life insurance, the unit may be $100 or $1,000 of coverage purchased.

Once the cost per unit is established, the insurer must look into the future to determine the percentage chance that the homeowner will suffer a loss, based on past experience and the rate of probability that a homeowner will file a claim. This historical experience

and the influence of new trends and developments (such as improved building materials) are also taken into consideration to determine the final rate to be paid.

Historically, insurers calculated each policy on a separate basis. But as business increased, this system proved to be too cumbersome, and insurance companies also found some glaring deficiencies in their existing methods. Rate setting (or “rate making”) soon became a group effort in order to make rates both profitable for the companies and fair to the policy buyers. These rates were published, and if variances were appropriate, the established rates became the basis point for these variations. The various lines of insurance began setting their own rates, and today, the industry trends suggest that independent rate making is the rule for all types of insurance coverage.

Rate Regulation Objectives

When a rate filing is submitted to the state insurance department by an insurance company, the data submitted is evaluated by the department, with three objectives in mind:

- To prohibit excessive rates for coverages.
- To maintain the financial solvency of the company.
- To avoid unfair discriminatory rates.

The strictness and meticulousness with which new rates are evaluated depends upon the state. In some states, for example, property and casualty rates require explicit approval by the insurance commissioner prior to the use of new rates. In other states, the "open competition" condition exists, and it is assumed that the competition will regulate costs much more effectively than the insurance commissioner. In the "open competition" states, the commissioner of insurance may curtail the use of certain rates, particularly those violating rating standards, but rates do not have to be filed and approved, as is the practice in the more rigidly controlled states.

It is worth noting here that anyone having a grievance against an insurance agent or insurance company is invited to file a complaint. However, the burden of proof that rate filings do, indeed, comply with the law is on the shoulders of the insurance company or the rating bureau.

Life insurance rates are not regulated in the same manner that other coverages are regulated. The control of these rates is indirect, or, in other words, based on supervision of mortality tables, dividends and interest rates used to compute the reserves of life insurers. When these controls are combined, the result is an indirect regulation of life insurance rates that are inadequate, excessive or discriminatory.

While the level for rates on many individual life policies and ocean marine insurance are not tightly regulated, there is a minimum set for group life by several state insurance departments. Property and liability rates are controlled by model rating laws. These regulations are based on historical records of prospective loss and expense, as well as the occurrence of catastrophic events and hazards within a certain area. When there is regulation of this sort, the insurance company must file premium rates, rating plans, coverage and rules for approval by the commissioner or a special committee. In this filing, the company must also provide support of any calculations with documentation.

Some insurers will go through a licensed rating organization rather than filing directly with the state commissioner; however, the commissioner can also disapprove any filing, as long as he or she specifies reasons why the filing was disapproved.

Each state commissioner must also approve a rating organization, and each rating organization must allow any qualified insurance company to take advantage of its services without any discrimination toward the company. There are technical requirements built into methods of recording and reporting loss and expense experience, exchange of rating plan data, and consultation with other states. The state commissioner usually taps a rating organization to collect this data.

Unless a company files an application for deviation, each subscriber must follow the rating organization's rates and policies; but the commissioner may also disapprove these applications if there is a hint of inadequate, excessive or discriminatory rates.

Regulating Reserves

Those companies writing property and casualty insurance should maintain loss reserves as well as unearned premium reserves. The loss reserve is the liability for claims and settlement costs that the insurer estimates. The unearned premium reserves are those at the time of valuation that represent all policies outstanding and their gross premiums.

The "sticky" area concerning regulators most about loss reserves is that most insurance companies estimate loss reserves lower than practicable, and, in turn, this situation leads to insolvency when the insurer is pressed for payment. Conversely, when insurers set reserves too high, they also increase their rates to excessive proportions. And, because most state insurance departments do not have the trained personnel to "police" these areas of a firm's operations, some insolvencies have occurred.

Life insurers have one principal reserve—the policy reserve. This reserve is calculated to meet all policy obligations, as well as premiums and assumed interest. The valuation on this reserve may be different from premiums charged by an insurer because it does not include an allowance or expenses and, in fact, may be calculated based on a different set of interest and mortality assumptions.

The Modified Reserve Standard is used by some life insurers because the bulk of the expense a company incurs is during the first year the policy is in effect. These expenses include premium taxes, general expenses on the part of the insurer and mortality costs. This leaves little of the premium left for the insurer and is definitely not enough to cover the reserve for the end of the first year.

Reserve options allow the insurer to postpone paying the full policy reserve. One such option is the "full preliminary term reserve plan." This option allows the insurer to pay no policy reserve at the end of the policy year. Each following year, the reserve amount is set for the full reserve amount on a policy written one year later for a period one year less.

Regulation of Dividends

The payment of dividends to policyholders is usually a matter of judgment on the part of the insurer. Some state insurance departments say they control this decision by limiting the surplus amount accumulated by the insurer, not to exceed 10 percent of the policy reserve. By this type of limitation, the insurance departments effectively prevent the accumulation of a large surplus, while dividends are lower or not paid at all. This type of regulation, according to insurance commissioners, also curbs the temptation of inefficiently utilizing a large store of assets.

Regulation of Business Capacity

If an insurance company writes new business at a fast pace, there is the possibility that this increase in business could exhaust the insurer's surplus and lead to insolvency. At

the end of World War II, for example, several insurance companies actually "sold out" their products because they wrote as much business as they could without bringing their surplus accounts down to low levels. Because they could not raise enough capital in a short period of time, the companies had to quit issuing new policies. Some insurers decided to become selective in who they insured, favoring the more profitable companies. The less profitable businesses were left without insurance. This "capacity problem" is particularly important in discussions of property and casualty insurance.

The branch of the insurance industry that does not seem destined for "capacity problems" is life insurance. The need for a large surplus is not as immediate in life insurance, and many states limit the accumulation of surplus by those companies that sell participating policies.

Regulation of Investments

With the exception of property and casualty insurers, which experience a majority of problems in the area of underwriting, most other branches experience the majority of their financial problems as the result of problems with their investments. Because of this fact, most states regulate investment of the assets of insurance companies. These restrictions may be either quantitative or qualitative—dealing with the types of investment media, the amount of security required, the percentage of admitted assets to be invested, and the percentage of admitted assets dedicated to a single area of investment, among others.

Liquidation of Insurers

When an insurance company becomes technically insolvent, the state takes over the company for either liquidation, rehabilitation or conservation. The commissioner may take over operations at any time if the company is not being operated in the best interests of those holding policies with that company. An insurance company suspected of nearing insolvency has a right to a hearing by the commissioner. At that point, if the need for a takeover is not sufficiently supported, the assets are returned to the company's management.

Taxes

Like any other industry, insurance companies in America pay local, state and federal taxes and fees. The bulk of these taxes are levied by the state; however, some communities and municipalities collect taxes as well. These mandatory payments include income taxes, property taxes, license and filing fees for annual financial statements, and fees for taking the insurance licensing exam. Companies also pay taxes on franchises (if they apply), premium taxes (although some states tax insurance companies as an alternative to premium taxes) and special taxes on workers compensation and various other types of insurance.

Applicable Tax Rates and Rules

While state taxation varies according to state requirements, income taxes are levied according to formulas found in the IRS Code, and taxation on real estate and property are the same as for any other taxpayer. In some states, taxes levied on fire insurance premiums go to support local fire departments. Likewise, the taxes on workers compensation insurance are used to establish the system, security funds and funds to underwrite programs for employing disabled individuals.

Conclusion

Insurance regulation has not only a long history but also a continued commitment to several important goals. Whether those goals relate to insurer solvency, nondiscriminatory rating practices, fair market conduct or any other number of issues, the primary goal of insurance regulation remains the protection of insurance consumers.

CHAPTER 5: MARINE INSURANCE RISKS

Introduction

Although modern technology has had an indisputable impact on the ways businesses sell their products, the dot-com era hasn't eliminated society's dependence on old-fashioned shipping methods. In fact, one could even make the case that the increasingly global nature of the economy has made the successful transportation of goods by sea more important than ever. The United States alone sees roughly 8 million shipping containers come through its ports on a yearly basis and, according to the RAND Corp., is involved annually in national and international shipments that are worth a total of nearly $10 trillion.

With so much money invested in trade, it's no wonder there is an elaborate insurance market for shippers, receivers and common carriers. Goods in transit are typically covered by some form of "marine insurance."

Compared to other kinds of property and casualty insurance, marine coverage is often a misunderstood or ignored topic among businesses and their clients. However, it is an issue that can have an impact on any company that relies on the safe transport of products from one place to another. When businesses and their insurance advisers take the time to understand the fundamentals of marine insurance, they are doing more than just putting themselves in a strong, proactive position against major losses. They are playing a small part in ensuring that international trade remains profitable.

Many Policies for Many Purposes

Marine insurance can be broken down into many categories and subcategories. The right category of coverage for a business will depend on what is being insured and where.

Broadly speaking, "ocean marine insurance" is property and liability insurance for people who have a vested interest in a ship's safe journey. Though the ship is usually a waterborne commercial vessel, the insurance can also be used to cover offshore oil rigs and some private yachts.

Property insurance in the ocean marine market can pertain to either the ship itself ("hull insurance") or the cargo onboard ("cargo insurance"). Liability insurance in the ocean marine market is sometimes known as "protection and indemnity insurance" (P & I) and covers ship owners when they are held responsible for property damage, personal injury, illness or death.

Most of the property covered by ocean marine insurance does indeed make its way across an ocean, but coverage extends along other waterways, too. Marine insurance professionals sometimes differentiate between ocean risks and non-ocean risks by using the terms "blue water" and "brown water." In general, a blue-water risk is a risk that is associated with international transportation across an ocean. A brown-water risk is a risk that is associated with transportation across inland waterways, including rivers and lakes.

When products are shipped by land rather than by water, they may be covered by "inland marine insurance." Besides insuring items that are sent on trucks and trains, this kind of insurance can be used to cover man-made facilitators of transportation, such as bridges and tunnels. Businesses also use it to protect easily movable property of great value.

This chapter will take you through each kind of marine insurance. But before moving on to the specifics of each type, we should review how marine insurance got its start.

A Brief History of Marine Insurance

Marine insurance is where large-scale risk management and all other forms of insurance came from. In ancient China, merchants realized that transporting all of their products in a single shipment was an overly perilous practice, so they began protecting themselves from total losses by employing multiple crafts. Meanwhile, wealthy individuals in Phoenicia were giving loans to ship owners and merchants and allowing them to use their vessels or cargo as credit. For an extra amount of interest, lenders agreed to forgive the borrower's debt if a property loss occurred while the ship or cargo was at sea. These financial agreements were known as "bottomry loans" (in regard to vessels) and "respondentia loans" (in regard to cargo).

By the Middle Ages, insurance arrangements that did not involve credit had emerged in parts of Italy. In order to cover losses that might have occurred on a voyage, shippers, captains and their representatives created documents that listed the name of the craft, the crew members involved and the proposed route. These documents were presented to private investors. By signing their names beneath the listed information, the investors agreed to compensate property owners for losses in exchange for a fee. This is how the term "underwriting" came into existence.

Early underwriting was hardly a science. The people who agreed to insure vessels and cargo frequently didn't have enough experience to quantify the likelihood of losses. The information provided by merchants or sea captains would often be taken on little more than faith. Yet over time, local underwriters gravitated to the same areas around the closest ports and started sharing information with one another. The most famous of such gatherings took place regularly at an English coffee house run by Edward Lloyd near the River Thames. Some 300 years later, Lloyd's of London is recognized as one of the largest insurance markets in the world.

The Modern Marine Insurance Market

The influence of the past is still reflected in many aspects of the modern marine insurance market. Ocean marine policies, which predated inland marine policies by several centuries, are often filled with words and phrases that seem to have come straight out of a dusty, yellowed law book. Hull coverage forms, in particular, tend to contain stiffer language than today's insurance licensee is probably used to. And even the more down-to-earth cargo forms sometimes utilize an antique British vocabulary, as evidenced by their use of the word "assured" to mean "insured."

Connections to past centuries can also be observed in the way the U.S. marine market remains linked to foreign insurance entities. Even when a local business insures its cargo or its vessels with help from a U.S. agent, the international nature of shipping makes it likely that the business's transit risks will be transferred directly or indirectly to Lloyd's of London or another foreign market. On a worldwide basis, hull insurance is more likely to be secured through London or Norway than through the United States. Meanwhile, Japan and Germany represent two of the biggest markets for international cargo risks.

The U.S. marine market is flexible enough to insure many kinds of risks under many different circumstances. But it's also one that insurance brokers and consumers should discuss with great care. Hull, cargo and some other kinds of marine coverage are often detailed in policy forms that are not filed with state insurance departments. This lack of regulation allows marine underwriters to address many specialty risks in ways that suit their clients' goals, but it has also created a situation in which coverage forms might differ greatly from one insurance company to the next. Though trade groups like the American

Institute of Marine Underwriters have drafted forms that members can adopt as their own, there is no guarantee of uniformity among U.S. insurers.

The above point should be kept in mind while you read the rest of this course material and whenever you answer consumers' questions about marine insurance. Please understand that the information contained here is meant to be general in nature and might conflict with the policy language favored by a particular insurance company. Questions about specific policy language or the likely outcome of a specific claim should, of course, be handled only by experienced, knowledgeable professionals.

Ocean Cargo Insurance

A good cargo policy can cover seemingly any property that is transported on a vessel, with the understandable exception of stolen or illegal items. Though the insurance was created to handle losses that occur at sea, today's cargo policies typically extend coverage to include some losses on land. In many cases, ocean cargo insurance can even cover shipments on planes.

A business or individual can insure cargo without owning it. To become an assured under a policy, a person must only demonstrate an "insurable interest" in the property. Within the context of cargo insurance, an insurable interest is merely a valid reason for wanting goods to arrive undamaged from the shipper to the recipient. Thanks to the broadness of insurable interest and the complexities of business relationships, it is possible for transported products to be insured by a seller, a buyer, a freight forwarder or a ship owner.

Risk Transference Among Senders, Recipients and Ship Owners

Before examining the provisions and exclusions in ocean cargo insurance contracts, businesses may want to become aware of the times when international cargo risks (including the possible responsibility for having adequate insurance) may be transferred from the sender to the recipient. Since the 1930s, these moments of transfer have been standardized by the International Chamber of Commerce. The standards are updated periodically and are known as "Incoterms."

The 11 most recent Incoterms, published in 2010, clarify who is usually responsible for freight costs, duties and other matters at various points in the international shipping process. Though readers who are interested in understanding all 11 Incoterms can order their own copy, a few of them are explained below with an emphasis on risk transference:

- **Free on board (FOB):** In this kind of arrangement, the risk of damage to cargo usually stays with the sender until the cargo is placed onboard a vessel.
- **Cost, insurance and freight (CIF):** In this kind of arrangement, the risk of damage to cargo usually stays with the sender until it is received by the recipient at a designated location.
- **Free alongside ship (FAS):** In this kind of arrangement, the risk of damage to cargo usually remains with the sender until it is placed near the side of the ship.
- **Ex works (EXW):** In this kind of arrangement, the risk of damage to cargo usually stays with the sender until it is off his or her premises. For example, the recipient might become responsible for insuring cargo the second it leaves the sender's warehouse.

