

INSURANCE CONTINUING EDUCATION

INSURANCE POLICIES: AN ESSENTIAL RESOURCE

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INSURANCE POLICIES: AN ESSENTIAL RESOURCE

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INTRODUCTION

Many continuing education courses are very narrow in their focus. They might limit themselves to only a few major topics or stick to explaining just one type of insurance. There's certainly nothing wrong with insurance professionals choosing courses that deal exclusively with their areas of expertise. But it's sometimes helpful to step back and see how a particular kind of coverage fits into the broader world of insurance and risk management. While it's important to disclose important policy exclusions to insurance applicants, full service isn't possible unless a producer can go a step further and explain how other kinds of coverage might fill those gaps.

"Insurance Policies: An Essential Resource" is intended to help financial professionals create comprehensive insurance strategies for the common entrepreneur. It explores several major forms of commercial insurance that an owner or risk manager might consider purchasing. Early chapters summarize the most essential and most common kinds of coverage. Later sections address commercial policies that might not always be necessary but should at least be considered by risk-averse businesses. More specifically, the order of major topics in the course material is as follows:

- Chapter 1 provides an overview of fair claims practices in all lines of insurance and explains possible roles for a producer during the settlement process.
- Chapter 2 is about property insurance, including coverage for buildings and coverage for personal property.
- Chapter 3 explains important concepts relating to liability insurance, including bodily injury, personal injury, contractual liability and defense costs.
- Chapter 4 looks at employee injuries and the insurance-related solutions to them, including workers compensation and employers liability insurance.
- Chapter 5 goes into detail regarding major topics in health insurance, including plan options for employer-sponsored groups. (For an explanation of the reforms mandated by the Patient Protection and Affordable Care Act, refer to our companion course, "Principles for Insurance Professionals.")
- Chapter 6 summarizes the many facets of business interruption insurance, including coverage for lost income and coverage for extra expenses.
- Chapter 7 explores the positive aspects of group life insurance, including the potential for death benefits and tax savings.
- Chapter 8 briefs readers on commercial auto insurance, including coverage for businesses and coverage for employees.

Although the material as a whole is framed within the context of helping businesses, a significant amount of time is spent connecting commercial insurance to personal insurance. Students who are accustomed to assisting individuals and families will be able to see how the commercial versions of auto and life insurance, for example, are similar to or different from the versions they're familiar with.

To those students who are already experts on these topics, we hope you will benefit from a review and will be reminded of how important your role as an insurance professional can be. For those for whom these topics are new, our goals are to help you identify the risks faced by businesses and to give you enough background information so that you can figure which issues might be worthy of further study. And who knows? You might even learn something that ends up taking your career in a new, exciting direction.

CHAPTER 1: FAIR CLAIMS PRACTICES

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

Claimants who don't receive the kind of compensation they expect from their insurer are likely to take their business elsewhere. A survey released in 2012 by J.D. Power and Associates found that property insurance claimants who reported low satisfaction with their insurer's claims process were nine times as likely to switch carriers than claimants who reported a high amount of satisfaction. The same document, known as the "J.D. Power and Associates 2012 Property Claims Satisfaction Study," also said lowly satisfied claimants were roughly five times more likely to at least shop around for a different insurer within the next year than highly satisfied claimants. Even if a dissatisfied policyholder decides not to look for other coverage or switch insurers, that person is unlikely to recommend the carrier to anyone and may even harm the company's reputation through bad word of mouth.

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

Courts and regulators who believe an insurer has acted in bad faith toward claimants might have the power to impose serious sanctions on the company. Arguments over a small amount of money can result in tremendous penalties. For example, a 1992 dispute in California regarding nonpayment of \$192 ended in a \$30,000 fine being imposed by the state's insurance commissioner.

The Producer's Role in Claims

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

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

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

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

Producers should also keep in mind that the people who purchase insurance have invested some trust in them. Because they lack much insurance-related experience, typical consumers are likely to believe an agent or broker who oversells a positive policy feature and fails to mention contingencies or exclusions. For example, a first-time homeowner who is told she has replacement-cost coverage might not be aware that this kind of coverage, in and of itself, does not guarantee there will be enough money to completely rebuild a building. Similarly, she might not understand how losses from hurricanes might be exempted from coverage on the basis of a flood exclusion. Unless she takes the time to carefully examine her policy (something consumers are not likely to do), she will only learn about these things if the person selling the insurance mentions them or if she actually experiences these kinds of losses.

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

The Claims Process

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

Duties of the Insured

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

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

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

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

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

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

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

Insurance Adjusters

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

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

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

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

An adjuster who is set to receive a percentage of a settlement might feel tempted to inflate loss estimates in order to make more money. Similarly, adjusters who receive bonuses from insurers might put pressure on themselves to keep the size of settlements down. Despite the loyalties adjusters might owe to insurers or claimants, they obviously shouldn't let compensation have an inappropriate influence on their valuations.

Communicating With Claimants

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

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

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

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

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

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

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

Settling Disputes With Consumers

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

If disputes with an insurer can't be resolved internally, arbitration is another possibility. In arbitration, the carrier and the consumer both pay to have the matter settled by a third party. By engaging in arbitration, both sides agree to abide by whatever arrangement the arbitrator produces.

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

Claims Issues in Specific Lines of Insurance

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

Property Insurance Claims

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

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

Catastrophic Claims

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

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

Although insurers have the right and the obligation to ensure that money isn't provided to perpetrators of fraud, they should recognize that delays in providing legitimate compensation can

ultimately lead to more losses. The sooner a family can start rebuilding their home, the less the insurer will have to pay for additional living expenses like hotel and restaurant bills. The quicker a business is able to get up and running with the help of insurance money, the smaller its business interruption claims will be.

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

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

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

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

Auto Insurance Claims

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

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

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

In many states, it is illegal for an auto insurer to only cover repairs when they are completed at a favored shop. Even when insurers give the consumer the choice of going elsewhere, they shouldn't influence the claimant's decision by making potentially false statements. For example, it

may be unethical (or even illegal) for the insurer to stress that repairs done by a different shop are unlikely to be completed properly or quickly.

Casualty Insurance Claims

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

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

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

Third-Party Claimants

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

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

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

Still, the lack of a contractual relationship with a third-party claimant doesn't entirely excuse the insurer from certain requirements. In states where the NAIC's Unfair Claims Settlement Practices Model Regulation has been adopted, insurers might not be allowed to advise third-party claimants

to make claims against their own insurance when the insurance company's customer is clearly the one at fault.. So, if it is reasonably clear that a homeowner suffered damage due to a neighbor's negligence, the neighbor's insurance might not be allowed to tell the homeowner to make a claim against his own insurance.

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

Unclaimed Life Insurance

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

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

Though specifics differ by state, unclaimed life insurance benefits will remain with the insurance company for at least a few years after a death. During that time, the insurance company is able to invest the money within reason and keep the resulting interest. At the end of this period, the money is usually transferred to a state fund, and the state will earn interest on the death benefit until a beneficiary claims it.

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

Regulation of Claims Practices

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

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

Some state insurance departments will only take disciplinary actions against an insurer for poor claims handling if they have received multiple complaints about the same carrier. If the department determines that an insurer's unfair response to a claim is a general business practice

rather than an isolated incident, it may impose fines amounting to several thousands of dollars. Not all complaints will lead to fines, but even the threat of a state-conducted audit is sometimes enough to get a disputed claim paid.

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

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

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

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

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

Unfair Claims Settlement Practices

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

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

- **Denying a claim without conducting an appropriate investigation:** Following a combination of an earthquake and a fire at his home, Joe files a property insurance claim. Joe has coverage for fire losses but not earthquake losses. Instead of sending an adjuster to determine how much each peril contributed to the damage, his insurance company denies his entire claim outright.
- **Failing to settle a claim when the insurer's liability is reasonably clear:** Wayne and Mary are involved in a car accident in separate vehicles. Although Wayne freely admits the accident was his fault, his insurance company delays compensating Mary for her losses and instructs its legal team to find a loophole in the policy so it can deny all claims.
- **Intentionally offering to settle for an amount below what the claimant actually deserves:** Laurie's home was broken into by robbers, who stole most of her personal

possessions. She has kept good records of what she owned and was sure to purchase coverage that was in line with what her belongings were actually worth. However, her insurance company views the settlement process as a negotiation and decides to offer her a much smaller amount. (This practice is often referred to as “lowballing.”)

- **Withholding money for a covered portion of a claim while disputing the rest of a claim:** Sarah’s home was damaged by a hurricane. She and her insurer agree that at least a portion of her losses are covered. Coverage of her other losses are in dispute and depend on the wording of a flood exclusion. Rather than at least give her the money for the uncontested portion of her losses, her insurer decides to give her nothing until the flood-related dispute has been settled.
- **Requiring a deadline for providing proof of loss that isn’t stated within the insurance policy:** Ben was listed as a beneficiary on his father’s life insurance policy. The policy wasn’t discovered until nine months after the father’s death. Although the policy lists no deadline for providing proof of a death, the insurance company denies Ben’s claim and says he should’ve provided a death certificate within six months of his father’s passing.
- **Refusing to pay a claim because other sources of compensation may be possible:** George slips on a neighbor’s steps and hurts his back. His health insurance company refuses to pay his medical bills because it holds the neighbor responsible for the accident. George’s insurance policy makes no mention of this kind of situation, yet his insurer tells him he has no choice but to sue his neighbor.
- **Failing to make claimants aware of statutes of limitations:** Roberta has been fighting with her health insurance company over unpaid doctor bills for nearly two years. After those two years, she will not be allowed to take legal action against the insurer. The insurance company knows her deadline is approaching but doesn’t disclose it in a timely manner. The deadline passes, and Roberta is left without the ability to have the matter settled in court.
- **Reducing or eliminating policy benefits in order to facilitate a quicker settlement:** Jean’s home requires major repairs after a fire. The amount offered by the insurer won’t be enough to restore the home to its prior condition. In order to convince Jean to accept this amount, the insurance company stops paying for the apartment where she and her family are temporarily residing.

Fraud and the Producer’s Role

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

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

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

CHAPTER 2: INSURING PROPERTY

Running a business is difficult enough without having to worry about theft, accidents or natural disasters that could result in the loss of property. Good property insurance will not be able to stop those unfortunate events from occurring, but it can certainly help a business get back on its feet.

The most common kind of property insurance for businesses is based on contractual language from a document called the “Building and Personal Property Coverage Form.” The form was created by the Insurance Services Office (ISO), a private company specializing in information about property and casualty insurance. This course material contains explanations of the ISO form. However, some companies use policy forms that are broader or more restrictive.

What Is Covered Property?

There are three basic kinds of covered property, with each one having its own dollar limit. These three are listed below and will be addressed one at a time in the next few sections:

- The business’s building.
- The business’s personal property.
- Personal property of others that is in the business’s possession.

The Business’s Building

The building is the place of business described on the policy’s declarations page. Although we generally view buildings as singular structures, a “building” can mean any of the following things:

- The entire structure at a single address.
- Multiple structures described on the declarations page.
- A single unit in a multi-unit building.

Building coverage is for more than just walls, ceilings, windows and doors. It is broad enough to include additions the insured makes to the building and various fixtures, equipment and machinery that are permanently installed in the building. Depending on the carrier’s interpretation of the term, “permanently installed property” might have any of the following definitions:

- Something merely attached to the building.
- Something that can’t be removed without changing the building’s structure.
- Something that was specifically listed in the real estate contract when the owner bought the building.

If a business rents space from a property owner, it might not be responsible for insuring the building. Tenants should review their leases carefully and discuss their insurance obligations with their landlord. Then they should determine what additional insurance ought to be purchased for their own protection.

The Business’s Personal Property

Coverage for a business’s personal property generally applies to any item inside the insured building or within 100 feet of the premises. More specifically, the typical policy states that the following items are insured:

- Office furniture and fixtures.
- Machinery and equipment used to conduct business.
- Property the insured owns and uses for business purposes.
- Outdoor signs (valued up to \$2,500).

- If the insured is a tenant, any improvements the insured has made to the building that were not paid for by the owner.
- Leased property that the business agrees to insure.
- Improvements made to other people's property, such as replacement parts that are installed by the business.

Stock could also be part of the above list. In regard to the Building and Personal Property Coverage Form, "stock" can be defined as follows:

- Items currently being sold by the business.
- Items the business plans on selling but is keeping in storage.
- Items the business is in the process of producing.
- Any raw materials the business uses to make its products.

Businesses are also covered for the materials they use to ship their stock, including padded envelopes and crates.

Property of Others

Commercial property insurance can cover other people's property while it is in the business's possession. For this kind of property to be covered under the Building and Personal Property Coverage Form, it must be either inside the insured building or within 100 feet of the building. If the property is outside the building, it can be either out in the open or in a vehicle.

The insurance for property of others is explained in an early portion of the Building and Personal Property Coverage Form and typically has its own dollar limit, as chosen by the business. It can be capped at any amount and is designed for businesses that commonly keep customers' property on their premises.

Alternatively, if a business doesn't normally take possession of other people's property and doesn't want to spend extra money to manage a comparatively small risk, it may be able to apply a small amount of its own personal property coverage to "personal effects" and "property of others." This option is available at no additional expense and reimburses the policyholder and various employees when their personal items are lost or damaged at the business premises. The coverage also applies to the property of others that is in the business's care. However, items pertaining to this optional, extended insurance are only covered for up to \$2,500 at each premises.

Replacement Cost v. Actual Cash Value

Property can be insured for either its "replacement cost" or its "actual cash value." A business that does not understand the difference between the two may be in for some unpleasant surprises after a loss.

Property's "replacement cost" is the amount it would take to rebuild or replace the property without taking depreciation into account. If the property is to be replaced, the replacement property and the old property must be of like kind and quality. When a building is to be replaced at its replacement cost, the new building and the old one do not need to be identical in every little way. However, the essential features must be the same.

An item's "actual cash value" is its replacement cost minus depreciation. The actual cash value may be determined by taking the replacement cost and multiplying it by the remaining amount of time the item would otherwise be expected to last. For the purpose of an example, pretend a new computer costs \$800 and is expected to last 10 years. If the insured has owned a similar

computer for five years (50 percent of 10 years) and loses it in a fire, the insurer might calculate the item's replacement cost as \$400 (\$800 multiplied by 50 percent).

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

By default, most kinds of commercial property will only be covered up to their actual cash value. Replacement-cost insurance can be included for an additional price. Annual adjustments for inflation are also available.

Covered Perils

Along with choosing how much insurance to buy, a business needs to decide which "perils" or causes of loss should be covered. There are usually three options to choose from.

The most basic kind of property insurance will typically cover businesses against losses caused by the following perils:

- Fire.
- Lightning.
- Explosion.
- Windstorm or hail.
- Smoke.
- Aircraft or vehicles.
- Riot or civil commotion.
- Sinkhole collapse.
- Volcanic action.
- Vandalism.
- Sprinkler leakage.

An intermediate form of property insurance will also help pay for losses caused by four additional perils:

- Falling objects.
- Weight of snow, ice or sleet.
- Accidental discharge of water or steam (from a system or appliance).
- Sudden collapse.

Most businesses go a step further and purchase all-risk property insurance. This covers them against all perils other than those specifically excluded in their policy.

Excluded Perils

Even insurers offering all-risk commercial property insurance will exclude some perils from their policies. The next several sections address those commonly excluded risks. Businesses concerned about excluded losses might want to purchase another type of insurance.

Water Damage

Other than sprinkler leakage, the Building and Personal Property Coverage Form is not designed to cover water damage. This includes losses linked to any of the following causes:

- Floods.
- Waves.
- Mudslides.
- Seepage.
- Sewer backups.

Earth Movement

Significant kinds of earth movement can include earthquakes, landslides, volcanic eruptions and sinking. Separate insurance is necessary if a business is concerned about earth movement. However, a business can choose to insure against sinkhole collapse and volcanic action. Fire damage remains covered even if the fire is caused by earth movement.

Pollutants

Standard kinds of commercial property insurance do not cover pollution losses, other than the cost of cleanup. Furthermore, the cleanup is only covered when it results from a covered peril. Some substances that might qualify as pollutants are listed below:

- Smoke.
- Soot.
- Fumes.
- Acids.
- Chemicals.
- Waste (including waste being held for recycling).

The most the insurer will pay for cleanup of pollutants is \$10,000 per year. This is additional insurance and has no impact on the insurer's other limits of liability. To have a claim for cleanup covered, the business must report any cleanup expenses to the insurer within 180 days of the triggering loss.

Power Failures and Surges

Businesses receive no insurance benefits when a power failure can be traced back to problems at a utility company. There is also no coverage when artificial current does damage to personal property.

In general, some coverage remains intact when a power failure or power surge causes damage from a covered peril. In other words, if a business experiences a power surge, computers damaged by that surge will not be covered. But if that surge were to cause a fire, the business would still be covered for fire losses.

Theft

Losses from theft can often only be covered through all-risk insurance or crime insurance. If a business rejects both of those options and a burglary occurs, the insurer might only pay for repairs to the building. Replacing any stolen items will probably be the business's responsibility.

Coinurance

Most forms of commercial property insurance have "coinsurance requirements." A coinsurance requirement usually states that if property is not covered up to a certain percentage of its actual cash value (or, in some cases, its replacement cost), the insurance company will not fully compensate the business for a loss. Instead, the insurer will pay a prorated amount based on how close the business was to meeting its coinsurance requirement. This includes scenarios in which only a portion of covered property is damaged.