In general, a ship owner is responsible for insuring his or her craft but is not responsible for insuring all of the ship's cargo. In most cases, the ship owner's liability for lost or damaged cargo onboard a U.S. vessel is limited to $500 per package by the Carriage of

Goods by Sea Act. Liability risks (not just related to lost or damaged goods) for ship owners can be managed by purchasing protection and indemnity (P & I) insurance. This insurance will be explained later in this material.

Freight Forwarders

Instead of looking for coverage on their own, many businesses rely on cargo insurance from "freight forwarders." A freight forwarder acts as an intermediary between the sender and the entity that actually transports property to its intended recipient. Along with other services, freight forwarders can handle the necessary paperwork for imports and exports, pack goods in a manner fit for transportation and store items for the sender until the actual day of shipment. Other tasks, such as transporting the stored items to the vessel, may be completed by the freight forwarder or delegated to a third party.

The choice between using a freight forwarder or not is often based on the sender's shipping activity. Freight forwarders may be attractive to an infrequent shipper because they have more experience with international transportation and have well-established relationships with marine insurers. However, businesses that do a lot of shipping tend to believe it is more cost-effective to bypass freight forwarders and obtain their own cargo insurance. The latter is especially likely when the sender has a long shipping history with few property losses.

When a business buys cargo insurance through a freight forwarder, the forwarder often relies on the concept of insurable interest and covers the sender's property under its own policy. The forwarder reports the value and frequency of its shipments to its insurance company and uses part of the sender's payment to offset its insurance costs. A certificate of insurance is provided by the forwarder to the sender, and the certificate is sent to the forwarder's insurer after a loss. This proof of insurance helps set compensation in motion.

Why Buy Your Own Cargo Insurance?

Thanks to the services provided by freight forwarders and the shared responsibilities articulated in the Incoterms, many businesses do not bother purchasing their own cargo insurance that covers property from the sender's warehouse to its intended destination. However, marine insurance experts point to several reasons why senders and recipients should look into buying broader coverage for themselves.

Some benefits of having your own comprehensive cargo insurance policy are speedy compensation and personalized service. If a loss occurs and insurance responsibilities cannot be determined clearly through the Incoterms, the harmed business can file a claim with its insurer, receive quick payment and let the insurance company recoup its money through possible legal action against the other party's insurer. If a business takes initiative and secures its own insurance, it may also have an easier time getting professional help with a claim.

Even when the Incoterms are clear, some businesses believe it is in their best interest to purchase insurance that can cover cargo at any point during a shipment. Suppose, for example, that the terms of sale call for a CIF arrangement, in which the shipper is responsible for insuring the cargo until it is delivered to the recipient at a designated location. Unless the two parties agree to stricter terms ahead of time, the sender would have the right to purchase basic cargo insurance rather than a comprehensive all-risk policy. Instead of relying entirely on the potentially inadequate coverage obtained by the shipper, the receiving business could use its own insurance to fill potential gaps.

Duration of Coverage

Whereas early kinds of cargo insurance only covered goods that were on the water, today's policies can remain in force after the shipment has hit land. The common policy insures property on a "warehouse-to-warehouse" basis, with coverage beginning at the shipper's warehouse and continuing on the vessel and on the road to the recipient's storage facility. Coverage generally ends at the recipient's warehouse, but some forms (such as the one promoted by the American Institute of Marine Underwriters) will terminate coverage if the cargo is taken off the vessel for several days and not delivered promptly to its intended destination.

In a few cases, warehouse-to-warehouse coverage might be too big a risk for underwriters, who will prefer to insure cargo strictly from port to port. Businesses might encounter this problem if a shipment is being transported inland in a community where cargo theft is especially common. Inland coverage to or from a warehouse might also be excluded if goods are not packed in standard shipping containers.

In contrast to port-to-port coverage, "stock throughput" coverage is one of the most comprehensive forms of cargo insurance. In addition to insuring the cargo from warehouse to warehouse, stock throughput insurance might remain in effect until the shipped items are put out for sale to the public.

Open Cargo Policies

Instead of purchasing new insurance whenever a shipment is set to take place, most cargo insurance customers opt for the blanket coverage that is available through an "open cargo policy." An open cargo policy covers all shipments involving the assured for one year or until the policy is canceled.

To ensure proper pricing, the insurance company behind an open cargo policy will require periodic shipping reports from the assured. For example, a manufacturer might have to disclose the value of all its shipments every month, every quarter or every year. Sometimes premiums are adjusted and due every month. Alternatively, the assured might make a premium deposit with the insurance company at the beginning of the policy term. The cost of coverage will then be taken out of this deposit until the money has been exhausted.

The typical cargo shipment is insured for an amount equal to the cargo's value, the cost of freight and an additional 10 percent. The extra 10 percent is used as a precaution in case additional expenses are incurred by the sender or recipient as a result of a loss. According to a report by the trade publication American Agent & Broker, some underwriters may impose different coverage limits depending on whether cargo is stored on deck or below deck on a ship.

Covered Perils

Like other types of property insurance, cargo insurance can provide financial protection against a short list of perils, or it can be written on an all-risk basis. A basic cargo policy provides compensation to the assured when a loss is specifically covered by the policy. If a claim involves a loss that is either specifically excluded or not mentioned at all in the basic coverage form, it will be denied. All-risk policies, on the other hand, cover all losses except those that are specifically excluded in the coverage form.

In this section, we will address some of the perils that are likely to be covered by a business's cargo insurance policy. Many of them are covered under even the most

rudimentary cargo insurance contracts. A few may be excluded in a very basic policy but can commonly be covered via an endorsement.

Some of the commonly covered perils in marine cargo insurance policies are:

- **Perils of the sea:** This term can mean different things to different people, but it is used generally to describe risks that have always been linked to sea voyages. Bad weather, sinking, stranding, collision and some forms of water damage are commonly recognized as perils of the sea. The term is usually not used to describe perils that involve negligence by ship commanders or crew members.
- **Fire:** Especially when cargo is far away from port, fire can be a major marine risk. In addition to covering straightforward fire losses, an insurer might agree to compensate the assured for damage that is created as a result of putting out harmful flames. An insurer might exclude fire losses that are caused in large part by the chemical makeup of the cargo.
- **Barratry:** Among marine insurers, "barratry" refers to acts committed by ship personnel that cause damage to people or property. While some legal definitions of "barratry" are broad enough to include seemingly any kind of negligence by masters and crew members, the term is often used to describe situations in which people commit negligent acts for personal gain.
- **Jettison:** Jettison occurs when cargo is thrown overboard.
- **Explosion:** Like fire, this peril is a concern because cargo vessels often transport a large amount of chemicals. Even when explosion is listed as a covered peril, the policy is likely to exclude explosions that are caused by acts of war.
- **Theft:** A cargo insurance policy might only cover instances of theft that involve violence or some other form of force. Basic policies might exclude cases of pilferage, in which unarmed thieves rummage through property and leave with only a few items.
- **Earth movement:** Some cargo policies cover losses caused by earthquakes and volcanos.
- **Leakage or breakage:** Under some circumstances, losses caused by these perils can be covered by an all-risk policy or by endorsement.

General Average and Particular Average

A business that files a marine insurance claim for a partial loss has suffered either a "general average" loss or a "particular average" loss. General average losses occur when property is voluntarily lost or damaged to protect the vessel or other cargo. For example, crew members on a sinking ship might try to solve the problem by throwing cargo overboard.

After a general average loss, everyone who had an interest in the ship's safe journey usually must compensate the party whose property was sacrificed. That includes everyone who had cargo on the ship as well as the owner of the vessel. Since the responsibility for compensating the property's owner is shared among all interested parties, each party with insurance can file a claim for a partial loss.

A partial loss that is not a general average loss is called a "particular average" loss. Particular average losses have nothing to do with protecting other people's property. They affect no one but the senders or intended recipients of the lost or damaged items.

Coverage of particular average losses varies greatly in the marine insurance market. We will address this issue in greater detail in the section titled “The Average Clause.”

Excluded Perils

Despite the use of the term “all-risk” to describe many cargo insurance policies, there are guaranteed to be several important exclusions within the fine print. Businesses that want cargo insurance deserve to know about these gaps in coverage so that they can plan ahead and find other ways to protect themselves.

This section notes some of the risks that are unlikely to be covered by a cargo insurance policy. Keep in mind that many of these risks can be managed by purchasing other insurance products.

Some of the commonly excluded perils in marine cargo insurance policies are:

- **Inherent vice:** “Inherent vice” is a phrase that is used to describe damage, spoilage or deterioration that is relatively natural in regard to the property and not caused by an unexpected force. Depending on the circumstances, spoilage of food might be considered an example of inherent vice. The rusting of metal shipments might also fit into this category.
- **Breakage:** This peril will usually be excluded if it results from poor packing. If the cargo is especially fragile, breakage might not be covered at all.
- **Willful misconduct:** Cargo is not covered if the assured intentionally engages in negligent behavior.
- **Loss of market:** For various reasons, situations arise in which intended recipients of cargo do not accept a shipment. This might cause financial harm to the sender if the intended buyer did not pay upfront for the goods. The insurance company is not required to compensate the assured for retracted or failed business deals.
- **War and riot risks:** These perils can often only be covered through additional insurance. “War and riot risks” can mean any of the following perils:
    - Acts of war.
    - Strikes.
    - Riots.
    - Civil commotion.
    - Torpedoes.
    - Insurrection.
    - Rebellion.
    - Terrorism.
    - Martial law.
    - Radiological damage.
    - Nuclear accidents or attacks.
    - Land mines.

The Average Clause

A cargo policy will cover total losses that are caused by covered perils and will also help the assured pay for partial losses that are general average losses. However, coverage of particular average losses will depend on the language found in the policy's "average clause." As was mentioned earlier, particular average losses are partial losses that only impact the sender or intended recipients of the lost or damaged items. They are not losses that are caused when property is sacrificed to protect other people's property.

Cargo policies that are "free of particular average" provide very limited coverage of particular average losses. According to the American Institute of Marine Underwriters, this kind of insurance will only handle particular average losses when they are caused by stranding, sinking, collision or fire. Cargo policies that are "with average" broaden coverage to include all partial losses that are caused by perils of the sea.

Among polices that are "with average," some include a "franchise deductible" that applies to all damage done by perils of the sea. A franchise deductible is equal to a specific percentage of the property's insured value and acts like a benefit trigger. If a particular average loss is lower than the franchise deductible, the loss will not be covered by the insurance company. If a particular average loss is equal to or greater than the franchise deductible, the insurance company is generally obligated to cover it.

The Sue and Labor Clause

The "sue and labor clause" makes the assured responsible for taking all reasonable steps to prevent a realized loss from getting worse. If, for example, the assured has reason to believe that insured property could be damaged by water, he or she is expected to move the property to a dry place. The sue and labor clause also allows the assured to be reimbursed by the insurer when extra expenses are incurred from protecting property.

The Concealed Damage Clause

When cargo is delivered to its intended recipient, the recipient often must sign a form as proof that the items have arrived in one piece. But since the stresses on people's time usually don't give the recipient a chance to inspect the property immediately, damage that occurred during transportation is often not discovered until later.

Some cargo policies feature a "concealed damage clause," which allows transit-related damage to be covered even if it is not noticed at the time of delivery. To be reimbursed for such losses, the assured must report the damage within a specific timeframe, which can last anywhere from a few weeks to a few months from the date of receipt.

The Refrigeration Clause

Marine insurance policies often contain an inherent vice exclusion that can prevent perishable cargo from being covered if it spoils. As a way of working around this exclusion, businesses that ship food products often add a refrigeration clause to their cargo policy. The refrigeration clause will reimburse the assured when cargo is damaged because of a malfunctioning refrigeration unit.

Businesses that are interested in modifying their policy with a refrigeration clause need to pay close attention to contractual language. Depending on how the clause is worded, the insurer might exclude losses caused by human error, such as a crew member's failure to keep a refrigerator plugged in. The clause might also feature a time element. For instance, the clause might only apply to cases in which a refrigerator failed for at least 24 hours.

The Inchmaree Clause

Named after an English ship from the 19th century, the “inchmaree clause” covers cargo losses that are caused by burst boilers, machinery failures or other problems with a vessel. It also makes the insurance company responsible for paying claims when losses arise from navigational errors or negligent behavior by a ship’s captain or crew.

The Shore Clause

Sometimes called the warehouse-to-warehouse clause, the “shore clause” explains the kinds of losses that will be covered on land, including on wharves, on docks or during inland transit. These perils might include collision, earthquakes, sprinkler damage, floods and fire. Perils covered on land might not be covered on water, and vice versa.

Dealing With Delayed or Late Shipments

When a shipment of cargo falls behind schedule, it is possible for the assured to keep coverage intact. Although the insurer generally expects cargo to remain in transit until it has reached its destination, a layover that is beyond the assured’s control will not release the insurer from its contractual duties. Similarly, if a delay or some other factor creates a situation in which the intended recipient no longer wants the cargo, the insurer will often continue covering the shipped goods until they have been returned to the sender.

Extra expenses relating to a delayed or late shipment can be covered by purchasing special endorsements. These additions to a cargo policy might reimburse the sender for return shipping costs when transported cargo is declined by its addressee. Another potentially important endorsement might cover extra expenses when a problem at sea causes a shipper to cancel a waterborne shipment and send the cargo through the air instead.

Cargo Insurance Deductibles

A “deductible” is the amount of an otherwise insured loss that a policyholder must pay out of pocket before benefits will be provided. Deductibles can be a flat dollar amount, or they can be equal to either a predetermined percentage of the insured property or a predetermined percentage of the loss. When an insurance product does not feature a deductible, it is known as “first-dollar” insurance.

Among those companies using deductibles, the size of the assured’s out-of-pocket expenses for an otherwise insured loss might depend on the value of the property and the cause of the damage. Usually, insurance for expensive shipments will involve a higher deductible than insurance for inexpensive shipments. No matter the cargo’s value, the insurer might require a higher deductible when losses relate to certain perils, such as breakage or leakage.

As was mentioned in an earlier section, some “with average” policies feature a franchise deductible that must be satisfied whenever a partial loss is caused by perils of the sea. The franchise deductible is equal to a predetermined percentage of the cargo’s insured value.

Hull Insurance

Hull insurance is essentially designed to insure the vessel that will be transporting cargo. No matter if they relate to a total loss caused by bad weather or a partial loss brought on by mechanical failure, hull insurance claims can put a great strain on insurance companies. Even when the frequency of these claims stays the same, their average size tends to get bigger and bigger.

In some ways, the magnitude of the typical hull insurance claim is a byproduct of the modern shipping environment. With a greater amount of goods coming to and from Asia and other far-off corners of the world, today's ships must be larger and more technologically advanced than their predecessors, a requirement that is guaranteed to elevate the financial consequences of any total loss. Meanwhile, the high demand for seaworthy vessels has convinced many ship owners to keep their crafts out in the water when a break for maintenance might be more appropriate.

From a typical business owner's perspective, the happenings in the hull insurance market might seem irrelevant. After all, even among those that frequently ship cargo overseas, most companies do not own their own watercrafts. They are rarely the ones who purchase hull insurance policies.