Even for insurance veterans, coinsurance requirements can be confusing. Let's look at a few examples of how the requirements might affect a business. In all examples, let's assume there is an 80 percent coinsurance requirement.

A business owner purchased insurance that covers his property for up to \$80,000. After a fire, it was determined that his property was actually worth \$100,000. Since the policy limit (\$80,000) was equal to 80 percent of the property's value ($\$100,000 \times 80\% = \$80,000$), the owner met his coinsurance requirement and his entire claim will be paid.

Another business owner purchased insurance in the amount of \$90,000. After a windstorm damaged the business's roof, it was determined that the value of covered property was actually \$100,000. Since the amount of coverage (\$90,000) was greater than 80 percent of the property's value ($\$100,000 \times 80\% = \$80,000$), the owner met her coinsurance requirement and had her claim paid.

A third business owner purchased insurance in the amount of \$60,000. After a major hailstorm, it was determined that the value of his property was \$100,000. Since the amount of insurance (\$60,000) was less than 80 percent of the property's value ($\$100,000 \times 80\% = \$80,000$), the business did not meet its coinsurance requirement and was only covered for a portion of its losses.

Conclusion

In printed form, a commercial property policy can amount to less than 30 pages. But each of those pages contains a lot of important information. Even if agents don't deal with it specifically on a daily basis, the Building and Personal Property Coverage Form can help them recognize various commercial risks. By applying their knowledge of risks to a business's specific situation, agents are more likely to keep policyholders satisfied and well-protected.

CHAPTER 3: COMMERCIAL LIABILITY

The most ethical business owners can still be kept up at night by fears of major lawsuits. Visitors to offices might slip on a wet floor. Purchasers of a product might become ill or injured while trying to use it. A traveling salesperson might knock down a fragile heirloom at a prospect's home. Even if a court determines that a business isn't responsible for these accidents, the cost of a good defense can be high.

Commercial liability insurance is beneficial both to businesses and their customers. Entrepreneurs who know they're at least partially protected against major mishaps are more likely to start new companies or offer new services. When members of the public are injured or suffer a property loss due to a company's negligence, insurance makes it easier to receive fair compensation.

Many common risks for businesses are managed through the purchase of "commercial general liability insurance." The insurance is relatively broad in scope and was designed to be adaptable for a wide variety of policyholders. Entities that provide services, build property or manufacture goods are all likely to either have it or need it in some form.

In today's market, commercial general liability insurance makes carriers responsible for covering losses related to property damage, bodily injury, medical payments, personal injury and advertising injury. The coverage, which will be described in greater detail over the next several pages, might be purchased independently of other insurance or as part of a multi-layered insurance package.

Commercial general liability insurance was introduced in the 1940s and was originally known as "comprehensive general liability insurance." With insurers adding more and more exclusions to their policies, the industry eventually decided the word "comprehensive" was too misleading. The

name change and several other modifications were made in the 1986 edition of the standard coverage form, which was written and issued by the Insurance Services Office (ISO).

Most commercial general liability insurance policies are based in large part on ISO language. However, it would be incorrect to assume this insurance is essentially the same for everyone who buys it. Significant additional limits on coverage may be mandatory for certain kinds of businesses or for every applicant who wants insurance from a particular carrier. Some exclusions might be added at the policyholder's request as a way of lowering premiums, and others might even be deleted when the insured agrees to pay more. So although this chapter explains the basics of commercial general liability insurance, it shouldn't be used as a substitute for thorough knowledge of a carrier's specific products.

Producers who are unfamiliar with this insurance should also keep in mind that the best commercial general liability policy will still leave a business unprotected from some important risks. Injuries to employees, damage to an insured's own property, and lawsuits alleging unfair employment practices are all problems that should be addressed through other insurance or other risk-management strategies.

Basic Commercial Liability Concepts

Before going into detail about commercial general liability insurance, we should summarize some legal concepts that impact businesses. If you have a solid understanding of these ideas, you will probably have an easier time comprehending the intent and meaning of policy language. The important concepts covered in this section are as follows:

- Premises and operations liability.
- Product liability.
- Completed operations liability.
- Contractual liability.
- Vicarious liability.
- Compensatory damages.
- Punitive damages.

Premises and Operations Liability

Examples of premises and operations liability are probably what come to mind when the average person thinks about commercial liability risks. On a very simplistic level, this kind of liability can be described as liability that arises from accidents at the insured's place of business or while the insured is conducting business.

Liability related to the business premises might arise if the building, office or other space occupied by the insured somehow becomes unsafe. For instance, pretend that ice is allowed to form on the steps outside the insured's building. If a customer stumbles and suffers an injury, the insured might be held liable for it. For another example, imagine the insured has erected a sign over its place of business. If the sign falls and damages someone else's property, the business might be legally obligated to replace the broken item.

Liability related to operations occurs when the actions of the insured—not the condition of the premises—cause harm. Suppose a server at a restaurant trips and splatters hot food over a customer. In this case, the restaurant might be liable for any resulting medical expenses or dry-cleaning bills.

Product Liability

Product liability is a concern for businesses that manufacture or sell goods. The potential for product liability exists whenever a product leaves the business premises and causes harm to people or property. If a toy manufacturer sells products that turn out to be dangerous for children, the manufacturer might be liable for injuries, illnesses or deaths. Similarly, if an automotive product actually causes automobiles to break down, the manufacturer might be liable for the damage.

Completed Operations Liability

Liability for completed operations arises when work or a service has already been finished beyond the business premises and the business's poor performance causes harm. Completed operations liability is a common concern among builders and practically anyone who provides skilled labor in homes or commercial buildings. Pretend an electrician has finished wiring several new circuits at an apartment building. A few months later, a fire destroys the building, and investigators determine that the electrician's use of inferior materials is to blame. If the fire had occurred while the electrician was still working on the circuits, the incident would involve the regular form of operations liability (the kind often paired with premises liability). But because the damage occurred after the work was finished, the liability in this example involves completed operations. This is an important distinction because insurers often treat accidents differently depending on whether work was finished by the time of an accident or was still in progress.

Contractual Liability

Contractual liability is liability that's accepted as part of an oral or written agreement. A common example of this acceptance of liability is a hold-harmless agreement that transfers liability from one party to another. Even though a restaurant that rents itself out for a wedding might ordinarily be liable for any injuries sustained at the premises by guests, the couple might sign a hold-harmless agreement in which they agree to accept liability for any accidents during the festivities.

Commercial general liability insurance will only cover contractual liability under certain circumstances. We'll review those circumstances later in this chapter.

Vicarious Liability

Vicarious liability exists when one party is held indirectly responsible for damage caused by someone else. It frequently becomes an issue for businesses when an employee or a subcontractor does bad work or causes an accident.

Compensatory and Punitive Damages

"Compensatory damages" and "punitive damages" are the two basic kinds of damages that can be awarded by the judicial system. Compensatory damages will result from the court's decision that the plaintiff lost an amount of money because of the party at fault and should be reimbursed for it. They are intended solely to repay or compensate the injured party for the loss incurred. Punitive damages, on the other hand, are meant to punish someone for an action. Instead of simply making the plaintiff whole again after a loss, they're designed to teach the guilty party a lesson.

Some states prohibit insurance companies from covering punitive damages. After all, if the risk of having to pay those damages can be transferred to an insurer, their intended impact as punishment could be minimal or nonexistent.

Who's Covered?

Commercial general liability insurance can be used to manage risks for a variety of people who may be affiliated with a business. But it's important not to make any assumptions about who's actually covered by it.

When the person named on the policy's declarations page is an individual instead of a business, the individual is covered along with his or her spouse. Coverage applies to activities involving any business of which the named insured is the sole owner. Liability in regard to personal accidents—such as a slip-and-fall at the couple's home—is excluded.

When the named insured is a partnership or joint venture, the insurance typically covers the business entity, the partners and the partners' spouses. Partners and their spouses are only covered for liability in regard to the business named on the declarations page. Liability for personal activities or other business activities is excluded.

When the named insured is a limited liability company (LLC), commercial general liability insurance covers the company, its members and its managers. Again, individuals who have coverage in this setup are not covered for personal activities or other business activities.

When the named insured is another kind of business entity (such as a corporation), the insurance protects the business, its directors, its officers and its stockholders. Directors, officers and stockholders are not insured when they act in other capacities or are exposed to liability beyond the business.

Employees

Regardless of whether the named insured is an individual, a partnership, a corporation or some other entity, employees and volunteers are usually also covered by the policy. Exceptions to this rule include cases in which employees harm each other or damage the business's own property. Employees will also lack coverage if they're sued for their role in providing or failing to provide medical care. Depending on the circumstances and state law, this exception can have a major impact on employees when a customer, client or visitor requires first aid.

Additional Insureds

Policyholders also have the option of adding a specific person or specific business entity to their general liability insurance as an "additional insured." This is especially common in the building trade, where contractors often insist on being added to a subcontractor's policy.

If a person or business is named as an additional insured on someone else's policy, that insurance will often be treated as primary coverage. Any other commercial general liability policies that the business might have will be treated as secondary insurance.

The additional insured will only be covered by someone else's policy when liability relates in some way to both the additional insured and the other party. In other words, if the Brian Bricklaying Company adds the Barry Building Group to its general liability policy, the Barry Building Group is probably only covered for projects involving both companies. For projects involving a different bricklaying company, the Barry Building Group will need insurance from some other source.

Bodily Injury and Property Damage

Commercial general liability insurance is used mainly to cover businesses when they're liable for bodily injury or property damage.

Bodily injury can include accidental cases of physical injury, illness or death. It usually doesn't include emotional stress, although some courts have ruled differently.

Property damage can include physical damage to property as well as the loss of use of undamaged property. For example, a business can be covered if it accidentally sets fire to another person's building. It might also be covered if it accidentally sets fire to its own premises and causes an otherwise unharmed neighbor to evacuate while the fire is put out.

Courts are likely to award money to harmed parties when injury or damage results from a business's "negligence." Negligence generally occurs when someone doesn't act with as much care as a reasonable person.

Be aware that liability can also be attached to a business by law rather than by anyone's negligence. Even court-awarded amounts that have nothing to do with a business's carelessness might be covered by commercial general liability insurance if they relate to bodily injury or property damage.

Many instances of accidental bodily injury or property damage will be sudden, but businesses can also be covered when the harm done to people or property is gradual and goes unnoticed for long periods of time. Investigating the circumstances of gradual damage is an especially important task when the date of an accident and the date when damage is actually noticed don't fall within the same policy period. If the policyholder either switched insurers or wasn't covered at all between those two dates, arguments might arise regarding who should pay for what. You'll read more about the timing of accidents and the timing of claims in the section "Occurrence and Claims-Made Policies."

Common Exclusions

At first glance, most of the wording in a commercial general liability coverage form seems to deal with the risks that are excluded from insurance rather than the ones that aren't. Exclusions are usually added or broadened when the ISO makes revisions to its standard policy form. Then, insurers who use the form are likely to include other exclusions by endorsement.

The increase in policy exclusions over the years is the main reason why the insurance had its name changed from "comprehensive general liability insurance" to "commercial general liability insurance." With so many exclusions capable of denying coverage to consumers, using the word "comprehensive" didn't seem fair anymore.

While reading about common exclusions over the next few pages, you should keep a few things in mind. We will focus our attention mainly on the exclusions with the greatest chances of being relevant to a typical business. So although the standard policy excludes liability related to wars, we will not discuss the particulars of that exclusion here. Secondly, as you may already know, the existence of an exclusion in a commercial general liability policy often just means a particular risk isn't covered by this particular brand of insurance. It doesn't necessarily mean coverage can't be secured at all. For example, despite the narrowness of pollution coverage in commercial general liability insurance, concerned businesses might be able to purchase separate insurance for pollution exposures or pay a bit more to have their policy's pollution exclusion changed.

Intangible Property

For property damage to be covered by commercial general liability insurance, it must have been done to something tangible. This means the property subjected to damage needs to be something you can actually touch. Computers, discs and flash drives can be touched, but the data stored on them can't. This might create a huge coverage gap when a business is held responsible for the loss or corruption of valuable electronic information.

Economic Losses

Property damage covered by commercial general liability insurance can't be purely economic. Giving bad financial advice to a client might lead to a lawsuit, but it's usually not the kind of suit in which coverage would be triggered. If a financial loss isn't linked directly to bodily injury or physical damage to tangible property, it might only be covered by other insurance, such as errors and omissions insurance.

The Business's Work and Items Being Worked On

A few of the more complex exclusions are designed to ensure that the business retains at least some of the risks involved with doing faulty work or making substandard products. For example, if a business is tasked with repairing or servicing property and damages it while performing work, the business will usually be uninsured for the damage. Similarly, if work has been finished somewhere other than the business premises (such as at a person's home) and is later found to be substandard, the business's insurance company typically won't pay to have the work redone. The insurance company can help with accidents, but it isn't interested in covering people who are simply bad at their jobs.

Pollution

Until the 1960s, pollution was an afterthought for most commercial liability insurers. But literal and figurative messes caused by oil spills in that era forced carriers to take a more cautious approach to the risk. Carriers' concerns were heightened even more in the 1980s, when insurers were faced with expensive asbestos-related claims.

The increased attention paid by regulators and the public to environmental hazards is at least partially responsible for the extremely strict pollution exclusions in the modern market. A liability insurer can refuse to be involved in claims related to practically any form of pollutant, including gasses, fumes, liquids, waste, smoke or chemicals.

In spite of the extensiveness of today's pollution exclusions, they do leave room for a few exceptions. For example, most insurers will cover a business when smoke or fumes from a fire cause bodily injury or property damage. Another exception provides coverage to businesses when the work materials they are using in a building expose inhabitants to fumes. This type of situation might arise when a company is painting a premises or using strong cleaning products. Exposure that occurs outside of the building remains excluded.

Electronic Data

As was mentioned earlier, loss of electronic data is usually excluded from commercial general liability insurance policies. This amounts to no coverage for nearly anything created, used or saved on computer systems or electronic media. Electronic data may be excluded because it can't be touched and, therefore, doesn't fall into the common definition of "tangible property." And just in case there's any argument about what constitutes tangible property, policies sold today will often also have a separate, specific exclusion for electronic data.

Property in the Business's Care, Custody or Control

Commercial general liability insurance won't protect a business when it damages someone else's personal property within its care, custody or control. This is a significant coverage gap for repair shops, cleaning companies and just about any other entity that's entrusted with its customers' belongings. The exclusion can apply if damage is done to the property before, during or after it's been serviced by the insured.

The exclusion of personal property within the insured's care, custody or control raises several questions. For example, if a carpet cleaner is given keys to a customer's home and performs his work while the owner is out of town, would all of the home's contents be under his care, custody and control? Although most insurers would probably agree that he wouldn't be insured for damaging the carpet (which is clearly under his care, custody or control), there might be debate regarding whether he should be covered for accidental damage to other property in the rest of the house.

There's also the issue of who the exclusion actually applies to. Even if we assume a business's employee isn't covered for damage to property in his or her care, custody or control, what about

the employer? Will the insurance company claim that property under an employee's care is, in effect, also under the employer's care? If the carpet cleaner in our previous example is sued for damaging the homeowner's property, would his employer's insurer cover the employer but refuse to cover the employee?

These uncertainties help explain why many businesses opt to cover property in their care with other insurance. Some coverage might be available as part of the business's own property insurance. Alternatively, companies that specialize in accepting other people's property for repairs or services are often good candidates for a "bailee" insurance policy, which is specifically designed to cover a customer's belongings.

Intentional Acts

Liability insurance is meant to cover the insured for accidents, not for intentional damage. Doing otherwise would have negative social consequences because it would give people an excuse to commit bad behavior.

When determining the applicability of the intentional acts exclusion, most courts look at the intent of the insured's actions and judge it against what resulted from them. Suppose a painter leaves a customer's front door open so she can go back and forth between her truck and her worksite. Because the door is left open, the customer's pet escapes and is hit by a car. In this case, the painter's intentional act (leaving the door open) produced unintentional results (the pet's escape). For many courts, having an unintentional result is enough for the intentional acts exclusion to be a non-factor.

It's less clear what would happen if the insured actually intended to cause some damage but ended up causing a lot more than expected. If a business owner intentionally punches someone and the victim hits his head on the ground and dies, would the incident be excluded as an intentional act? Or would it be covered because punching someone is usually not done with the intent of killing the person? Those are probably questions for a court to decide.

Vehicle Liability

Liability arising from the operation of cars and other vehicles is supposed to be covered by commercial auto insurance. With this in mind, commercial general liability policies usually won't cover businesses after accidents involving automobiles, planes or boats. This exclusion also extends to claims alleging that a business was negligent in hiring or supervising drivers or pilots.

Businesses offering delivery services should be aware that the typical vehicle liability exclusion leaves them uninsured while they're loading or unloading their vehicles. This part of the exclusion means businesses might not be covered from the time they pick up items with the intent of putting them in a vehicle to the point where the items have been handed off to their intended recipient. Consider a furniture manufacturer that is delivering a couch. If workers bump into a wall or drop the couch on someone's foot while loading or unloading it, commercial general liability insurance is unlikely to respond. Coverage might not be reactivated until the couch is placed in its proper spot inside the new owner's building.

A minor exception to the vehicle liability exclusion is made when businesses park other people's cars on or near their premises. However, this exception for valet service is only intended for damage to bodily injury or other vehicles. Damage to the car being parked might still be excluded because the vehicle would be under the business's care, custody or control.

Impaired Property

Most commercial general liability insurance policies contain an exclusion for "impaired property." In order to be impaired, the property must satisfy two requirements. First, it must be unusable or less useful as a result of either the insured's bad work or the insured's defective product.