Still, it would be incorrect to say that hull insurance is entirely disconnected from the people who merely put their goods in containers, place them on a ship and pray that their items reach their intended destination. If the owner of a vessel is improperly insured and suffers a loss, that owner might not have enough financial resources to continue in the shipping business, thereby leaving senders in an undesirable position. If ship owners are having trouble insuring themselves at a reasonable price, they are likely to charge more for cargo transportation services.

Even more than cargo coverage forms, hull insurance policies contain poorly aged phrases and can be difficult to understand. In order to help businesses and producers comprehend the risks faced by ship owners, the next several sections will summarize the basics of these contracts.

Kinds of Covered Property

Hull insurance is property insurance that can cover nearly any kind of floating commercial vessel, including cargo ships, tugboats and barges. Though it does not cover cargo onboard such vessels, it usually does insure other property that is attached to or used on the craft. More specifically, a hull insurance policy commonly covers the following types of property:

- Hull.
- Lifeboats and rafts.
- Bunks,
- Boilers, machinery and other equipment.
- Furniture and supplies used by the crew.
- Property installed on the vessel but not owned by the assured.

Covered Perils

With a few exceptions, the perils covered by hull insurance are similar to the ones covered by cargo insurance. Some of the risks that can be managed by a hull insurance policy are listed below:

- Perils of the sea.
- Fire.
- Lightning.
- Violent kinds of theft.

- Earth movement.
- Bursting of boilers or mechanical failures.
- Jettison.
- Losses sustained by the craft during the loading or unloading of cargo.
- Explosions.
- Negligence of crew members or senior officers.
- Contact with planes or rockets.

Excluded Perils

Like cargo insurance policies, hull insurance policies do not help the assured manage every kind of loss. Some commonly excluded perils appear below:

- **Damage to or loss of cargo:** With the possible exception of a ship owner's contribution to a general average loss, a hull policy does not cover cargo. Cargo risks can be managed by purchasing cargo insurance.
- **War and riot risks:** These assorted perils are often covered through additional insurance.

Protection and Indemnity Insurance

Some liability insurance for ship owners is included in hull insurance policies, but that coverage can be very limited. In most cases, the liability insurance only applies to accidental collisions, and even then, it often only covers the assured for damage to property that is not on the ship. A hull policy provides no coverage for collision liability in cases of bodily injury, death or illness. It also does nothing to help ship owners when they are held responsible for damage to cargo on their own vessel.

Another problem with the collision liability coverage within a hull insurance policy is that a liability loss often counts against the policy's overall dollar limit. So if a ship owner has a hull policy and nothing else, a major hull loss might not leave enough money to cover collision liability claims. Conversely, a major lawsuit against a ship owner might leave the assured without much coverage for his or her own property losses.

"Protection and indemnity insurance" (P & I) is purchased by ship owners to remove those coverage gaps. In addition to helping policyholders manage their collision liability exposures, the typical P & I policy makes the insurer responsible for many other liability claims relating to property damage, bodily injury, illness or death. Usually renewed every two years, P & I policies aren't purchased by most businesses, but like hull insurance, they can have an effect on shipping costs.

Covered Perils

P & I insurance is much broader than the simple collision liability coverage found in hull insurance policies. It typically addresses the ship owner's liability in regard to the following situations:

- **Death, illness or bodily injury to ship personnel or the public:** Liability coverage includes the cost of medical expenses that result from these perils. Liability for breakouts of disease might not be covered if the vessel traveled to a port where the illness was known to have been a problem.

- **Property damage:** Despite exclusions that apply to cargo onboard the vessel, the ship owner is covered for damage that the ship or crew does to other property.
- **Collision liability:** Though some P & I policies exclude collision liability, many of them will cover it when it exceeds the amount of coverage available through a hull policy.
- **Salvage:** Some P & I policies do not reimburse ship owners for salvage costs, but many make an exception when the removal of a wreckage from the sea is ordered by the government.
- **Defense costs:** In most instances, the insurance company is obligated to defend the ship owner in a legal dispute. It makes no difference whether a lawsuit appears to be legitimate or frivolous. If the insurance company wants to settle a dispute and the assured disagrees, the insurer will only be responsible for covering the amount of the proposed settlement.
- **Fines:** The insurer will pay fines that the assured incurs for breaking certain laws during the course of conducting business. The insurer can deny coverage of fines when the assured was aware of a law but violated it anyway.
- **Port costs:** These costs might be covered when the ship makes an unexpected stop in order to help a sick or injured person.
- **Burial:** If a crew member dies, burial costs might be covered up to a certain amount.

Policy Exclusions

P & I insurance addresses many kinds of liability. Still, there are some situations in which even a decent policy might not be of much help. Perils that might be excluded from P & I coverage are as follows:

- **Pollution:** Strict environmental laws have made pollution a hot topic among P & I underwriters. Some policies cover pollution liability under limited circumstances. Others exclude it entirely.
- **Punitive damages:** In spite of the policy's coverage of defense costs, the insurer often will not reimburse the assured for legal penalties that have more to do with punishing a defendant than compensating a plaintiff.
- **Salvage costs:** This exclusion may be waived if the salvage is mandated by the government.
- **War and riot risks:** This exclusion typically applies to the following perils:
    - Acts of war.
    - Strikes.
    - Riots.
    - Civil commotion.
    - Insurrection.
    - Rebellion.
    - Terrorism.
    - Martial law.

- Radiological damage.
- Nuclear accidents or attacks.

Ocean Marine Underwriting Factors

Veteran marine underwriters know some losses are just part of doing business. Every once in a great while, a ship will sink, or a fire will materialize below deck and damage some highly priced cargo. Such unpleasantness can happen to even the most careful ship owners, the most experienced crews and the most diligent freight forwarders.

In spite of that reality, marine insurers still say most of the losses they cover can be prevented, and they will almost certainly prefer to do business with applicants who take risk management seriously. The next few sections contain information about how underwriters evaluate marine risks. Once applicants know what is attractive and unattractive to those underwriters, they may find it easier to obtain the coverage they want at a price they can afford.

Seaworthiness

Cargo insurance, hull insurance or P & I insurance will not be made available to applicants when the vessel associated with the policy is not seaworthy. In a basic sense, “seaworthiness” refers to the degree to which a ship is capable of safely reaching its intended destination.

Very often, a ship’s seaworthiness can be verified by viewing a recent report from a “classification society.” Classification societies formulate guidelines for the construction of safe ships, perform periodic inspections on constructed vessels and give each ship a rating based on compliance with safety standards. Though good marks from a classification society will not always ensure that an underwriter will be willing to cover a ship or its cargo, a reduced rating for a ship might jeopardize existing hull coverage. If a ship is reclassified in a negative way during the policy period, the insurer may be able to rescind the policy.

When a business applies for cargo coverage, the insurance company might be interested in the age and size of the ships that are likely to transport the goods. Some companies require the assured to pay extra when the vessel shipping the cargo is more than 10, 15 or 20 years old or weighs less than 1,000 metric tons. The shorter the journey, the more likely that a ship will be older and lighter.

Experience

Due to the high amount of human error in the marine shipping business, an insurance company will want to work with people who know how to keep losses at a minimum. When a business applies for cargo insurance, it may be asked to provide a loss history that dates as far back as the last five years. The experience of the ship’s crew may also be an important underwriting factor, especially in today’s busy shipping environment where there are not always enough qualified workers to meet demand.

Cargo Theft

Figuring out the prevalence of cargo theft isn’t easy. Many victims of this crime don’t bother to report it, maybe because they don’t want to see a rise in their insurance rates or maybe because they don’t think alerting authorities to the problem will do much good. Members of the law enforcement community have a full enough plate as it is, what with all the homicides, security threats and other gravely serious matters in the world, and they rarely have the luxury of making anti-theft campaigns a top priority. Still, marine insurance

experts say stolen cargo is a major problem, with annual U.S. losses estimated at $10 billion and worldwide losses approaching five times that number.

When evaluating a cargo insurance applicant's exposure to theft, an insurance company may be interested in knowing the kinds of products that will be shipped and the way they will be packed. Thieves have taken a special liking to cigarettes, electronics and other items that can be resold with relative ease in the black market. Food products and pharmaceuticals are also popular targets.

As for packing, some underwriters might prefer that cargo be shipped in containers with inconspicuous labels. The contents of the containers should be disclosed on a need-to-know basis, as should the identities of the shipper and recipient.

Piracy

Piracy is not quite theft and not quite terrorism. Its participants are not the wooden-legged, gold-hunting characters with parrots on their shoulders who appear in classic literature and cartoons. Today's pirates ride in high-speed vessels and use technologically advanced assault weapons to take over cargo ships and hold crews for ransom.

Recent years have seen a spike in piracy that has affected insurers of some international voyages. The International Marine Bureau tallied nearly 300 attacks in 2007, with the highest amount of risk hovering over waterways near underdeveloped sections of Asia, Africa and other locations that bridge the gap between the West and its Chinese and Indian trading partners.

For the most part, piracy has little or no impact on the market for cargo insurance, but it can be a major risk for underwriters in other corners of the marine business. A vessel that is taken over by force is likely to sustain some property damage, and any ransomed crew member who is hurt or injured could create liability concerns for the ship's owner. Coverage of these losses can be obtained in different ways, depending on where insurance is purchased. U.S. insurers usually exclude piracy from their main marine policies but include it as part of their war risk policies. Many foreign insurers take the opposite approach.

Like the risk of theft, piracy can influence the availability of affordable insurance for overseas missions. For risk management purposes, a list of communities that are at high risk for piracy can be obtained through the Joint War Committee at Lloyd's Market Association.

Packing and Loading

The ways in which cargo is stored and transported on and off of ships can influence a policyholder's exposure to risks. Consequently, insurance companies might enforce special coverage limits or special rates when items are not shipped in a standard fashion. In order to grasp the connection between certain risks and the handling of cargo, let's briefly go over how shippers, freight forwarders and marine laborers pack, load and unload property.

Cargo can be shipped in bulk, with raw unpackaged materials being deposited into designated parts of a vessel, or it can be shipped in containers. The duration of a cargo insurance policy may depend on which of these two shipping methods will be used. Cargo shipped in standard containers might be eligible for warehouse-to-warehouse coverage, while bulk cargo might only be insurable form port to port. There may also be exclusions and dollar-based coverage limits depending on whether bulk cargo or a container is stored above or below deck.

Time and Route of Shipments

The assured will be exposed to different degrees of risk depending on the time and route of a shipment. Even with improved technology that can steer vessels clear of some storms, it would be obviously unwise to set sail toward an area that is gearing up for an expectedly harsh hurricane season. As has been mentioned in other parts of this course, location is also important because different countries and communities experience different levels of piracy and theft.

Besides focusing merely on a shipment's proposed starting point and end point, insurance companies will adjust coverage and pricing in ways that reflect any significant breaks in the journey. To keep thieves at bay, underwriters might prefer to approve applicants whose shipments are going straight to their destinations instead of being stored in a warehouse during a layover. Breakage is also a concern in this regard since the unloading and reloading of cargo make accidental damage more probable.

Inland Marine Insurance

During the first hundred-plus years of the United States' existence, ocean marine policies were broad enough to insure people against the most common kinds of trade-related losses. But as the nation became increasingly industrialized, the shipment of goods on land and along inland waterways grew in importance. Many businesses began transporting their products on trains and trucks, and those who still relied on oceanic vessels realized that the land-based coverage in cargo policies wasn't as comprehensive as they would have liked.

By the 1920s, the American insurance industry had begun promoting an offshoot of the marine insurance market. Known as "inland marine insurance," this line of policies attempted to help shippers manage the evolving risks that came with road and rail transportation. In time, it also attracted businesses and individuals who were dissatisfied with the various limits and exclusions in conventional kinds of property insurance policies. Thanks in part to regulatory flexibility, inland marine insurers started covering many of the risks that had previously been targeted by fire insurers.

Battles over market share between marine insurers and fire insurers eventually prompted action by insurance authorities across the country. The year 1933 saw the creation of a national definition for inland marine insurance, which dictated the kinds of risks that could be managed by inland marine insurers and the ones that could only be covered by fire insurers. The definition has been modified several times since then and generally permits inland marine underwriters to cover the following kinds of property:

- Property that has been imported but has not yet reached its destination.
- Property being warehoused in the United States with the intent of shipping it at a later date.
- Property that is in the process of being moved from one U.S. location to another U.S. location.
- Man-made property that makes inland transportation possible (such as tunnels and bridges).
- Property that is entrusted by its owner to a business.

- Highly valued property that is easily portable.
- Property that, by its very nature, has a value that is constantly fluctuating (such as accounts receivable).

Kinds of Inland Marine Insurance Policies

The property mentioned in the previous section is only a sample of the many items that can be covered by inland marine insurance. Despite representing only 2 percent or so of the entire property and casualty market, inland marine is an incredibly versatile line that can be broken down into more than 100 types of personal and commercial policies.

Since we've already spent a considerable amount of time studying shipping and transportation risks, let's briefly look at how inland marine coverage can apply in other situations. Some of the most common inland marine policies that insure items besides shipped goods are listed below:

- **Builders risk policies:** "Builders risk insurance" covers a building while it is being rehabilitated or constructed and insures the building materials that have been purchased for the project. It may be bought by the owner of the building or the general contractor in charge of construction. When secured by the general contractor, it can cover a specific construction project from beginning to end or all of the contractor's construction projects within a specific timeframe.
- **Installation floaters:** Similar to builders risk insurance, an "installation floater" is used to insure materials that are used to install or construct a specific item or feature in an already-constructed building. If, for example, a specialist is hired to install a new electrical system, he or she might rely on an installation floater to cover loss of materials.
- **Contractors equipment policy:** Whereas builders risk and installation policies cover materials that will ultimately become part of a contractor's final product, a "contractors equipment policy" insures the tools that are used to complete the job. Coverage applies at the contractor's workplace, at the worksite and in transit. It also covers commercial vehicles that are exempt from coverage in commercial auto policies, such as bulldozers and forklifts.
- **Bailee policies:** "Bailee policies" are bought by businesses that specialize in servicing other people's property, such as dry cleaners and repair shops. They may help the business compensate the owner of lost or damaged property regardless of whether the business was at fault.
- **Block policies:** "Block policies" are designed to cover merchandise for businesses that specialize in selling highly valuable and very portable items. Strong candidates for block policies include jewelers, furriers, art dealers and owners of music shops. Items covered by block policies are usually very attractive to thieves. Therefore, an applicant's commitment to a strict and thorough security plan might be important to an underwriter.

Conclusion

Marine insurance has been essential to international trade for centuries and has been adjusted over those years to cover a wide variety of commercial risks. By becoming familiar with cargo policies, hull policies and other marine products, insurance professionals make it more likely that the task of managing those risks will be easier for businesses.

CHAPTER 6: WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE

Introduction

In the competitive business environment of Japan, some physicians and government agencies have acknowledged an odd tendency among the country's corporate workers. Despite the absence of hazardous workplace conditions, a number of executives have been known to die on the job. Even without pre-existing medical problems to their name, bosses and employees have suffered fatal heart attacks and strokes.

The circumstances surrounding these incidents often show that the victims took commendable work habits to dangerous extremes. For professional and personal reasons, they may have labored regularly into the night until their overtime hours nearly equaled their regular hours. They may have been successful in business, but they allowed themselves to become casualties of "karoshi," a term that literally means "to work oneself to death."

Though workaholic attitudes in the United States have yet to spawn an American version of karoshi, there was a time when occupational fatalities were relatively common and widespread.