Secondly, the property must be capable of being restored merely by replacing or repairing the bad work or defective product.

Since exclusions of impaired property can be hard to grasp, let's go over some examples. In one famous case, nut clusters in a breakfast cereal were found to contain wood splinters. When the business that supplied the clusters to the cereal company made a claim, its insurance company argued that the incident shouldn't be covered because of an impaired property exclusion. However, a court disagreed, ruling that the tainted cereal couldn't be repaired by simply recalling the product and removing all the clusters. For all practical purposes, a box of cereal containing the splinters was not merely impaired. It was beyond repair.

For an alternate example, imagine a plane with defective navigational equipment. In this case, the manufacturer would typically not be covered if the pilot were to ground the aircraft for safety reasons and sue for loss of use. As long as the plane isn't actually damaged and can become usable again by replacing or repairing the manufacturer's equipment, it would probably be classified as impaired property.

Contractual Liability

Many people assume that contractual liability refers mainly to a business's failure to honor an agreement. But in the world of liability insurance, the term is typically used to describe a situation in which liability of one party is assumed by another. In an apartment lease, for example, the tenant might agree to accept liability for all instances of property damage or bodily injury occurring at the property. This includes accidents for which, in the absence of the lease, the landlord would legally be responsible.

Despite containing an exclusion of contractual liability, most commercial general liability policies apply several exceptions to the rule. Liability that's accepted by the insured for property damage or bodily injury can be covered if the other party to the contract would have otherwise been held liable for those things by law. So if a subcontractor agrees to accept liability from a general contractor for bodily injuries that occur during a construction project, the subcontractor's insurance might pay for bodily injuries that the general contractor would ordinarily be held liable for under the law. Defense costs for the other party can be covered, too, if this stipulation appears in the contract between the two parties.

The standard policy will continue to exclude damages that neither party would otherwise owe to someone under the law. In other words, even if a contractor agrees to cover the cost of any damage caused by a natural disaster until construction on a home is completed, the contractor's insurance won't absorb that risk. After all, in the absence of a contract, neither the contractor nor the property owner would owe anyone money because of the damage.

The contractual liability exclusion is also waived in situations where contractual language merely restates a kind of liability that the accepting party would still possess in the absence of any agreement. If the law says a bicycle repair shop is liable for damages to customers' bikes, the fact that this is stated in a contract between a repair shop and its customers won't have a negative impact on the shop's coverage.

Finally, there are a few specific kinds of contracts to which the contractual liability exclusion doesn't apply. These include leases for a business premises, easements and elevator maintenance agreements. Property damage or bodily injury liability assumed under these contracts will be covered unless they're subjected to a different exclusion.

Liquor Liability

Liquor liability can be a headache for restaurants, taverns and any business serving alcohol at a party or corporate event. If someone's intoxication results in property damage or bodily injury, the provider or server of alcoholic beverages might be blamed for the trouble.

Commercial general liability insurance won't be of any help when an entity in the business of serving or manufacturing alcohol is accused of contributing to someone's intoxication. Separate insurance is used for that purpose.

On the other hand, coverage for liquor liability remains intact if an insured doesn't sell, provide or serve alcohol as part of its business. This exception to the rule is sometimes cited as a protection for employers who serve alcohol at office parties. It also helps property owners who lease space to bars or restaurants.

Workers Compensation and Disability Benefits

Commercial general liability insurance won't provide any benefits that employers are legally obligated to pay under workers compensation or disability laws. The insurance almost never responds to injuries suffered by employees or to physical damage to their own property.

Employment Practices

Commercial liability insurance rarely covers businesses for employment practices liability. This form of liability usually involves cases in which workers are sexually harassed, discriminated against or wrongfully terminated. Separate insurance exists for some of those risks.

Even though a commercial general liability policy might not contain a specific exclusion regarding employment practices, multiple parts of the insuring agreement have often been used to deny a claim. As an example, think of a case in which a business is accused of wrongful termination. The act of firing someone is usually considered an intentional act, and intentional acts are excluded from coverage. Also, the losses suffered by a fired individual are usually economic, and purely economic losses are typically excluded, too. Even if the fired person claims to have suffered bodily injury on account of emotional distress, courts have generally said that emotional distress doesn't meet the definition of "bodily injury" found in the standard policy.

Professional Liability

Professional services are often defined as services requiring special skills that are intellectual rather than physical. Providers of these services include lawyers, doctors, financial planners and insurance producers.

Liability related to professional services is rarely covered by commercial general liability insurance because it hardly ever involves bodily injury or property damage. When a professional gives bad advice or fails to address a client's situation properly, the result is usually limited to economic losses rather than physical harm. Medical professionals are certainly capable of causing bodily injury, but an insurer will often wipe out coverage for that risk by adding an ISO-created endorsement to the standard policy form. Risks associated with professional services can usually be managed more effectively by purchasing errors and omissions insurance or some specific type of malpractice coverage.

No-Fault Medical Coverage

A special section of a commercial general liability insurance policy deals with no-fault medical coverage. This portion of the policy exists so that there's a smaller chance of a lawsuit or costly settlement after an accident.

The no-fault portion of the policy usually has its own dollar limit. If the insured is accused of being at-fault for bodily injury and runs out of no-fault medical coverage, the main body of the policy (described in the previous sections of this chapter) will take over.

The no-fault medical portion of the commercial general liability insurance policy can cover anything from first aid and x-rays to doctor visits and funeral expenses. The insurer will cover bills for these treatments and services if they're needed within a year of the accident. To be eligible for payments, the injured person may need to agree to an examination by the insurer's chosen physician.

Exceptions to coverage for no-fault medical payments under the commercial general liability policy include injuries to employees and injuries suffered while engaged in athletics. (Think of a business with a company softball team.) Injuries for employees and other workers are meant to be addressed through workers compensation or other insurance.

The exclusions mentioned in previous sections of this material (intentional acts, liquor liability, contractual liability, etc.) are also applicable to the no-fault portion of the policy.

Personal and Advertising Injury

Despite our emphasis so far on property damage and bodily injury, commercial general liability insurance can cover other risks, too. Most notably, it's used to help businesses when they're accused of causing "personal injury" or "advertising injury." Since these terms usually aren't understood by the general public, we'll explain each of them in their own individual sections.

Personal Injury

In a very basic sense, personal injury occurs when people's rights or reputations are taken away from them. Be careful not to confuse personal injury with bodily injury. As far as commercial general liability insurance is concerned, personal injury can occur even if the injured party suffers no bodily injuries or property damage.

The forms of personal injury covered by the typical commercial general liability policy are as follows:

- False arrest, detention or imprisonment. (**Example:** A business believes someone on its premises has broken a law and refuses to let the person leave.)
- Malicious prosecution. (**Example:** A business repeatedly takes unreasonable legal action against a competitor.)
- Wrongful entry. (**Example:** A business renting property to a tenant enters the property and uses it without the tenant's consent.)
- Wrongful eviction. (**Example:** A business changes the locks on rented property without informing a tenant and in violation of a lease.)
- Libel. (**Example:** A business publishes a damaging, untrue statement about a person or another business.)
- Slander. (**Example:** A business says a damaging, untrue statement about a person or other business.)
- Publication of private information. (**Example:** A business publishes something about a competitor's or customer's personal life.)

Advertising Injury

In regard to a commercial general liability policy, advertising injury occurs when a business commits an offense against someone in its promotional materials. This form of injury has become a more significant coverage issue in recent years thanks to the internet. Courts and insurers are confronted regularly with the issue of whether a particular feature on a website—such as a blog post or a comment on a message board—is a form of advertising.

Whether committed online, in print or in some other form, examples of advertising injury that are likely to be addressed by commercial general liability insurance include the following:

- Committing libel or slander in an advertisement.
- Disclosing private information about someone in an advertisement.
- Using copyrighted material in an advertisement without permission.
- Using another business's trademark or slogan without permission.
- Using another business's advertising idea without permission.

You may have noticed some overlap between the actions covered as personal injury and those covered as advertising injury. The overlap allows instances of libel, slander or disclosures of private information to be covered no matter if they are done in an advertisement or in some other form. However, be aware that the overlapping coverage of personal and advertising injury doesn't extend beyond libel, slander and disclosure of private information. For example, commercial general liability insurance covers businesses for copyright infringement, but only when the infringement occurs in an ad. Other instances of infringement are excluded from the standard policy form.