Safety Issues and the Industrial Revolution

By the late 1800s, the Industrial Revolution had put the United States on a new path. Railroads were being built, factories were replacing farms, and heavy-duty machinery was being utilized in new ways to increase productivity. With those changes came new risks for the average laborer. Older people from agrarian backgrounds and younger people just entering the workforce had to adapt to perilous manufacturing jobs with little or no training. Safety standards were either very basic or nonexistent, and labor laws that could have cut down on major accidents were years away from being passed.

Thanks to a growing pool of people who were willing to do hazardous work for little money, employers had few incentives to reduce their employees' exposure to danger. And with no social insurance in place for the poor or the disabled, breadwinners who exposed themselves to possible injuries or occupational death were also exposing their family to financial devastation.

Legal Challenges in Early Workers Compensation Cases

Unlike such major European powers as Germany and Great Britain, the United States lacked a workers compensation system and relied on tort law to determine whether injured workers were entitled to reparations. If a worker was injured during the course of employment, the person could only receive compensation if he or she took the employer to court and proved the employer had been negligent. Meeting those requirements was expensive and difficult for most plaintiffs. One study, cited in the government periodical Social Security Bulletin, found that employers from the era were judged to be at fault for less than 20 percent of workplace accidents.

Part of the problem for workers in those situations related to the multi-faceted power of the employer. From a financial perspective, the employer was more likely than the employee to be capable of affording talented legal counsel. Also, on a psychological level, the employer's ability to retaliate against its workers was an intimidating weapon that kept witnesses from testifying against a negligent company.

Similar concerns often dissuaded injured people from pursuing any kind of legal action in the first place. If workers believed recovery from an injury was at all possible, they didn't want to get into a dispute with an employer and hurt their chances of getting their job back.

Those workers who dared to push their way into court were often sent home without compensation because of three popular legal defenses favoring businesses at the time:

- Under the "contributory negligence defense," an employer could avoid liability for an accidental injury if the employee in any way caused or helped cause the accident.
- Under the "fellow servant defense," an employer could avoid liability for an accidental injury if the accident was caused by a coworker or some other person besides the employer.
- Under the "assumption of risk defense," an employer could avoid liability for an accidental injury if the nature of the injury was considered common in that line of work. So, hypothetically, a firefighter who was harmed by fire in the line of duty could have been denied compensation because coming into contact with flames was part of the job.

In many cases, these defenses were absolute. (A contributory negligence defense, for example, could shield an employer from all liability even if the employee was only partially responsible for the injury.) But they became less iron-clad over time, and other developments helped reduce the legal challenges for workers. Instead of holding an employer entirely blameless on account of a worker's contributory negligence, courts started employing the concept of "comparative negligence" and awarded compensation to workers in an amount that was proportionate to the employer's role in an accident. Instead of accepting the fellow servant defense in nearly all cases, some courts determined the employer could be held liable if an injury was caused by a worker's supervisor. Flexibility also extended to spouses, who eventually won the right to continue a suit against an employer after a worker's death.

The Beginning of Workers Compensation Laws

Workers compensation received federal attention in 1908 when Congress passed the Federal Employers Liability Act, a law that created a procedure whereby injured railroad workers could make claims for damages. Another law—the Federal Employees' Compensation Act—followed a few years later and provided compensation to an assortment of injured government workers.

In between the passage of the two federal acts, Wisconsin became the first state to develop a constitutionally viable workers compensation system of its own. By 1950, every state had instituted a similar system and allowed injured employees and families to collect compensation from employers regardless of fault.

More than 50 years later, each state's workers compensation system has gone through changes in its details. But the principles and goals behind those systems have remained consistent. No matter the region, and with nearly no regard to profession, employees have a simplified process for receiving compensation after an injury. Perhaps without even realizing it, they are enrolled in one of the most successful social insurance programs in American history.

Understanding No-Fault Insurance

Legislators in every state have made workers compensation a no-fault system. In practical terms, this means an injured employee does not need to prove negligence by the employer in order to collect benefits. As long as claimants were engaged in work-related tasks at the time of an accident, they can be harmed by the actions of coworkers, bosses, customers or themselves and still have their losses covered. In most cases, the contributory negligence defense, fellow servant defense and assumption of risk defense cannot prevent them from receiving compensation.

In exchange for not having to prove negligence by their employer, people who are covered by workers compensation laws generally forfeit their ability to sue their employer after an accident. Employers must provide compensation in the amount prescribed by state law, but they are usually not liable for pain, suffering or punitive damages.

This method of compensating injured employees also limits liability for coworkers. If a worker causes an accident that harms another worker, the injured party will be compensated by the employer in an amount determined by state law. The injured worker does not need (and might not have the right) to sue the other worker for damages.

There are, however, a few situations in which the no-fault component of workers compensation is absent. When an employer or coworker harms an employee intentionally or had reason to believe an injury would occur, the employee can take the employer or coworker to court and sue for pain, suffering and punitive damages. The courts are also an option for workers who are not covered by their state's workers compensation laws. But because these individuals fall outside of the no-fault workers compensation system, they may lose their cases on the basis of the contributory negligence defense, the fellow servant defense or the assumption of risk defense.

In spite of their occasional arguments over how much workers compensation programs give injured workers, neither employers nor employees have argued wholeheartedly against the system's no-fault status. Undoubtedly, this is because both sides recognize some benefits from a relatively uncomplicated arrangement that aims to keep lawyers and judges out of the picture. For the worker, the decision to make fault a non-issue helps ensure that compensation is readily available. For the employer, it makes the cost of risk management more predictable by putting some limits on a company's liability.

Different Laws for Different States

No-fault workers compensation systems exist in all U.S. states and territories, including Washington D.C., Puerto Rico and the Virgin Islands. But it must be stressed that no two systems are exactly alike. An absolute expert on workers compensation has more than 50 sets of laws and regulations to deal with, and the assorted differences among states can be significant.

As a way of demonstrating this point, let's go over the insurance-related requirements employers must follow. At the time this course was being written, laws in practically every state required employers to have some kind of workers compensation insurance. Depending on the state in question, the coverage could be purchased from a government entity, bought from a private company or created through some kind of state-approved self-insurance arrangement.

Yet in the state of Texas, employers could choose between obtaining coverage and not purchasing insurance. If an uninsured Texas employer happened to be sued by an injured worker, the employer could not use the contributory negligence defense, fellow servant

defense or assumption of risk defense, and its liability for pain, suffering and other damages could have been unlimited.

People who specialize in workers compensation insurance should also understand that some state laws, which have a direct impact on insurance coverage, have changed frequently and dramatically in the last few years. In all likelihood, states will continue to change and refine their workers compensation systems as a way of promoting fairness and managing the economy.

Please keep the issues of change and non-uniformity in mind while you read the remainder of this chapter. Although you will find occasional references to specific states in the text, the information is provided for general purposes. It might not reflect all the particulars of your state's workers compensation system, and it is not a substitute for advice from licensed legal professionals. Producers who assist businesses in the purchase of workers compensation insurance are strongly encouraged to review current statutes and administrative rules from their respective states.

Who's Exempt From Workers Compensation?

As evidenced by the railroad-specific Federal Employers Liability Act of 1908, workers compensation laws of the past were sometimes geared specifically toward people with highly hazardous jobs. Employers are in a very different situation today and are generally required to purchase insurance covering all workers regardless of risk.

Exceptions to this rule exist in every part of the country and are listed in workers compensation statutes and administrative rules. If a certain kind of worker is specifically not protected under state statute or rule, an employer does not need to obtain insurance to cover the worker's injuries. Therefore, if all of an employer's workers fall outside of the state's statute and rules, the employer is allowed to conduct business without insurance. If some but not all of the employer's workers are not covered by statutes or rules, coverage must still be obtained for the other employees.

The next several sections mention classes of people who are often excluded from workers compensation systems. Exclusions differ among states and might not apply to businesses in all industries. Companies involved in accident-prone fields (such as construction and food services) might be required to insure their employees under every circumstance.

Small Businesses

Some states will exempt a business from workers compensation requirements if it only employs a few workers. Cutoff points for this exemption might be as high as five employees or as low as three employees.

Family Businesses

Perhaps assuming that relatives are more likely to look out for one another's safety and less likely to sue, a few states do not force employers to cover family members who work for them. Still, even when this exemption exists, it is important for businesses to read the fine print.

Before opting to leave a family member uninsured for workers compensation, the employer ought to learn who actually qualifies as a relative under state law. In some states where family exemptions are permitted, eligible relatives might include everyone who is part of the employer's family by blood or marriage. Elsewhere, the exemption might only be allowed in cases where the uninsured employee is the employer's child and is below a certain age.

Several states do not make a distinction between relatives and non-relatives. Unless a family member is a co-owner of a business, states such as California might determine that the person should be covered for workers compensation. Insurance may be necessary in these states even if the relative is working voluntarily and is not on the company's payroll.

Self-Employed Individuals

Since self-employed people are responsible for their own safety at the workplace, they generally aren't covered by workers compensation statutes and do not need to purchase insurance for their own occupational injuries. In effect, this exemption helps people with employees reduce their workers compensation premiums and lets many one-person businesses operate without buying a policy.

Many states, including Illinois, will extend the rights of their workers compensation statutes to a self-employed person if the individual purchases insurance. The option of covering oneself for workers compensation might be especially appealing to company owners who are not protected by health insurance and disability insurance.

In states where there is an insurance exemption for small businesses, a self-employed person is usually not counted as an employee. In other words, if a state requires all businesses with two employees to purchase workers compensation coverage, and a self-employed person has one other person on the payroll, the self-employed person probably does not legally need to buy insurance.

Executive Officers

In a manner somewhat similar to self-employed individuals, a company's shareholders, directors and executive officers can sometimes choose not to have themselves insured for workers compensation. This option might save companies some money, but, according to a report published by the trade publication Risk Management, it usually does not reduce a company's number of employees and does not release the business from having to cover its other workers.

Interns and Volunteers

Having volunteers or interns assisting at a business can be beneficial to everyone involved. The business owner may be able to avoid doing some simple tasks at the office, and the volunteer or intern may receive a great deal of experience and personal satisfaction.

However, uncertainty can arise when unpaid workers are injured. When these people are hurt while performing their duties, are they entitled to the benefits spelled out in workers compensation statutes? Will they be able to sue the business for their pain and suffering?

Determining whether a volunteer or intern is covered by workers compensation laws is a tricky task that might be open to interpretation by a court. When a court or insurance company is faced with this issue, answers to the following questions are likely to be important:

- Was the injured person performing tasks in order to further his or her education?
- How much did the business benefit from the injured person's assistance?
- Were tasks performed in exchange for any kind of compensation, including room and board?

In general, uncompensated volunteers who are doing tasks of little value as part of their education are less likely to be covered by workers compensation laws.

Domestic Employees

Because most people don't view their residence as a place of business, many households that employ maids, nannies and other domestic workers don't think about workers compensation requirements. While many domestic employees operate outside the workers compensation system, a family may need to cover an employee if work is done on a regular basis for an extended period of time.

If employers of domestic workers believe they are covered for liability through their homeowners insurance policy, they might be in for an unpleasant surprise. Although the liability side of a homeowners policy can help pay medical costs incurred by injured workers, the coverage is subject to a dollar limit and cannot be utilized in every situation. When an injured domestic worker is supposed to have been covered through a state's workers compensation statute, the issuer of the homeowners policy can deny liability claims.

Independent Contractors

Workers compensation is for employees, not independent contractors. The exact meaning of "independent contractor" will depend on state and federal law and is generally based on the relationship between the worker and the business. If several of the following statements are true, the worker might qualify as an independent contractor. If several of them are false, the worker is more likely to qualify as an employee:

- The tasks performed by the worker do not relate to the specific nature of the business.
- The business does not have the right to determine the worker's schedule.
- The business does not have the right to determine where tasks should be performed.
- The worker openly performs similar tasks for other businesses.
- The duration of the relationship between the business and the worker is predefined, rather than indefinite.
- The worker is responsible for providing his or her own tools and supplies.
- The worker does not receive employee benefits, such as health insurance or paid vacation days.
- The business provides no training to the worker and does not dictate how tasks are to be performed.
- The worker is compensated via a flat fee rather than a regular wage.

When a business hires an independent contractor, it is not required to cover the person for workers compensation or pay various payroll, Medicare and Social Security taxes. This explains why many companies prefer to hire individuals as independent contractors instead of as regular employees. However, business owners must realize that a person is not an independent contractor simply because the company says so. Even a business contract naming the individual as an independent contractor can be irrelevant if the company actually treats the worker like an employee.

When a business inappropriately classifies a worker as an independent contractor on purpose, it is committing fraud and exposing itself to multiple kinds of liability. You will read more about the prevalence of this illegal activity in a later part of this course.

Industry-Related Exemptions

There are some industries and professions that are independent from state workers compensation laws. This independence may exist because occupational injuries in these fields are especially common and severe. Industries are also often exempt from state statutes when they play a direct role in facilitating interstate commerce. In either case, many of the workers in these exempted industries can obtain compensation by way of federal laws.

State workers compensation laws might not be applicable to the following kinds of people:

- **Marine workers:** Dock and harbor workers, as well as those who work on the navigable waters of the United States, may be eligible for workers compensation in amounts allowed by federal law. The Longshore and Harbor Workers' Compensation Act generally covers workers who perform maintenance on ships or who load and unload goods that are transported on vessels. The Merchant Marine Act provides a simplified way for injured workers to sue employers for work-related damages that are suffered while at sea.
- **Coal miners:** Miners with black lung disease are compensated in accordance with the Black Lung Benefits Act. Based on this law, mining businesses must pay special taxes toward a federal compensation fund and are required to insure their workers against the disease.
- **Real estate licensees:** In some states, real estate licensees might not be covered by workers compensation laws if they work entirely on commission.
- **Religious organizations:** Some states let these and other non-profit entities operate outside of the workers compensation system.

Before we move on to the kinds of assistance that are available through workers compensation systems, we should mention that people who are not included in workers compensation laws can still be eligible for some insurance benefits. This is because the workers compensation insurance bought by businesses is almost always coupled with "employers liability insurance."

Employers liability insurance pays benefits when an employer is held liable for an occupational injury that is not covered by workers compensation laws. Unlike workers compensation insurance, employers liability insurance is limited to a specific dollar amount and can only be used when an employer is believed to be at fault.

Employers liability insurance can help a company cope financially with many kinds of lawsuits related to occupational injuries, but it doesn't fully protect businesses in every industry. The standard policy does not cover an employer's liability under the Longshore and Harbor Workers' Compensation Act, the Federal Employees' Compensation Act or other federal laws. Businesses impacted by these laws can add liability protection by endorsement.

Later in this chapter, you'll read more about how employers liability insurance can protect businesses when workplace injuries fall outside state workers compensation systems.

Workplace Injuries

A person may be eligible for workers compensation after suffering a workplace injury. In order for the individual to be covered for any resulting medical expenses and receive other benefits, the following three facts must be established:

- The person was an employee of the business at the time of the injury.
- The injury was accidental.
- The person suffered the injury in connection with his or her job duties.

Let's briefly address each of those three facts.

Employees

You've already learned a great deal about who does and doesn't count as an employee for workers compensation purposes. In spite of the coverage exemptions that may or may not apply in a particular state, an overwhelming majority of workers in the United States are covered employees. Nearly all employees must be insured for compensation by their employer. If state law permits an exemption for certain employees, a business often can ignore the exemption and still cover all employees by purchasing insurance.

Accidents

By requiring that injuries be accidental, lawmakers and insurance companies remove incentives for people to harm themselves on purpose. But as you already know, the injured person can be at fault for the accident and still receive compensation. For example, employees who accidentally overexert themselves while lifting boxes are no less entitled to workers compensation than employees who are accidentally hurt by a supervisor.

Job Duties

The question of whether or not an injury was suffered in connection with a person's job duties is sometimes challenging. Much might depend on the insurer's flexibility, the details of the accident and, possibly, the opinion of a state court.

On occasion, injured workers might be able to receive state-mandated compensation even if they weren't specifically performing assigned tasks at the time of the accident. For instance, some workers who are hurt during a lunch break while at the business premises might still qualify for benefits. Similarly, a worker who slips on ice while climbing stairs on company property might be able to file a valid claim. As both of these examples make clear, the person's activities at the time of the injury might only need to be related in some way to the person's job duties. They do not always need to be identical to them.

To the benefit of employers and insurers, not all accidental injuries at the workplace are covered. If an employee is having personal problems with an estranged spouse and the spouse intentionally injures the employee at the business premises, the victim might not receive workers compensation. If an employee does not perform strenuous work and has a heart attack at the office, a claim for compensation might be denied. If employees hurt themselves while engaged in rowdy and irresponsible misbehavior, there is a good chance they will not receive benefits.

Occupational Diseases

When workers compensation laws first emerged in the early 20th century, they catered only to employees who experienced workplace injuries. By the 1920s, some statutes had expanded to include a limited amount of coverage for occupational diseases. If a worker suffered a scratch that resulted in the transmission of harmful bacteria, medical expenses and lost wages were handled by either the employer or the employer's insurer.

These days, a broader assortment of diseases can lead to workers compensation claims. In general, a person who contracts a disease is covered for workers compensation if either of the following statements is true:

- The person's assigned tasks or work environment are responsible for causing the illness.
- The person's assigned tasks or work environment are responsible for worsening a pre-existing medical condition.

Those might seem like fairly simple requirements, but employees who try to meet them may encounter several challenges. It is much more difficult to obtain compensation for an illness than for an injury. Several studies have concluded that the percentage of workers compensation claims relating to occupational diseases is in single digits.

Despite having grown in recent decades, the list of commonly covered occupational diseases is hardly unlimited. Some illnesses, like the flu, are so common that they are likely to fall outside of workers compensation statutes even when they are contracted from coworkers or customers.

It is more likely that an occupational disease will be covered if job duties made the person more prone to the illness than the average worker. Examples of successful claimants might include firefighters who develop respiratory problems and emergency medical technicians who are exposed to infectious ailments.

Sometimes workers claim to have contracted a health problem but don't have enough science in their corner to guarantee compensation. This is especially possible when an ailment is alleged to have come from the workplace environment rather than from a contagious person. While an employer or an insurer might not dispute that exposure to mold or secondhand smoke is potentially harmful to human beings, there may be disagreements regarding the amount of exposure that must be present in order for a worker's health to be negatively affected. In terms of secondhand smoke, for example, the employer and the insurer might be willing to honor a claim for asthma, but they might dispute a claim for lung cancer.

Another problem for people who contract an occupational disease relates to statutes of limitations. When workers are hurt on the job, a statute of limitations requires that they report the cause of their medical condition by a particular date, usually within one year of an accident. If an ailment is reported after the date specified by the statute of limitations, compensation can be denied.

Workers typically have more than enough time within the statute of limitations to report bodily injuries, but the time constraints are sometimes impractical for people with occupational diseases. Unlike bodily injuries, which are usually apparent at the time of an accident, diseases can develop slowly. In some cases, a sick person can go several years without experiencing serious symptoms.

In an effort to ensure that people with slow-developing illnesses receive fair compensation, some states have stretched their statutes of limitations for occupational diseases. Instead of basing the time limit on the date when a worker was last exposed to a contagious disease or hazardous environment, the state might base it on the date when the worker was first diagnosed.

Cumulative Injuries and Ailments

Workers compensation applies in situations besides single accidents and single exposures to hazardous environments. A worker is also covered when an injury or illness is brought on by long-term, cumulative situations.

We have already hinted at some occupational diseases that might fit into this category. Major respiratory problems caused by secondhand smoke are highly unlikely to develop in people who are not in a smoky workplace for very long, but they might be noticeable among people who have worked in that environment for several years.

Bodily injury can work the same way. Whereas someone who is only an occasional typist should be able to draft a document in a word processing program without suffering physical discomfort, constant typing for hours at a time can put debilitating stress on the fingers, hands and wrists.

A slow-developing injury, often brought on by repetitive tasks, is sometimes known as a "cumulative injury." At times, employers and insurers have blamed cumulative injuries and diseases on genetic factors. Older women have sometimes said they received less compensation for repetitive stress injuries than men, possibly because of gender-based differences in bone density. Black men have sometimes claimed they receive fewer benefits than other workers after suffering circulatory ailments, possibly because of statistics suggesting a link between race and a person's susceptibility to blood-pressure problems. Not surprisingly, these reductions in benefits have instigated debates over the difference between fair and unfair discrimination.

A cumulative injury may also raise the issue of who should be responsible for compensating the worker. Suppose a person has performed the same basic tasks throughout a career and has worked for several companies. If the person requests workers compensation for a repetitive stress injury, which employer pays? As in most matters of workers compensation, the answer may depend on the state where the worker lives and the circumstances of the injury. Compensation for the employee might come from all past and present employers, or it might only be received from the most recent employer.

Medical Coverage

When an employee is injured or contracts a disease at work, workers compensation pays for the person's medical expenses. Unlike reimbursement for lost income, this coverage begins immediately after an accident and is not limited to a particular dollar amount. There is no deductible for the employee to worry about, and there are no co-payments for medical services. Even when an employee suffers an injury without missing a single minute of work, this nearly unlimited coverage can be utilized to pay for all reasonable medical care.

The medical coverage component of workers compensation can be used for more than just doctor visits, hospital stays and prescription drugs. Covered workers can also receive compensation for rehabilitation expenses and may even be reimbursed for their travel expenses and meals if they go a long way to visit a physician. If a worker is hurt and requires medical equipment (including dentures, leg braces or prosthetic limbs), the cost of these materials will also be paid by the employer or an insurance company. In some states, replacement costs are covered if a worker is hurt and breaks medically necessary items, such as glasses.

When employees request workers compensation for medical care but not for lost income, they make what is known as a "medical-only claim." Because they do not involve lost

wages, medical-only claims can be relatively inexpensive. Contrary to popular belief, the majority of workers compensation claims are medical-only claims.

Picking Physicians

Workers compensation statutes rarely give employees the absolute power to choose their own doctors. If they want their medical care covered under the no-fault system, they usually must see at least one physician who has been approved by their employer. In some states, patients may be allowed to see their favored physician at their employer's expense if they first undergo an examination by the employer's requested doctor. In other parts of the country, the employee must choose among a group of medical providers who have been pre-approved by their company. If the employee is not satisfied with one doctor from the group, additional care might only be covered if it is administered by another member of the group.

A multi-state study conducted by the Workers Compensation Research Institute and the Public Policy Institute of California sums up the positives and negatives of employer-controlled health care in the workers compensation system. In general, respondents who went to a physician who was chosen by their employer received less-expensive care and returned to work more quickly. Respondents who went to a physician of their own choosing expressed greater overall satisfaction with their treatment.

Wage Replacement

When an injury causes an employee to miss work for more than a few days, the person can make a "lost-time claim." Lost-time claims are not as common as medical-only claims, but they tend to be much more expensive because they involve payment of lost wages.

For a lost-time claim to be valid, an employee must first miss a certain number of workdays. If the employee comes back to work without having missed the specified number of days, that person will not be compensated for lost wages. The employer or the insurer will only need to pay for the person's medical expenses.

Though some states have required at least a week-long absence, employees are usually eligible for lost-income benefits if an accident has kept them out of work for three days. If absenteeism lasts for a longer period of time (typically two weeks or more), lost wages from those first three days will be provided to the worker. If absenteeism lasts longer than three days but less than two weeks, wages from the first three days will usually be treated like an uninsured loss for the worker.

The amount received for lost wages will depend on the worker's financial situation, as well as on the provisions in the state statute. For most claimants in the United States, the amount will be based on roughly 66 percent of their regular income over the past year. If the person does not do any work while recuperating, the entire 66 percent will probably be available to the employee on a weekly, prorated and tax-free basis. If the person does some work while recuperating, wage replacement might be equal to approximately two-thirds of the difference between the employee's pre-accident salary and the employee's post-accident salary. Alternative or additional amounts of compensation may be available if a person is permanently disabled but not unable to work.

States set minimum and maximum amounts for wage replacement in order to benefit their citizens and discourage wrongdoing. Minimum amounts of compensation (such as 66 percent of one's income) have been formulated so injured workers and their families are less likely to live in poverty. Meanwhile, caps on wage replacement have been put in place so injured people have a good reason to eventually rejoin the workforce.

Injured workers who are reasonably wealthy might find that their compensation for lost wages is based on less than two-thirds of their salary. Maximum weekly benefits are likely to be equal to some percentage of the average wages for workers in the area. There are also some predetermined amounts of compensation for people with specific conditions and certain levels of disability.

Levels of Disability

Before injured or ill people become eligible to receive compensation for lost wages, they usually must be evaluated by a physician. The physician will determine the severity of the injury or illness, and the severity might determine the duration of wage replacement benefits. The severity might also entitle the person to a predetermined lump sum instead of a weekly income-based award.

As a way of simplifying the compensation process, many states have formulated specific durations of wage reimbursement for common and severe injuries. In a hypothetical example, a state might decide that all workers who lose an eye are entitled to receive no more (and possibly no less) than 100 weeks of wage replacement benefits. The formulas for compensation are usually based on guidelines from such professional organizations as the American Medical Association.

Predetermined durations of wage reimbursement are very common in cases of permanent partial disability. Let's quickly go over the different levels of disability and how they relate to workers compensation.

Permanent Total Disability

Employees have a "permanent total disability" when they cannot perform any reasonable kind of work and are unlikely to ever improve enough to have another job.

Permanent total disabilities are very rare, with the National Council on Compensation Insurance estimating that they account for only about 1 percent of all lost-time claims. Still, the duration of wage reimbursement in these situations is long and costs insurers a lot of money. In addition to covering the injured person's disability-related medical care for life, the employer or the employer's insurer usually must reimburse the person for lost income until the employee turns 65. Some states allow wage benefits to last throughout the person's lifetime.

Permanent Partial Disability

Employees have a "permanent partial disability" when they will never fully recover from an injury but are still capable of working. Many permanent partial disabilities, such as the loss of a limb, an eye or one's hearing, entitle the employee to a preset amount or duration of wage replacement benefits. These are known as "scheduled" disabilities. Other debilitating conditions have no predetermined amount or duration of wage replacement benefits and are known as "unscheduled" disabilities.

In a general course like this, it is nearly impossible to include concrete statements about how income-based benefits for permanent partial disabilities are calculated. Unlike the basic "two-thirds of wages" formula that is used for most instances of total disability, the mathematical operations used for partial disabilities vary greatly from state to state and injury to injury. Some states base compensation on the medically determined degree of impairment, regardless of how an injury impacts a person's work. Others will be concerned mainly with the difference between pre-injury income and post-injury income. Employees in some parts of the country will have their benefits affected by their expected loss of future

earnings, while other people's benefits will not take such hypothetical financial figures into account.

The duration of the calculated benefits might be more predictable than the amount of each check, but it, too, will depend on where the person lives and what kind of permanent partial disability has been suffered. For most scheduled disabilities, income benefits will be paid for the specific period of time appearing in state statutes. Income benefits for unscheduled disabilities can have a maximum duration of a few years or (in a decreasing number of states) continue throughout the worker's lifetime.

Temporary Total Disability

Employees have a "temporary total disability" when they are incapable of working but will be able to recover and resume their job duties at a later date. Temporary total disabilities are the most common causes of compensation claims for lost income. They usually involve cash benefits that are based on two-thirds of the employee's salary. Weekly maximum amounts of compensation are typically based on a certain percentage of the average income in the area, and minimum amounts might be based on the local minimum wage multiplied by 40 hours.

Temporary Partial Disability

Employees have a "temporary partial disability" when they are able to return to work in some capacity but are still in the process of full recovery. If their reduced duties or reduced hours cause a drop in their income, they might be entitled to two-thirds of the difference between their pre-injury income and their post-injury income.

Death Benefits

When workers die as a result of a workplace accident, their family members and dependents are likely to receive a death benefit from the employer's insurance company. The death benefit will usually be provided on a weekly basis and will be based on roughly 66 percent of the worker's wages. It generally will be close to the amount the worker would have received for a permanent total disability. Like disability payments, death benefits may be capped at a certain percentage of the state's average weekly income.

A family member's right to a workers compensation death benefit will depend on the person's relationship to the deceased and the number of people who had the same relationship. Some states will lower the death benefit if the recipient was not significantly dependent upon the worker for money.

The most common beneficiaries of workers compensation death benefits are spouses. A widow or widower is likely to receive compensation on a regular basis until death unless he or she remarries. Upon remarriage, the deceased's husband or wife typically is given a one-time lump sum from the insurance company in an amount equal to one or two years of benefits.

The deceased's children, whether biological or adopted, are also eligible for death benefits. These benefits last until a child turns 18, but they can be extended under some common circumstances. If a son or daughter remains a full-time student, benefits can continue during early adulthood. If a son or daughter is incapacitated at the time of the worker's fatal accident, the child may be able to receive death benefits throughout his or her incapacitation.

When a worker dies without leaving behind a spouse or child, workers compensation can go to the person's parents. If parents are not alive, benefits can sometimes be provided

to grandparents or grandchildren. But more often than not, parents, grandparents and grandchildren will receive no compensation if they were not financially dependent upon the employee.

States differ regarding what must be done when a worker dies without having any dependents. A few pass death benefits along to the state, which deposits the money into a workers compensation fund. Some let a limited lump sum go toward the deceased's estate. Many do not require that benefits be paid at all.

Funeral Expenses

Survivors of deceased workers receive a few thousand dollars for funeral, burial and other end-of-life expenses. The employer or insurer provides this money even if the worker had no dependents.

Do Benefits Apply in All Situations?

Up until now, most of the statements we've made about workers compensation have been general. However as any insurance professional knows all too well, the specifics of a situation can make a big difference in deciding whether a loss is covered or not.

The next several sections address some relatively specific circumstances that might or might not fall under a state's workers compensation statute. They prove that the "who," "what," "where" and "how" details of an accidental injury are very important in determining liability. They might relate to some of the hypothetical questions you've had about workers compensation, and the answers found in them might surprise you.

Offsite Accidents

When first learning about workers compensation, it's probably easiest for people to think about workers who are hurt at a single location where they remain throughout the 40 or so hours of their workweek. But, of course, risks aren't always so centralized, and accidents can happen anywhere at any time. People can be hurt on the road to work, on their way home, in the company parking lot or in their home office, and they may need to know how those injuries fit into a state's compensation laws.