Personal and Advertising Injury Exclusions

The personal and advertising injury portion of a commercial general liability insurance policy has its own set of exclusions. Some of the most common exclusions are as follows:

- Copyright infringement in material other than an advertisement.
- Personal or advertising injury that occurs beyond the policy's coverage territory. (This exclusion is usually waived in the case of advertising injury committed over the internet.)
- Copyright infringement or libel committed in materials that were published before the policy period.
- Knowingly printing false information.
- Intentional acts. (Since certain acts, such as eviction or improper advertising, are almost never an accident, the insurer will often initially agree to at least cover the insured's defense in these cases. Then, if it is later determined that the business knowingly violated the law, the insurer might refuse to cover any judgments and ask to be reimbursed for the defense costs.)
- Libel, slander or any kind of advertising injury committed by advertising agencies, publishing companies, internet service providers, web designers, broadcasters or search engine providers.
- Offenses committed on internet bulletin boards or in chat rooms.
- The use of someone else's name or product in a Web address, email address or metatag. (A metatag is essentially data used by search engines to organize online content.)
- False advertising of products or services.

Some of these excluded acts, such as libel committed by publishers or broadcasters, can be managed with the help of other insurance. Others, such as intentional acts, usually aren't meant to be covered by insurance at all.

Defense Costs

Even if a court finds that a business isn't liable for damage or injury, costs related to defending the matter can be high. The commercial general liability policy deals with this problem by making the insurer pay to defend the business in any situation in which the policy *might* be applicable. If there's at least some chance that the issue at hand is covered by the policy, the insurance company is typically required to pay for the insured's defense. In fact, the duty to defend the insured is usually broader than the duty to cover settlements or court-awarded damages.

Defense costs under the commercial general liability policy will continue to be covered until the amount paid by the insurer for settlements and court-awarded damages equals the policy's dollar limit. Money paid for defense purposes has no effect on the limit.

Let's demonstrate the points in the previous paragraph with an example. If a company has a policy with a \$1 million limit, spends \$50,000 on a defense team and is ultimately required to pay \$1 million in damages to a plaintiff, the insurer will pay for the whole defense and all the damages. But if the same company is sued again during the same policy period, the insurer won't pay for a defense because the \$1 million policy limit was reached in the first dispute.

Since it's responsible for handling defense costs, the insurer behind the commercial general liability policy can settle disputes without the insured's consent. Similarly, the insured is not allowed to settle disputes without the insurance company's permission. The assumption is the insurer has a better idea of how a court will rule and what kind of settlement (if any) is reasonable.

Occurrence and Claims-Made Policies

Commercial general liability insurance can be issued through the use of either an "occurrence" form or a "claims-made" form. With an occurrence policy, coverage depends mainly on when an accident occurs. With a claims-made policy, coverage depends mainly on when a demand for money from an accident occurs. The distinction between the two forms can be extremely important when damage or injuries don't materialize at the same time as the accident that caused them.

Everything else being equal, coverage offered on an occurrence basis is usually preferred over claims-made coverage. With an occurrence policy, a business remains insured for liability even if it cancels coverage before any demand for money is made.

With a claims-made policy, the opposite is often true. Regardless of when an accident actually happens, claims will be denied if they're not made during the policy period. Unlike an occurrence policy, a claims-made policy seemingly guarantees that an insurer will not be surprised by more claims after a certain date.

To better understand the difference between occurrence coverage and claims-made coverage, it may be helpful to know why claims-made forms were introduced. During the 1980s, many people who had occupied buildings with asbestos were experiencing serious health problems. Arguing that asbestos contributed to their conditions, they sued property owners and builders for millions of dollars. In turn, the owners and builders looked to their insurance companies to protect them. Even in cases where the plaintiffs had not occupied the properties in several years, and even in cases where the owners and builders had allowed their coverage to lapse 30 years earlier, the insurance companies were expected to pay. This encouraged insurers to stop issuing so many occurrence policies and to start issuing claims-made policies.

Retroactive Dates in Claims-Made Policies

A consumer who's considering claims-made insurance should be made clearly aware of the policy's "retroactive date." Even if a claim is made on a claims-made policy during the policy period, it will be denied if the accident associated with it occurred before the retroactive date.

Think of a claims-made policy that has a retroactive date of January 1, 2016, and is set to expire on December 31, 2016. If a claim is made on December 30, 2016 for an accident from 2015, the policy won't respond. It will only cover liability for accidents that happened from January 1, 2016, to December 31, 2016.

The retroactive date for a claims-made policy is usually the date when claims-made coverage from that carrier first went into effect. In other words, if a business purchases claims-made

coverage from a carrier on January 1, 2016, and renews it on January 1, 2017, the retroactive date for the renewed policy should continue to be January 1, 2016. If the retroactive date is moved up to a more recent date, the business could be left with a major insurance gap.

It's also possible (though unlikely) for a claims-made policy to be issued without a retroactive date. In this case, the business would be insured for claims made during the policy period regardless of when an accident occurs.

Extended Reporting Periods for Claims-Made Policies

Much to the benefit of business owners, claims-made policies typically include an "extended reporting period" at no extra charge. The extended reporting period provides temporary coverage when commercial general liability insurance is cancelled, replaced or not renewed. Sometimes known as "tail coverage," it can be particularly helpful when a company goes out of business or switches from one insurance carrier to another.

Having a claims-made policy with an extended reporting period is similar to having a very limited and temporary occurrence policy. The extended reporting period puts great importance on the date of an accident and deemphasizes the date of an actual claim.

The basic extended reporting period gives the business 60 days after the end of the policy period to report accidents and have them covered by a claims-made policy. If those accidents are reported in time, claims stemming from them will be covered for five years, up to the policy's dollar limits. For example, if a shopkeeper is scheduled to have her insurance cancelled but knows a customer slipped at her premises just prior to the policy's cancellation date, she can report the incident to her insurer and be covered for it for the next five years. However, if the shopkeeper is not aware of the incident and therefore doesn't report it within 60 days of the policy's cancellation date, she won't be protected by insurance. Although coverage is often available for businesses that want more than 60 days to report accidents or more than five years of protection from those accidents, it isn't included in the typical policy free of charge.

For an incident to be covered as part of the extended reporting period, it still needs to have occurred during the policy period. So if the policy covering the shopkeeper in our previous example expires on January 1, she won't be covered at all for accidents occurring on January 2. It makes no difference whether she reports the accident within 60 days of her policy's cancellation date.

Conclusion

Commercial general liability insurance is something practically any insurance professional should know about. Almost every business will have a use for it, yet it has many nuances that should be explained by a knowledgeable agent or broker. Demonstrating an awareness of how the typical policy works can create trust with business owners and give them a clearer idea of what other risks are worth managing.

CHAPTER 4: EMPLOYEE INJURIES AND INSURANCE

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, a breadwinner who exposed himself to possible injuries or occupational death was also exposing his family to financial devastation.

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, he could only receive compensation if he took his 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 a worker believed recovery from an injury was at all possible, he didn't want to get into a dispute with his employer and hurt his chances of getting his 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:

- 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 his own 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.

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 forfeit their ability to sue their employer after an accident. Employers must provide compensation in the amount prescribed by state law, but they are not liable for pain, suffering or punitive damages.

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 49 states 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 coverage 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 purchasing of workers compensation insurance are strongly encouraged to review current statutes 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. If a certain kind of worker is specifically not protected under state statute, 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 statute, the employer is allowed to conduct business without

insurance. If some but not all of the employer's workers are not covered by the statute, 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.

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.

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.

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.

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.

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.

Wage Replacement

When an injury causes an employee to miss work for more than a few days, the person will probably 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.

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.

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.

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.

What's in the Standard Policy?

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 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.

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.

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.

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 out-of-state.

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.

Conclusion

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.

CHAPTER 5: HEALTH OPTIONS

Many insurance producers won't want to admit it, but the average person has a relatively decent chance of avoiding many of the problems insurance was designed to manage. Most homeowners, for example, insure their homes against fire even though their property is unlikely to ever burn down. Similarly, they have liability insurance at a time when being sued by someone—even in our increasingly litigious society—isn't a guarantee. In many cases, they also have permanent life insurance when the need to provide financial stability for their beneficiaries is only temporary.

None of those statements is intended as an attack on insurance products or on the people who sell them. Indeed, fires, lawsuits, deaths and other causes of loss can produce financial ruin. Taking steps to minimize their negative impact is an inarguably smart thing to do, and purchasing adequate insurance is often the most important step in the process.

Still, the chances of losing lots of money on account of those problems seem significantly smaller than the likelihood of needing expensive medical care. There are plenty of people who never have a fire, never get sued and end up dying without leaving a financially needy dependant behind. Yet expecting those people to also go through life without eventually having a chronic or serious illness or injury is extremely unrealistic.

The near-inevitability of needing health care is a major reason why more than 250 million Americans had health insurance in 2010 (according to numbers from the U.S. Census Bureau) and why laws were passed during that year to extend coverage to 32 million more citizens. The enacted reforms sparked considerable debate among lawmakers and taxpayers. But hardly anyone disagreed with the basic premise that having a well-insured population is good for society.

Since so many people either already have the insurance or at least realize its importance, health coverage shouldn't be such a mystery to the public. Yet one of the most important kinds of insurance is also one of the least understood. Applicants tend to shop for it based mainly on price or by what's available through their employer. Important limits placed on benefits or on access to physicians often aren't noticed until care is actually needed.