Under what has become known as the "going and coming rule," workers are usually not covered for injuries they suffer while on their way to work or on their way home. There are, however, some exceptions to this rule. Emergency workers, for example, might remain covered if they are on call and are hurt while traveling to the scene of a crime or accident. Workers might also receive compensation if they conduct business in multiple locations and are injured while traveling nonstop from one of those locations to another.

Employees are sometimes covered for accidents on the business premises even though they might not have begun their work. A slip-and-fall accident that occurs on the walkway to the employer's building might be grounds for compensation. Somewhat similarly, a worker might be able to collect workers compensation if an injury occurs during a lunch break at the business premises. Injuries that occur during offsite break periods are usually not covered.

Telecommuters might be covered for the injuries they suffer at home, but the cause of the injury needs to have related to the person's job duties. Office workers who take their work home with them might not be covered beyond the business premises unless their employer knows they are completing tasks from an offsite location.

Undocumented Workers

There are millions of undocumented workers in this country, and many of them are employed in high-risk environments, such as kitchens and construction sites. The many injuries suffered by these immigrants have forced courts to address the ways in which these people fit into workers compensation systems.

When injuries to undocumented immigrants occur at a workplace, employers and insurers sometimes claim that giving compensation to them would be contrary to the intent of federal laws and legal precedents. As part of their argument, they often point to the Immigration Reform Control Act, which criminalized the hiring of illegal immigrants, and the 2002 case Hoffman Plastic Compounds, Inc. v. National Labor Relations Board, in which the Supreme Court ruled that people who are employed illegally are not entitled to back pay upon being fired.

Those federal developments have not stopped the individual states from taking a different position in the argument over illegal employees. Courts in nearly every state have ruled that employers must provide workers compensation benefits to an undocumented worker.

The general idea behind most of these rulings is that if employers were allowed to avoid paying workers compensation to illegal workers, immigration problems would actually worsen and lives would be put at risk. According to various courts, exempting undocumented workers from workers compensation systems would merely encourage cost-conscious employers to hire more undocumented workers. Furthermore, a company employing undocumented immigrants would not necessarily have a reason to promote safety at the workplace and could jeopardize the health of everyone at the company, including those who work there in full compliance with the law.

In general, courts have not been convinced that allowing illegal workers to receive compensation encourages undocumented people to fake or stage accidents. A survey conducted by the Massachusetts Department of Public Health showed a majority of foreign-born employees were not even aware that a workers compensation system exists in the United States.

In spite of the many rulings favoring workers compensation for undocumented workers, a few courts have decided that compensation for illegal employees does not need to be equal to compensation for legal employees. Since they are not supposed to be working in the United States at all, some undocumented immigrants have been denied rehabilitation benefits that might have helped them return quickly to their jobs. An item published in the Journal of Insurance Regulation reported that some courts have awarded wage reimbursement to these immigrants but have adjusted the reimbursement to reflect the amount of money the workers would have made if they had remained in their native country.

Illegal Workers and the Standard Workers Compensation Insurance Policy

The debate over whether undocumented immigrants are entitled to workers compensation gives us an opportunity to address how the standard workers compensation insurance policy relates to state compensation laws.

The first main part of the policy explains how the insurer will handle compensation required by state statute. It is intentionally general and only contains a few concrete exclusions. This part of the policy doesn't cover payments an employer must make in excess of the regular requirements in state statutes. However, any amount of compensation that is a regular requirement of the state workers compensation statute is covered by this portion

of the policy. This flexibility makes it possible for insurers to use the same basic policy in multiple states and ensures that businesses with insurance will remain covered whenever changes are made to workers compensation laws.

This early portion of the standard policy does not make any assumptions regarding whether an illegal worker is entitled to workers compensation. It does not specifically make the insurer responsible for an undocumented employee's medical expenses or lost wages, but it doesn't specifically say those things won't be covered either. It only says the insurer is not responsible for any fines or extra compensation an employer must pay because it knowingly hired an illegal worker.

The employers liability portion of the standard policy (which is utilized when injured workers are not protected under a state's workers compensation statute) is more restrictive and contains more references to undocumented workers. It states that the insurance company is not responsible for paying damages to an injured employee if the employer or one of the employer's officers knew the person was being employed illegally. It also makes the employer responsible for any fines or punitive damages related to the person's illegal employment.

Insurers understand that employers can be fooled by job applicants with false forms of identification. If an employer hires an undocumented worker in good faith and does not learn of the person's illegal status until after an injury has occurred, damages might be covered by insurance.

Intoxicated Workers

Not surprisingly, employees who abuse alcohol and other drugs are more likely to be involved in workplace accidents. The Bureau of Labor Statistics has estimated that drug use may be partially responsible for one-eighth of all occupational deaths.

As a general rule, employees cannot receive workers compensation if their injuries can be blamed on their intoxication. However a positive drug test might not, on its own, prevent a person from collecting benefits. To avoid liability, the insurer or the employer might need to prove that the accident would not have occurred if the injured person had not been under the influence of drugs. If, for example, an intoxicated worker and a non-intoxicated worker both slip on the same wet floor, it would probably be difficult to deny compensation on the basis of drug use.

Employers might even face challenges when a test proves traces of a drug were in a worker's system. Different drugs take different amounts of time to get in and out of the body. Whereas moderate amounts of alcohol might only be detectable within a few hours of consumption, moderate amounts of other drugs, such as marijuana, can still have an influence on test results several days after use. With this in mind, an injured employee might claim—successfully or otherwise—that the dangerous effects of the drugs had worn off by the time of the accident.

Employers who are interested in reducing their workers compensation costs might want to institute a drug-testing policy at their workplace. Due to privacy laws, employers are advised to speak with an attorney before making drug tests mandatory.

Work-Related Social Events

Many businesses try to reduce employees' stress levels by scheduling the occasional work-related social event. A small company might close its doors for a few hours and throw a holiday party in a break room or at an offsite location. A larger organization might hold an annual picnic for employees and their families. Companies and their competitors might

encourage their workers to play against one another in a softball game or some other sporting event.

When injuries occur at these sorts of events, the employee's right to receive no-fault workers compensation is likely to depend on whether the person's participation was mandatory. When attendance or participation is required by an employer, injuries in these settings are often covered by workers compensation statutes. Employees who are injured at voluntary events will often only receive compensation if they can prove that their condition was caused by someone's negligence.

Misbehavior

Practical jokes and roughhousing are common in many work environments and have the potential to cause significant injuries. When pranks go seriously wrong, employers and their insurers might not feel obligated to pay workers compensation. After all, by joking unsafely with coworkers instead of performing assigned tasks, the victim was probably engaging in willful misconduct.

Though many courts have supported employers by denying compensation to workers who engage in intentional misbehavior, a few recent cases prove that legal outcomes can be unpredictable. Some courts have based part of their rulings on the work environment and whether playful misconduct was generally accepted there. A Virginia court even ruled a hockey player who was hurt in an in-game brawl could collect compensation because fighting was an acceptable part of the sport and because the fight had been ordered by the player's coach.

Self-Inflicted Injuries

Employees can receive workers compensation for a self-inflicted injury if the injury was accidental. Intentional injuries are likely to be viewed as willful misconduct and are not covered under state statutes.

Suicides, of course, are the most extreme examples of self-inflicted injuries. The families of people who take their own lives while at work are usually not allowed to receive death benefits. A few courts have made an exception when a worker suffered an on-the-job injury and committed suicide in response to the pain.

How Is Insurance Obtained?

For the most part, employers who had to comply with early workers compensation laws did not have a private insurance market to help them manage their risks. When a statute granted compensation to an injured worker, money for the person's medical care and lost wages often came out of the business's own pocket.

Since many employers lacked the resources to self-insure for workers compensation, insurance companies began marketing policies to businesses and agreed to take on workers compensation risks in exchange for a premium. When some high-risk companies could still not obtain coverage from private insurers, states started stepping in as insurers of last resort.

Employers in practically every state must have some kind of workers compensation insurance, but the way coverage is secured often depends on local requirements and the employer's preference. A few states require that insurance be purchased from a single state entity, but most states encourage competition and let employers purchase cheaper coverage in the private market. Many states also give financially strong companies the option of using their own operating funds to self-insure, and some companies may be

eligible for a “large-deductible plan,” which falls somewhere between self-insurance and traditional kinds of private insurance.

In the next several sections, we’ll go over each of those coverage options in greater detail. Employers might not believe any one option is as practical and cost-effective as they would like, but they still must choose one of them. Even if an employer’s workers suffer no injuries, a business owner who operates without any kind of workers compensation insurance can be fined, shut down or sent to prison.

State Funds and Assigned-Risk Programs

When states started passing workers compensation laws, there were concerns that there would be a negative impact on local economies. If a high-risk business could not secure insurance from a private carrier, would it move to another state or close down completely? In either scenario, jobs would be lost.

In response to these concerns, every state has developed a system that guarantees coverage for all employers. The system might involve a monopolistic state fund, a competitive state fund or a residual market overseen by a non-governmental third party. These funds and markets generally operate without support from the typical taxpayer and are regulated in many of the same ways as private insurance companies. The insurance they offer is often more expensive than coverage in the open market, but they give their policyholders the chance to comply with state law and remain in business.

A few states operate a “monopolistic” workers compensation fund. When a fund is monopolistic, it is the only source of workers compensation insurance for employers. Private insurers are not allowed to compete against a monopolistic state fund.

Many states operate a “competitive” workers compensation fund. When a fund is competitive, it is not the only source of workers compensation insurance for employers. Competitive funds offer insurance that makes policyholders compliant with workers compensation statutes, but private insurers are allowed to fight for a fund’s customers by offering broader coverage at a lower price. If an employer is too high a risk for the private insurers in the state, the competitive state fund will serve as an insurer of last resort.

If a state lacks a monopolistic fund or a competitive fund, high-risk employers will be able to purchase workers compensation insurance through an “assigned-risk program.” Assigned-risk programs can be administered by the state or a state-authorized third party, such as the National Council on Compensation Insurance. When employers are denied insurance from a specific number of private insurers (sometimes one, sometimes two), they can send proof of the denial to the administrator of the assigned-risk program, and the administrator will select an insurer to provide the mandatory coverage. Because assigned-risk programs are utilized by high-risk employers, the insurance they offer is often very expensive.

Private Insurance

Most employers are covered for workers compensation by private insurance. Private insurance is usually less expensive than insurance from the state or an assigned-risk program, and the coverage might be more comprehensive.

The positive features of private insurance are not available to everyone who wants them. In order to offer quality coverage and remain in business, insurance companies sometimes must refuse to accept high-risk applicants.

Though one insurer's underwriting guidelines will be different from its competitors', an employer might be denied a workers compensation insurance policy for any of the following reasons:

- The employer's company has a history of serious workplace accidents.
- The employer's industry has a history of serious workplace accidents.
- The applicant is a new business, and the insurer cannot determine the likelihood of a workplace accident.

As was mentioned in the previous section, an employer who is unable to purchase private insurance in the voluntary market can often obtain coverage through an assigned-risk program. Employers who apply for assigned-risk coverage must be able to prove that a private carrier is unwilling to insure them.

Self-Insurance

If they do not want to spend money on private insurance, employers might have the option of self-insuring. Self-insurance is the least common kind of workers compensation coverage and is favored mostly by large companies with experience running their own benefit programs.

Businesses that self-insure do not purchase insurance. Instead, they provide state-mandated benefits on their own and are responsible for the administrative costs associated with handling claims. Administrative tasks may be done in house or passed off to a third-party administrator.

States do not allow just anyone to become self-insured for workers compensation. Interested employers must seek state approval and demonstrate their ability to pay employees' claims in a timely manner. The company usually needs to put up a statutorily determined amount of collateral as a way of proving its financial stability. At a minimum, it will need to give financial statements to regulators and prove that the employer or the third-party administrator has sufficient claims-handling experience.

Smaller companies sometimes join forces to create a "self-insured trust." A self-insured trust (or "self-insured group") is an arrangement in which members agree to share insurance risks among one another. All members make financial contributions to the trust, typically in an amount that is proportionate to the level of risk they bring to the group. When an employee of a group member is injured, those combined contributions are used to pay workers compensation claims. If members' initial contributions are not enough to pay all claims, members will have to contribute more money. In some states, all self-insured trusts can be assessed fees when one self-insured trust becomes insolvent.

Large-Deductible Plans

During the past 30 years or so, more and more employers have decided to purchase workers compensation policies with deductibles built into them. Deductibles can be as low as a few hundred dollars, and ones equal to hundreds of thousands of dollars are not uncommon. They can be enforced on a per-claim basis or be waived when multiple claims in the same policy period add up to a specified dollar amount.

When a claim is made and a policy has a deductible, the insurer provides full compensation to the injured worker. It is then the employer's responsibility to repay the insurer in an amount equal to the deductible.

"Large-deductible plans" are for employers who are comfortable with paying workers compensation on their own but want at least some protection against catastrophic claims. These plans take the concept of deductibles to an extreme and exist somewhere between self-insurance and private insurance. Rather than being entirely responsible for all but the first few hundred dollars of valid claims, insurers offering large-deductible plans are often only responsible for compensation exceeding $100,000, $500,000 or some other high amount.

Since most workers compensation claims will be lower than their deductible, employers with large-deductible plans often pay relatively low premiums. But because compensation below the deductible is paid by the insurer and then billed to the employer, companies must post collateral when applying for large-deductible plans.

What Does Coverage Cost?

When shopping around for workers compensation insurance, even the most risk-conscious businesses will be concerned about cost. The estimated size of the insurance premium will need to be known as soon as possible so employers can factor it into the prices they charge for goods and services.

The size of the employer's workers compensation premium will generally depend on three basic variables:

- The size of the employer's payroll.
- The kind of work done by the business.
- The employer's loss history.

An estimate of the employer's premium often appears on the policy's first page, commonly referred to as the "information page." At the end of a policy period, it is possible that the premium will be recalculated in a way that either nets the business a refund or requires the employer to pay more money.

When businesses are subjected to this recalculation, it is usually not because they hid something from the insurer or were the victim of an actuarial mistake. Something as simple as a hiring or a firing might have occurred during the policy period and had a significant effect on the company's payroll. When payroll changes, so does the employer's level of risk. When the level of risk changes, the premium does, too.

Premiums for workers compensation insurance are paid on a schedule determined by the buyer and the insurer. It is possible for them to be due every year, every six months, every three months or every month. Most policies are paid for on a quarterly basis.

In most kinds of insurance arrangements, all premiums paid within a single policy period are meant to cover claims that originate during that policy period. In other words, if an employer only pays premiums for one year and an employee covered by a policy suffers an injury that entitles him or her to two years of compensation, the insurer is obligated to provide compensation on the employer's behalf for two years. Compensation that continues beyond the policy period is the insurer's responsibility, and the employer does not need to renew the insurance in order to avoid liability for past accidents.

Now that we've covered some of the basics of workers compensation premiums, the next several sections will explain the specific step-by-step process for estimating an employer's insurance costs.

Employer Classifications

Regardless of a specific employer's loss history, actuaries make certain that businesses in high-risk industries pay higher workers compensation premiums than businesses in low-risk industries. The following industries, along with many others, are thought to be at high risk for occupational accidents:

- Construction.
- Security.
- Food service.
- Retail.
- Aviation.

To ensure that insurance is made available and priced fairly for nearly every industry, insurance companies start calculating premiums by looking up a company's four-digit "classification code." There are several hundred classification codes, and each code is shared by all businesses in the same line of work. All wineries, for example, will have the same classification code, and all shoe manufacturers will have another classification code. These codes are usually developed by the National Council on Compensation Insurance (NCCI), but some states have their own codes.

Although it is possible for a business's premium to be based on multiple classification codes, the code associated with the business's general degree of risk (and the one shared by all businesses in the same line of work) is known as the "governing classification code."

Each classification code has a numerical rate attached to it. The rate has been calculated by actuaries and is a mathematical representation of the basic risk level for all employers who share that classification code. Because underwriters often verify this rate by looking it up in a manual, the rate is known as the "manual rate."

Manual rates in most states are based on the loss histories of similar businesses over the past five years. The rates are determined through data that is reported to either NCCI or some other state-approved entity.

Once the manual rate is known, insurers can focus on calculating the "manual premium." The manual premium is calculated by dividing the employer's payroll by $100 and multiplying the result by the manual rate.

For some businesses—particularly small ones—the manual premium will be very close to what the employer will actually pay for insurance. For many other businesses, additional calculations will be applied to the manual premium in order to account for deductibles, the employer's specific loss history and various discounts.

Multiple Classifications

Insurance companies usually do not analyze the specific duties of each employee or assign a code to each worker. Doing that would take too much time, and verifying each person's actual duties would be a nearly impossible task. Instead, insurers are mainly interested in the general degree of risk posed by the business as a whole. However, there are exceptions to this general rule.

The manuals featuring classification codes also contain summaries. The summaries explain the kinds of tasks that fall under each code. If the summary associated with a business's governing classification code does not mention the tasks performed by a

particular employee, the employee might have to be classified separately. Depending on the nature of the employee's job duties, this could have a positive or negative effect on the employer's insurance premiums.

Situations that might require multiple classifications are explained in the next few sections.

Standard Exceptions

Insurers use governing classification codes as a way of acknowledging that each industry carries a different degree of occupational risk. If insurers were to pretend that workers compensation risks are equal across all industries, there would be many employers paying too much for insurance and other employers paying too little.

But insurers also recognize that some jobs are not industry-specific. Clerical employees, for example, are used by all kinds of businesses, including high-risk companies and low-risk companies. While these workers do suffer their share of workplace injuries, their chances of being hurt are unlikely to be significantly different when they transition from one industry to another.

In order to ensure that a business's manual rate does not skew the cost of insuring these common employees, insurers have agreed on a few "standard exceptions." Standard exceptions are classes of employees who are common across many industries and do not fall under a business's governing classification code. For employees to qualify as standard exceptions, they might need to be situated in a part of the business premises that separates them from people in other departments.

There are separate classification codes for standard exceptions, including ones for drivers, some salespersons, telecommuters and office workers. If those employees are not described in the summary for a business's governing classification code, these separate classification codes are used for them. If those employees are described in the summary for a business's governing classification code, only the governing classification code is used.

Like governing classification codes, codes for standard exceptions each have their own manual rate. To determine the manual premium for standard exceptions, you take the amount of payroll devoted to those workers, divide it by $100 and multiply the result by the standard exception's manual rate.

Employers with standard exceptions will start with at least two manual premiums. One of these premiums will be for employees who are part of the governing classification. The other premium will be for employees who are standard exceptions. Though these premiums will eventually be combined, they must be calculated separately. Applying the wrong portion of payroll to the wrong manual rate will result in an unfairly sized premium.

General Inclusions

Sometimes a business's governing classification can apply to employees who seem to be operating in an entirely different industry. The duties performed by these workers are known as "general inclusions."

General inclusions are incorporated into every governing classification, unless the manual being used says otherwise. Some of the more common general inclusions appear below:

- Maintaining the employer's premises.
- Printing the employer's materials.
- Repairing the employer's equipment.

- Running a medical clinic that is targeted at the business's employees.
- Running a restaurant or cafeteria that is targeted at the business's employees.

General Exclusions

There are some job duties that are risky enough to be excluded from nearly every governing classification. These duties are known as "general exclusions." Premiums for employees who perform these duties must be calculated separately, using a separate classification code and a separate manual rate. Unlike standard exceptions, general exclusions are only a concern for a small minority of businesses.

Some general exclusions appear below:

- Providing day-care services for children of employees.
- Piloting or serving as a crewmember on an employer's aircraft.
- Running a sawmill for the employer.
- Doing construction or renovation for the employer.

Experience Rating

The manual rate makes sure that businesses in high-risk industries generally pay more for insurance than businesses in low-risk industries. But it is mainly an average of the risk in a particular line of work, and it doesn't account for individual businesses that might be more or less safe than their competitors.

Suppose you own a barber shop and compete against a barber down the street. Since you and the other barber are in the same line of work, you are both exposed to the same occupational risks. However, your competitor has filed two claims for workers compensation over the past year, while you have filed zero. Despite this difference in loss histories, you and the other barber are subjected to the same manual rate and pay relatively the same amount for workers compensation insurance. It might not seem fair, but that's what happens when insurers do not use a method known as "experience rating."

Experience rating is an important step in premium calculations that compares the loss history of a single employer to the loss history of all employers within a governing classification. In other words, it increases the probability that a barber who files no claims will pay less for insurance than a barber who files two claims. By allowing individual loss histories to affect premiums, it encourages employers to promote safety and get their injured employees back to work as soon as possible.

To perform experience rating effectively, actuaries need a sufficient amount of data. They cannot assume a company with no claims and only a few employees is very safe or that a new business with one large claim on its hands is a high risk. They understand the small business might just be the beneficiary of good fortune, and that the new business might just be a victim of bad luck. If a business has what is believed to be an inconclusive loss history, it will not be subjected to experience rating.

As a way of keeping inconclusive loss histories out of experience rating, states do not let a business be rated on experience unless its past manual premiums were equal to or greater than a certain amount. For example, an employer in Illinois might be subjected to experience rating if its manual premium for workers compensation last year was at least $5,000. Alternatively, according to NCCI, a company might be rated in this way if its combined manual premium for the past two years was at least $10,000.

Experience rating only works if it is applied fairly to both high-risk businesses and low-risk businesses. A business that qualifies for experience rating must be rated in this way, even if experience rating will result in a higher premium. It cannot opt in and out of experience rating at will.

Experience rating usually involves looking at a business's loss history over a three-year span. In most cases, data from the most recent policy period is not complete, so losses from that year are not factored into the calculation for experience rating. For experience rating that would have been applied to the policy period beginning January 1, 2018, actuaries would have looked at a business's loss history for the years 2016, 2015 and 2014. If a business qualifies for experience rating again for the next policy period, actuaries will simply update the three-year loss history by one year. For experience rating that is meant to be applied to the policy period beginning January 1, 2019, data for the years 2017, 2016 and 2015 would be used.

Because experience rating is determined by data from three years, it might take a while for a business's premiums to change dramatically. If a business institutes a work safety program in 2019 and drastically reduces its amount of workers compensation claims, this positive change will probably not be reflected in the cost of insurance until 2021.

Experience rating also makes it possible for one bad year to influence the business's premium for a long time. If an employee files a significant number of workers compensation claims in 2019, those claims will be factored into the cost of insurance for 2021, 2022 and 2023.

The Experience Modification Factor

Experience rating uses a business's loss history to calculate an "experience modification factor." Whereas the manual rate represents the average degree of risk for all businesses in a particular industry, the experience modification factor shows the insurer whether a specific employer is riskier than average or safer than average.

We will not go into too much detail about how the experience modification factor is calculated. It involves a complex formula that is not identical in every state, and it is not something the common insurance producer is expected to do.

We should mention, though, that the formula for finding the experience modification factor puts greater emphasis on claim frequency than on claim severity. If one business has filed 20 workers compensation claims in a year for a grand total of $100,000 and another business has filed one claim for $100,000, experience rating will be more favorable to the employer who filed just the one claim.

Actuaries weigh those two factors differently because they believe frequency is a much better predictor of future losses than severity. Even a relatively safe business could suffer one severe loss, and since the size of a workers compensation claim can be influenced by an employee's wages, focusing strictly on claim severity might make low-paying employers appear deceptively safer than high-paying employers.

Once frequency, severity and several other factors have been weighed, the person calculating the experience modification factor will be left with a final number. The relationship between this number and one will be used to determine whether the employer should pay proportionately more or less for insurance than its peers. If the experience modification factor is less than one, the employer is considered a relatively low risk and will be billed less (per $100 of payroll) than the manual rate. If the experience modification

factor is greater than one, the employer is considered a relatively high risk and will be billed more (per $100 of payroll) than the manual rate.

The experience modification factor is multiplied by the manual premium in order to obtain a basic estimate of the employer's premium. This estimate is sometimes known as the "modified premium." The modified premium might be adjusted by the insurer in order to reflect administrative costs and policy discounts.

Schedule Rating

After experience rating is complete, a business might be subjected to "schedule rating." Schedule rating occurs when an insurance company reduces premiums in order to account for employer-specific factors other than loss history. Based on schedule rating, an employer might receive a reduced premium after implementing safety programs in the workplace.

Not all insurers engage in schedule rating, but many do it as a way of remaining competitive. In some states, the discounts that are possible through schedule rating are limited by regulators or statutes.

What's in the Standard Policy?

So far, we've spent a lot of time addressing how employees are protected by workers compensation statutes. In the next several sections, we'll look at how the typical workers compensation insurance policy can protect employers.

Workers compensation insurance is almost always paired with employers liability insurance. Workers compensation insurance covers employers for the medical costs and lost wages they must pay to employees in accordance with state statutes. Employers liability insurance covers the employer for damages and defense costs when an employer is believed to be liable for an occupational injury that is not covered by workers compensation insurance. The coverage provided by most insurers in the United States is based on NCCI's Workers Compensation and Employers Liability Insurance Policy.

A workers compensation insurance policy serves as a contract between the insurance company and the employer. Although the policy makes the insurer responsible for providing money to injured employees, the phrase "the insured" refers, in general, to the business paying for the policy.

The specific people or businesses covered by the policy are identified on the policy's "information page." The information page is like the declarations page in other lines of insurance and can be thought of as a policy summary. In addition to naming the insured, the information page is likely to contain the following pieces of information:

- The policy number.
- The policy period (typically lasting one year).
- The insured's mailing address.
- The states where coverage applies.
- The dollar limit for employers liability insurance.
- The estimated premium.

The policy itself is divided between a workers compensation section, an employers liability section and several other sections. We'll spend the next few pages summarizing the important points of those sections.

Workers Compensation Insurance

The workers compensation portion of the policy is relatively short. It covers the employer for nearly every medical expense and wage reimbursement that must be paid to employees in accordance with state statutes. If an employee is entitled to workers compensation, the insurance company must provide it. If an employee or an injury is excluded from state workers compensation laws, this portion of the policy does not force the insurer to pay anything.

Workers compensation insurance was designed to be flexible and easily adaptable to laws in different states. If anything in this portion of the policy differs with the kind of compensation that must be paid in accordance with state workers compensation laws, the wording in the policy can be disregarded. As long as a business has purchased insurance, its out-of-pocket expenses for workers compensation will almost always be limited to its insurance premium and deductible.

One of the few coverage restrictions in this part of the policy relates to the date of the worker's injury. Bodily injuries (including occupational deaths) are only covered by the insurance company if they occur during the policy period. So, if an employee is injured on December 23 and the employer's policy does not go into effect until December 24, the employer will be solely responsible for the person's medical expenses and lost wages. Claims made to the insurer will be denied. Similarly, occupational diseases are only covered if the worker's last exposure to the cause of the disease occurred during the policy period.

The date of an injury is also important when a worker's medical expenses and lost wages span several years. As long as the injury occurs during the policy period, compensation that must be paid after the policy period will remain the insurer's responsibility. The employer does not need to keep renewing the insurance until the injured person recovers.

The workers compensation portion of the policy is not subject to any dollar limit. This is different from the second portion of the policy, which addresses employers liability insurance.

Employers Liability Insurance

Employers liability insurance covers an employer when a worker is injured but is not protected by workers compensation laws. It also can be utilized in situations where a worker's injury leads to legal action by a third party, such as the worker's family. (Note that, within the context of this chapter, the term "employers liability insurance" refers to a very specific portion of a workers compensation insurance policy and is not intended to mean something more general, such as any type of liability insurance that will cover a business in a variety of different legal disputes.)

Like workers compensation insurance, employers liability insurance pays claims that are related to occupational injury, occupational disease or occupational death. The injury or death must have occurred during the policy period. Claims related to occupational diseases are only covered if the worker's last exposure to the disease or harmful work environment took place during the policy period.

Employers liability insurance does not make the insurer responsible for paying benefits that are required by workers compensation laws. Nor does it make the insurer responsible for paying damages when an employee's lawsuit is not related to a workplace injury, illness or death.

Unlike workers compensation insurance, employers liability insurance has dollar limits. Unless the employer agrees to pay more for additional insurance, coverage is usually provided in the following amounts:

- Up to $100,000 for each event causing an occupational injury (no matter how many people are injured in the event).
- Up to $100,000 for each employee who suffers an occupational disease.
- Up to $500,000 total for all instances of occupational disease arising during the policy period.

Third-Party Lawsuits

An employer does not need to be sued by an employee for employers liability insurance to be helpful. The insurance also covers damages, settlements and defense costs when the employer is sued by a third party in connection with a worker's injury.

The easiest way to think of these third-party suits is to think of a worker's family. Suppose the worker's spouse sues the employer because the injured worker can no longer contribute to a household. Or imagine the spouse takes legal action because a disease originating from the workplace spread from an employee to the employee's children. Though there are no guarantees that a judge or jury would rule in the spouse's favor, the employer would have coverage for both of these scenarios.

The same coverage might exist if an employer were to be sued by a third party who is engaged in a legal battle with an injured employee. Pretend for a moment that a factory worker gets his hand caught in a machine. If the employee wins a court case against the manufacturer of the machine, the manufacturer might sue the employer and claim the employer did not maintain the equipment adequately. Again, the insurer probably wouldn't pay the third party anything if there wasn't a decent case against the employer, but the coverage is there just in case.

Policy Exclusions

Sometimes even insurance is not enough to keep an employer from having to pay for work-related injuries. Situations in which liability is not entirely transferable from employer to insurer are summarized in the next few sections.

Intentional Injuries by Employers

When an employer does intentional harm to a worker, the worker can sue for damages. Defense costs, settlements and damages that are related to intentional harm are not covered by insurance.

Willful Misconduct

Workers compensation insurance does not cover any extra benefits or fines that employers must provide due to willful misconduct. This exclusion might be cited in cases where the employer did not specifically intend to injure someone but willfully engaged in unsafe behavior.

Multi-State Coverage

When employees suffer an occupational injury, their benefits might be based on the workers compensation laws in any one of the following states:

- The state where the injury occurred.
- The state where the employee resides.
- The state of the employer.

Most of the time, the injury, the employer and the employee's residence will all be in the same state. But when business trips are made or when a company expands, the employer might need coverage that can be used in other parts of the country. The appropriate kind of multi-state insurance can exist within a single policy if application forms are filled out properly and if multi-state activities are communicated promptly to the insurer.