One of the barriers to understanding health insurance is the lack of uniformity among plans and policies. Whereas most property and casualty insurers utilize standard coverage forms from the Insurance Services Office (ISO), health insurance contracts might only match one another to the extent that certain benefits have been mandated by law. Although the controversial Patient Protection and Affordable Care Act created greater standardization of benefits and aimed to simplify comparison shopping, it's too early to tell whether the law has helped consumers understand what they're buying.

Oddly enough, the confusion surrounding health insurance may have been nurtured by the industry's desire to satisfy consumer demand. In order to meet the needs of a diverse customer base, health insurance carriers developed a wide variety of coverage options. They introduced managed care to applicants for whom traditional reimbursement policies had become unaffordable. They added PPOs when consumers complained about HMOs not letting them see favored physicians. In time, they even cycled back to HMOs and reduced some restrictions as a way of regaining subscribers. The assortment of choices makes it more likely that careful shoppers will find something suitable for them, but it also means there are more variations to analyze. Someone who believes all health plans work the same way is making a serious mistake.

With all this in mind, any text attempting to explain health insurance should probably contain a statement like, "This is how health insurance works, except when it doesn't." We can't tell you exactly how a particular health insurance product will respond to any situation. However, we will

spend the next several pages giving you the tools to compare and contrast plans and policies on your own. You'll learn what to look for, as well as the reasons why various health insurance configurations were created in the first place. We'll also mention several insurance reforms within the aforementioned Patient Protection and Affordable Care Act and tell you when to expect to be impacted by them. Even if it serves mainly as a reminder to an experienced producer, we hope this chapter helps you guide people through the health insurance maze.

The Individual Market

To understand modern health insurance, we should start by reviewing what's known as the "individual market." In the individual market, people purchase an insurance policy issued solely for themselves and perhaps for a spouse or child. The applicant arranges coverage by personally contacting either an insurance company or a health insurance agent.

Most people with health insurance don't obtain it through the individual market. Instead, they become insured through an employer-sponsored plan in what's known as the "group market." In the group market, one person or entity (such as a business or union) purchases insurance to cover several non-family members under the same policy. Although an individual who wants to be covered by a group plan needs to complete an application and often must pay some of the costs, he or she doesn't personally contact the insurance company in order to initiate coverage. Administrative tasks—such as delivering enrollment forms and monthly premiums to the insurer—are usually handled by the sponsoring employer or union.

One positive of the individual market is that it puts applicants in control of their insurance decisions. Unlike members of most group plans, someone shopping for an individual policy tends to have several types of coverage to choose from. Buyers interested mainly in the comprehensiveness of coverage can gravitate toward policies with few exclusions and high benefit limits. Shoppers who place greater importance on out-of-pocket expenses can opt for insurance with low deductibles and minimal cost-sharing requirements. Individuals who already feel comfortable with a particular physician can choose a plan that already has a business relationship with their doctor. Cost, comprehensiveness and access will be different from policy to policy. Savvy consumers can browse through the market until they find a suitable mix.

Another benefit of purchasing health insurance in the individual market is portability. Covered members in a group plan risk losing their insurance when they change jobs or become unemployed. A policy bought in the individual market won't be impacted by changes in employment and can remain in force until the policyholder stops paying premiums or commits fraud.

Before getting too excited about the freedoms built into it, consumers should realize the individual market isn't everyone's best source for insurance. Applicants are often subjected to vigorous underwriting standards, which might result in them being denied a policy for medical reasons. Even healthy people who have a choice between individual coverage and group coverage tend to prefer the latter because the cost is usually shared with an employer. For these and other reasons, the individual market is filled almost exclusively with the following kinds of customers:

- Individuals who are self-employed.
- Individuals with part-time or temporary jobs.
- Individuals with full-time jobs at businesses without an employer-sponsored health plan.
- Individuals who retired before becoming eligible for Medicare.
- Individuals who are unemployed and have used up their COBRA rights or similar continuation coverage.

Applying for Individual Health Insurance

Depending on the insurer and the state where the applicant resides, qualifying for health insurance in the individual market can involve a relatively thorough process. This is particularly true in states where “medical underwriting” is allowed. In medical underwriting, an applicant will only be deemed eligible for insurance after the carrier has evaluated the person’s medical history and deemed him or her an acceptable risk. At the very least, applicants who are subjected to medical underwriting will need to complete a health-related questionnaire and disclose whether they have been diagnosed with particular illnesses or injuries. They will also be asked about any habits—such as tobacco use—linked to poor health.

Questions on health insurance applications should be answered honestly. Applicants who intentionally misrepresent information to an insurer can have their policy rescinded and may face additional penalties. The Patient Protection and Affordable Care Act made it illegal to cancel someone’s insurance based on incomplete information on an application, but this prohibition generally extends to cases of reasonable or innocent omissions. It doesn’t protect people who intentionally withhold important information. However, in rules finalized in February 2013, the Department of Health and Human Services clarified that misrepresentation of a person’s tobacco use is not an acceptable reason for rescinding health insurance. Instead, those same rules created a process whereby individuals who misrepresent their tobacco use can be required to pay penalties, including additional premiums.

Some applicants will also need to complete a physical examination and give the insurer access to their medical records. The extent of the examination and the need to review medical documents will be based—at least in part—on the answers indicated on the questionnaire and the comprehensiveness of the desired policy.

After the applicant has provided sufficient medical information and been evaluated by underwriters, the insurance company will usually respond by taking any one of the following actions:

- If the applicant is in decent health, the insurer will offer the desired coverage at its normal price. (Applicants in this scenario are known as “standard risks.”)
- If the applicant has a moderate amount of health problems, the insurer might offer the desired coverage for an extra cost. Alternatively, the insurer might charge the applicant the same amount as a standard risk but offer less coverage. (Applicants in either of these scenarios are known as “substandard risks.”)
- If an applicant has serious health problems, the insurer might not offer any insurance to the individual at all.

The major criticism of medical underwriting is that it makes health insurance inaccessible or unaffordable for people with serious medical conditions. For example, the California Department of Insurance has said consumers are unlikely to qualify for a policy in the individual market if they currently have any of the following health problems: (Applicants in nearly every other state are likely to experience the same predicament.)

- Cancer.
- Sleep apnea.
- Major depression, bipolar disorder or schizophrenia.
- Kidney failure.
- Diabetes.
- Heart disease.
- Cirrhosis.
- Multiple sclerosis.

- Muscular dystrophy.
- Lupus.
- Hepatitis.
- Lymphedema.
- History of organ transplants.
- AIDS. (Applicants in California who are HIV-positive but haven't been diagnosed with AIDS must still be accepted.)

According to the department, for an applicant who has recovered from one of the conditions mentioned above or has other major medical problems, desired coverage might only be available at a higher price.

Non-Medical Underwriting

As a way of making health insurance more widely available, a small handful of states prohibit medical underwriting. Applicants in these states are eligible for insurance regardless of health and are charged an amount based on “community rating” or “modified community rating.” Community rating serves as a pooling mechanism, whereby the risk of insuring high-risk applicants is shared from a cost perspective by everyone who purchases the same coverage. When modified community rating is performed, some factors will still make insurance cost differently from person to person, but health status generally isn't one of them.

The non-medical factors used in community rating differ by state. Some of the most common variables are as follows:

- **Age:** Since the body deteriorates over time, older applicants are charged more than younger applicants. Even after they've obtained insurance, policyholders in the individual market are likely to experience periodic rate increases as they age.
- **Geography:** Health statistics and the cost of medical care are unlikely to be the same across the country or even across ZIP codes. Someone in an urban area might pay a different amount than someone in a rural area.
- **Gender:** Women of child-bearing age tend to pay more in the individual market than men. A few states (including California) prohibit gender discrimination in health insurance.
- **Family composition:** According to a 2008 report from the Department of Health and Human Services, family coverage for one adult and one child might be cheaper than a similar policy for two adults.

The non-health factors listed above are also important to insurers doing medical underwriting. However, they take on greater importance when community rating is used.

No matter if it is medical or non-medical, information about an applicant is used to put the person in a “rate class.” The rate class is made up of similar people with the same insurance. Usually, when a policy comes up for renewal, changes in price are applied to everyone in the class.

Medical Underwriting and Health Care Reform

The Patient Protection and Affordable Care Act made sweeping changes to health insurance underwriting in 2010 and will continue to do so in 2014. Beginning in 2010, a health insurer in the individual market could no longer deny insurance to people under 19 because of their medical history. A similar ban is scheduled to go into effect in 2014 for adults.

Changes in 2014 are also set to change the way an insurer's rates are established. Instead of basing prices on an applicant's health status, insurers in every state will need to use either modified community rating or a less stringent system. Gender-based pricing will also become illegal. In fact, when two people (or two small groups) purchase exactly the same kind of health

insurance from the same company, only the following factors will be used to charge them different amounts:

- Age (with the cost for one age group equaling no more than three times the cost for another age group).
- Tobacco use (with the cost for smokers equaling no more than 1.5 times the cost for non-smokers).
- Geography (as determined by each state).
- Family composition.