The policy's information page has two important places where multi-state coverage may be indicated. The first place lists all the states where the coverage will apply at the time the policy first goes into effect. If an employer is doing business in additional states at the start of the policy period and those states are not listed in the appropriate place, coverage will only apply in the additional states if the insurer is notified within 30 days of the issue date.

Another portion of the information page allows employers to list the states where no business is currently being conducted but where coverage might be needed at a later date. When business is about to be done in one of these states, the employer must contact the insurer. The policy then goes into effect in that state.

If a business wants coverage to extend to multiple states, it might be a good idea for an insurance professional to examine workers compensation laws in those states. Some states might not allow an employer to use workers compensation insurance that was purchased in another state.

It is possible for employers liability insurance (as opposed to workers compensation insurance) to be used when an injury occurs anywhere in the United States, its territories or Canada. Claims involving foreign injuries can be denied, but the insurance can be used if the injured person is a U.S. resident who was temporarily in a foreign country.

Defense Costs

When an employer is sued in connection with a worker's injury or disease, the insurance company pays for the employer's defense. Defense costs do not affect the amount of money available to cover the employer's liability. The insurer must pay defense costs until the damages paid for bodily injury, disease or death have reached their dollar limit.

In exchange for paying defense costs and damages, the insurance company is allowed to settle with the plaintiff without the employer's consent. Upon paying benefits under any part of the policy, the insurer has the right to sue any third party who it believes is actually responsible for the injury. After an injury involving a machine, for example, the insurer might try to recoup its losses by suing the manufacturer on the employer's behalf.

Cancellations and Assignments

Like seemingly every other kind of insurance, workers compensation coverage can be canceled by either the insurance company or the policyholder. Policy cancellations will often affect the size of the final premium owed to the insurer. Due to the administrative

costs built into insurance premiums, the final premium can be larger when the employer is the one doing the canceling.

Policy cancellations require written notice from the canceling party. If the insurer is the one canceling coverage, notice must be provided no later than 10 days before the insurance is voided. Depending on the state where the policy was issued, notice might be required by an earlier date.

Notice must also be given to the insurer if the policy is meant to be "assigned." A policy is assigned when the rights and obligations in it are transferred from the original policyholder to another person or entity. While the policyholder is alive, the coverage cannot be assigned without the insurer's approval. If the policyholder dies, the coverage can be assigned to the person's legal representative if notice is given promptly to the insurer.

Responsibilities of the Employer

Employers have many obligations related to workers compensation besides purchasing insurance. These include responsibilities to employees, responsibilities to insurance companies and responsibilities to governmental regulators.

Before an injury even occurs, employers in most states must notify their employees that they have workers compensation insurance. This notification usually must be done by posting proof of insurance in an area of the business premises where all employees are likely to see it. Depending on the state and the circumstances, employers might also need to post a notice if they do not have the insurance.

When an accident occurs, the injured worker must alert the employer, who will then alert the insurance company of the accident and provide the proper forms for the worker to complete. The worker does not need to contact the insurance company to be eligible for compensation.

Employers are often required to file reports with state regulators when a workplace accident results in workers compensation. Regardless of whether compensation is provided to the worker, many workplace accidents must also be reported to the Occupational Safety and Health Administration (OSHA), which uses employer data to keep track of where and how occupational injuries occur. Specifics might vary depending on the severity of the accident and the type or size of employer.

Once an accident has occurred and workers compensation appears likely, the employer must take several steps to help the insurer settle potential claims. Some of these many duties are listed below:

- Inform the insurer promptly of the accident.
- Give the insurer the name and contact information of the injured worker and any witnesses.
- Give the insurer any requested documents pertaining to the accident.
- Give the insurer any requested assistance when it sues a third party in order to recoup its losses.

At any point during the policy period, the insurer has the right to audit the business's records and inspect the business premises. The employer's cooperation is required.

Modern Issues in Workers Compensation

By now, you should be familiar with the basics of workers compensation systems and how employers can use insurance to manage risks. Most of these basics have been important to employers, employees and insurers for several decades.

The remainder of this material will focus on some of the more timely issues that workers compensation insurers have had to deal with. When you are finished reading, you will have a better understanding of why premiums for workers compensation sometimes remain high in spite of greater attention to safety at the workplace. You will also be made aware of a few steps that employers and insurers have taken to get costs under control.

Medical Costs

For many years, most of the money that insurers paid toward workers compensation was for lost income. Back in 1996, for example, lost wages accounted for more than 60 percent of workers compensation benefits, according to the National Academy of Social Insurance.

But even before that statistic was reported, costs had been shifting steadily for many years. Today, in terms of dollars, workers compensation claims are split evenly between medical care and wage reimbursement.

There are many hypotheses as to why this shift in costs has occurred. An optimist might point to the fact that most workers compensation claims are medical-only claims, which are serious enough to involve medical care but mild enough to involve no payment of lost wages. A more general opinion is that the continually rising cost of treatment is to blame. But for many insurers, the causes are not quite so simple.

Care Utilization and Fee Schedules

In the opinion of some actuaries, it is impossible to express concern about the significant size of medical costs without also considering the rate of utilization. According to some studies, the proportion of medical costs has grown because workers are going to the doctor more often, receiving more care and trying a wider variety of treatment options than ever before.

Some insurance professionals have wondered if greater utilization of medical care is a byproduct of the way state compensation systems make benefits available to the public. They wonder, for instance, if utilization rates would drop if workers were made responsible for deductibles or co-payments.

In response to greater care utilization and rising costs for treatment, nearly every state has instituted fee schedules that apply when a physician treats an injured or sick worker. These schedules cap the amount a medical professional can charge for treatment and are sometimes based on a percentage of what would be an allowable charge in the federal Medicare system. These limits are, of course, not always popular among the medical community, where some say a limit on charges discourages good doctors from practicing occupational medicine.

Mental Health Coverage

American society has grown more sensitive to mental health issues, and our workers compensation system is no different. In fact, antidepressants are among the most commonly covered drugs for injured employees.

In all likelihood, mental health care will be covered by workers compensation if the worker's mental health is seriously affected by a physically oriented workplace injury.

Consider, for example, an employee who hurts her back while at work and is incapacitated for several months. If her incapacitation leads to depression, the insurer will probably pay for counseling or drug therapy.

While not exactly commonplace, there seems to be an increasing number of mental health claims that are not related to a workplace injury. Employees who escaped from physical harm during workplace shootings have occasionally sought workers compensation on the basis of post-traumatic stress disorder. Less-disturbing cases have seen some workers seeking compensation when the general stress of their job causes them to lose income or incur medical expenses.

Research conducted for this course did not unveil a clear, nationally recognized legal precedent for courts to apply in these various stress cases. It might be safe only to assume that a judge's response to a request for stress-related compensation will be unpredictable.

Return-to-Work Programs

Even when an employee is only dealing with a partial disability, many employers do not see a point in having the injured person come to work. This sort of attitude isn't just illogical. It can also make workers compensation claims more severe.

Studies have shown that the longer a person is away from work, the less likely the person is to ever return. Injured employees who are away from their jobs for a long period of time might become isolated and depressed, and those psychological hurdles might hinder their recovery.

For the employer, long-term absences can result in larger insurance claims, lost productivity and a larger payroll. Suppose a company's maintenance employee falls from a ladder, hurts his back and is unable to perform his regular duties for several months. During those months, the insurance company is expected to handle his medical expenses and will pay him a large portion of his regular salary. Meanwhile, projects at the business take longer than usual because the premises is not maintained by any specific person. In response to this loss of productivity, the employer eventually decides to hire someone to take the man's place. Of course, it takes time to train the new employee, which is another blow to productivity, and the employer must now pay the new person's salary.

Nothing in that scenario is helpful to employers or insurers, which explains why businesses are encouraged to develop "return-to-work programs." A return-to-work program is designed to get injured workers back on the job as soon as possible, even if that means giving them different responsibilities or reduced hours. The program's basic framework is determined by the employer, and important elements like job duties and work schedules are based on recommendations from the worker's physician.

For an example, let's go back to the maintenance worker with the injured back. Suppose the man is deemed too disabled to perform his regular duties, but his physician clears him to perform non-strenuous activity. Based on the doctor's recommendations, the employer invites the man back to work and assigns him to light clerical duties. The company is still without a maintenance worker at first, but having the man serve as an extra clerical employee allows the business to move forward with other projects, so overall productivity isn't reduced. Since being active has helped accelerate the man's recovery, the business only needs to hire a short-term replacement for maintenance. And since the man is at work instead of at home, he can train the temporary employee himself and let his supervisors deal with their regular responsibilities. At the same time, the insurer is pleased because lost income benefits are now based on two-thirds of the difference between the

man's pre-injury salary and his post-injury salary. It is no longer responsible for paying 66 percent of his entire wages.

It might take some time to develop a return-to-work program, but it might be time well spent. Some insurers are willing to provide coverage at a lower price if the employer has a program in place.

Terrorism

Like nearly every other line of insurance, workers compensation took a tremendous hit after the terrorist attacks of September 11, 2001. According to the Insurance Information Institute, workers compensation losses from the attacks amounted to roughly $2 billion, the most that workers compensation insurers had ever lost because of a single event.

Concerned that similarly destructive attacks might follow, insurance companies tried to rewrite their policies in order to exclude coverage of all future terrorism losses. The exclusions went into effect in seemingly every other corner of the commercial insurance market, but workers compensation insurers were not allowed to use them. Instead, insurers raised premiums in order to compensate for the risk, and private carriers sometimes refused to provide any coverage at all to employers in busy parts of major American cities.

At the urging of insurers and other businesses, Congress passed the Terrorism Risk Insurance Act of 2001. The law aimed to increase the availability of affordable insurance by making the federal government responsible for terrorism losses above a certain amount. Workers compensation insurers are entitled to this reinsurance, but the federal coverage does not apply when an act of terrorism involves nuclear, biological, chemical or radiological weapons.

Aging Workers

Due to economic factors and personal choice, we will probably see a major increase in the number of workers who are 65 or older in the coming years. This likely change in the workforce might have an impact on the severity and frequency of workers compensation claims.

When an older person suffers a workplace injury, the insurer's losses tend to be larger. Experts attribute this to the relationship between age and resiliency. As the body ages, it takes longer to recover from injuries and illnesses. Whereas a younger person might suffer an injury and miss a week of work, an older person with the same injury might be disabled for a month. It's also possible that losses are higher when an older person is involved because older workers tend to have higher salaries and are therefore entitled to a greater amount of income-related benefits.

Those negatives, though, are paired with a positive. Despite taking longer to recover from injuries, older employees are less likely than younger employees to suffer a workplace injury in the first place. This is particularly true when you compare new hires against people who have been at the same job for several years. According to the U.S. Bureau of Labor Statistics, one-third of workers compensation claims are filed for people who have been with their employer for less than one year.

Workers Compensation Fraud

When an employee claims to have been injured on the job, it's more than likely that the person is telling the truth. Still, there are several warning signs of worker-related fraud that

employers and insurance professionals should be familiar with. A fraud investigation might be advisable under the following circumstances:

- The worker has a history of occupational injuries but does not perform particularly dangerous tasks.
- The worker claims to have been injured, but nobody witnessed the accident.
- Even before the injury, employers and colleagues viewed the worker as dishonest.
- The injury occurred at a time when the worker's job was known to be in jeopardy.
- An accident occurs early in the day, and the injured worker is known to engage in high-risk behavior outside of work, such as skydiving, rock climbing or drag racing.
- The worker claims to have been injured but is seen engaging in strenuous physical activity outside of work, such as playing sports or moving furniture.

Some insurance veterans believe employer fraud is even more common than employee fraud. Employers might commit workers compensation fraud by not purchasing any coverage at all. Others might buy some insurance but misrepresent their workers to insurance companies in order to receive lower premiums. It is not uncommon, for example, for construction companies to intentionally misclassify the job duties of their most danger-prone employees.

As was mentioned near the beginning of this course, many businesses circumvent workers compensation laws by hiring people as independent contractors instead of as employees. In addition to reducing employers' insurance premiums, this practice might reduce the business's payroll taxes and other financial obligations. However, calling someone an independent contractor does not automatically relieve a business from having to insure the person for workers compensation. If the so-called independent contractor is actually treated more like an employee, the person probably needs to be protected by the business's insurance.

The Future of Second Injury Funds

As America neared the end of World War II, state legislators across the country started concerning themselves with the employability of returning soldiers. Businesses weren't entirely opposed to hiring veterans, but they feared that employing someone who had been disabled in battle might make their insurance too expensive. While an injury to a hand might have been a permanent partial disability for most workers, it might've counted as a total disability for someone who had already lost a leg while in the armed services.

Fearing employment discrimination against service members with pre-existing medical conditions, states created "second injury funds." These funds relieve the employer from having to pay for all medical care and lost wages when the effects of a new injury are made worse by a pre-existing condition. For example, in the case of the veteran who lost a leg and then injured his hand, the employer's insurer would pay the portion of medical costs and lost wages that would have been owed to the veteran if the wartime leg injury had never occurred. The rest of the medical costs and lost wages would come out of the second injury fund.

Whereas second injury funds used to exist in every state, they are now only found in roughly half the country. Some proponents of abolishing these funds claim they are no longer necessary because of laws like the Americans With Disabilities Act. Others believe the funds' assessment fees (which are paid by insurers and factored into an employer's

premium) are needlessly high. Time will tell if the elimination of second injury funds actually reduces employers' costs or exposes businesses to greater liability.

Alternatives to Workers Compensation

Despite being a fairly comprehensive system, workers compensation is not accessible to everyone. If an injury occurs when a person is not engaged in work-related activities, the employer is not responsible for paying medical bills or providing income-related benefits.

If workers compensation cannot be utilized, an employee might still be able to receive some compensation for lost income. These alternative sources of assistance are explained briefly in the next two sections.

Disability Insurance

A few states force businesses to insure their employers for short-term disability. This coverage provides income to a person when an injury makes working impossible for several weeks or a few months. Coverage for long-term disabilities is offered by many employers, but businesses are not required to purchase it.

Social Security

Social Security benefits are occasionally available to an individual who is ineligible for workers compensation, but most people will not qualify for them. To be eligible for disability benefits from Social Security, a person must have a total disability that is expected to last for at least a year or (if the person has a lower life expectancy) until death. Those who qualify will have to endure a five-month waiting period before they can receive any compensation.

After two years, a person who is receiving disability benefits through Social Security can have his or her medical costs covered by Medicare, the federal health program that usually serves senior citizens. Unlike the workers compensation system, the Medicare system usually makes the injured or sick person responsible for deductibles and co-payments.

It may be possible for an injured worker to receive workers compensation and Social Security at the same time. When this happens, compensation from workers compensation can reduce the person's Social Security benefits.

Conclusion

Insurance companies continue to be concerned about rising medical costs, terrorism and other issues, but there are many reasons to view today's workers compensation system in a positive light. Fatalities and lost-time claims are less common than in previous decades, and insurers' profitability has sometimes been very strong.

Workers compensation has clearly come a long way over the past century. The system's no-fault features have made it easier for employees to receive valuable assistance, and insurance has played a major role in limiting an employer's liabilities. By becoming knowledgeable about workers compensation, an insurance professional can help businesses protect themselves and put them in position to fulfill legal, financial and ethical obligations.

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