In order to dilute the risks involved with offering insurance regardless of health, the new rules about eligibility and pricing will be coupled with an “individual mandate.” Under the mandate, most Americans—including healthy, low-risk consumers—will need to obtain insurance or be fined by the Internal Revenue Service.

Insurance Options

You’re now aware of whom the individual market is for and how those customers are evaluated by insurance companies. But what kinds of policies are actually available for the purpose of managing medical expenses?

Medical insurance has traditionally been broken down into two broad groups. One group consists of “basic” coverage and is filled with products featuring relatively modest benefits. Another group is for “major medical” and “comprehensive” products, which aim to address a wider range of health costs. Admittedly, some of the policies within those groups—particularly in the “basic” category—have become very uncommon or practically nonexistent. Still, it’s important for you to have a background in them because they all contributed to the health insurance market we have today.

Basic Health Insurance

Basic health insurance policies can be purchased to help pay for hospital expenses, surgical expenses, physician expenses or a combination of the three. Historically, they have been made available as “first-dollar coverage.” Policyholders with first-dollar coverage can be reimbursed for medical expenses without having to pay any deductible out of their own pockets. They might also be spared from “coinsurance fees,” which require a patient to pay a specified percentage of otherwise coverable medical bills. However, in what might qualify as one of this chapter’s recurring themes, what was once a distinguishing characteristic of this insurance can no longer be considered a certainty. Many of today’s insurers have incorporated modest deductibles and other cost-sharing mechanisms into their basic policies.

In exchange for being subjected to little or no cost-sharing, patients with basic health insurance generally need to deal with relatively low benefit limits. Whereas patients who undergo brief hospitalization could conceivably have their entire stay covered in full, someone who needs extended care for a chronic condition might run out of insurance quickly. More commonly, these policies will pay up to a specified amount per day or per procedure but can be capped at a figure far below a provider’s actual charge. Also, depending on the chosen coverage, benefits might be limited to care received in a specified kind of facility (such as a hospital).

Since it may be inadequate for people who either have catastrophic ailments or need care in a variety of settings, basic health insurance is often supplemented by other insurance. You’ll read more about how basic policies can fit into a broader insurance plan in the section “Major Medical/Comprehensive Insurance.”

Hospital Expense Insurance

As its name probably makes clear, hospital expense insurance reimburses patients for care received in a hospital. The insurance tends to have at least two main parts. The first part applies to charges for room and board. The second pertains to other hospital expenses.

Coverage of room and board is based on the cost of a semi-private room. Meals are included, but non-essential services like the use of a television or phone are the patient's responsibility. Benefits can apply while the patient is hospitalized on an inpatient basis and can last anywhere from a few weeks to a year. (Many states have their own minimum requirements.) The insurer will either pay up to a flat amount per day of hospitalization (such as \$100) or a stated amount of the rooming charges (such as 100 percent or 80 percent).

Covered services besides room and board commonly include general nursing care, blood transfusions, medicine, medical tests, x-rays and supplies. Expenses for these services are usually covered up to a multiple of the dollar limit for room and board. For example, a policy with a \$100-per-day limit for room and board might cap coverage of other services at 10 times that amount (\$1,000).

In general, benefits from hospital expense coverage (including those not related to room and board) will only be provided if the patient has actually been hospitalized. Therefore, someone who goes to the emergency room but is never formally admitted to the hospital might not be able to utilize this insurance. Most policies make an exception if the trip to the emergency room relates to an accidental injury (not sickness) and occurs within a few days of the accident.

It's important to note that the charges picked up by hospital expense insurance are limited to the ones billed by the hospital. Very often, physicians, surgeons and other medical professionals charge their own additional fees when treating hospital patients. In these cases, the facility's charges will be reimbursable under the hospital expense contract. Charges from other parties will need to be paid out of pocket or with other insurance.

Surgical Expense Insurance

Surgical expense insurance reimburses the policyholder for fees paid to surgeons or anesthesiologists. The amount of covered expenses depends on the surgery being performed. Another important factor is whether reimbursement is based on a "fee schedule" a "relative value" point system or on what's considered a "reasonable and customary" amount. In fact, these three methods of determining reimbursement are used to varying degrees in many other areas of health insurance.

Fee Schedules

Insurers using a fee schedule will have already developed a list of surgical procedures and a maximum dollar limit for each of them. If a medical provider decides to charge more than the listed amount, the patient might be fully responsible for the difference.

Relative Value Systems

Rather than using flat dollar amounts, some insurers calculate surgical benefits through a "relative value" point system. In this method, the insurance company gives each surgical procedure a number of points. Simple procedures are usually worth few points, while complicated procedures are usually worth many points. Each point is worth a specific dollar amount, which is disclosed somewhere in the policy.

Reasonable and Customary Charges

Reimbursement based on what's "reasonable and customary" is potentially more responsive to medical inflation because it considers what many physicians actually charge. The insurer first

attempts to find an accurate price range for a given service in the patient's geographic area. Then statistical analysis is performed on the price range to determine how much is both reasonable and customary. For example, an insurer might determine that a reasonable and customary charge is equal to what roughly 80 percent of local doctors charge.

Unless they've entered into an agreement to accept a certain amount as full payment, physicians are allowed to charge more than what's reasonable and customary. Patients will be responsible for any excess charges, as well as for any deductibles, copayments or coinsurance fees.

If a policy bases coverage on what's reasonable and customary and also has a coinsurance requirement, the coinsurance calculation will utilize the reasonable and customary charge rather than the actual charge. In other words, let's pretend a patient underwent a procedure and was charged \$1,000 by a surgeon. Based on its statistical analysis, the patient's insurance company believes the reasonable and customary charge for the procedure is actually \$750. If the policy contains a coinsurance provision whereby the insurer agrees to pay only 80 percent of medical costs, the insurer will pay 80 percent of \$750 (the reasonable and customary charge). It won't pay 80 percent of \$1,000 (the actual charge). In this scenario, the patient expecting to only pay 20 percent of the bill would actually need to pay 40 percent.

Physicians Expense Insurance

You read earlier about how hospital expense insurance doesn't cover physician charges unless they're built into the facility's fees. Physicians expense insurance fills in this gap and might also help pay for office visits and house calls. The policy might have a cap on the dollar amount or on the number of visits.

Health-Related Indemnity Policies

While reviewing the three major kinds of basic coverage, you may have noticed the word "expense" in their names. Expense policies provide compensation based on the actual costs of received medical care. By contrast, an "indemnity policy" doesn't consider actual costs of services. It pays a specified dollar amount to the policyholder no matter how much care is actually received. An indemnity policy can even provide more money than what's actually spent on medical care, and the recipient can use it as he or she pleases.

Health-related indemnity policies are often marketed to consumers through television, print advertisements and mailings. They usually require no medical underwriting and are pitched at what first might seem like an attractively low price. Unfortunately, they're likely to only pay benefits under limited circumstances. For example, a hospital indemnity policy will only provide money for a patient while he or she is hospitalized and will only do so for a limited time, such as a month.

"Dread-disease" or "critical illness" policies are another form of health-related indemnity insurance. These policies are only triggered when a patient is diagnosed with one of the few diseases listed in them. (Cancer is probably the most commonly listed ailment.) Some financial professionals believe this insurance is worth having because it often costs no more than a dollar or two per day. Others believe the premiums still aren't in line with the chances of making a claim and that consumers are better off purchasing broader protection.

Major Medical/Comprehensive Insurance

Several decades ago, insurance companies decided that basic health insurance was inefficient. Since it was typically offered with no deductible or coinsurance requirement, the probability of an insurer having to pay for at least some of a policyholder's medical expenses was high. Meanwhile, the dollar and time limits attached to it meant someone who suffered an extremely serious health problem had a fair chance of running out of insurance. In short, basic policies did

the opposite of what good risk management is supposed to do. They paid for losses people could have absorbed on their own but left people unprotected from catastrophic situations that could have crippled their finances.

Insurers attempted to solve some of the problems of basic coverage by introducing “major medical insurance.” Major medical insurance pays for a combination of the services we’ve already mentioned, including those in the hospital expense, surgical expense and physician expense categories. And at least in the beginning, they were more likely to cover treatments and services that were excluded under basic contracts. For example, major medical insurance was more likely to compensate patients or providers for prescription drugs, mental health care, physical therapy and outpatient trips to the emergency room. (Basic plans sold today might cover some of these on a limited basis.)

For many years, arguably the greatest distinction between basic coverage and major medical coverage related to cost-sharing. Basic policies have historically offered first-dollar coverage with no deductible or coinsurance fees. As long as the cost of rendered care was within a policy’s limits, the entire amount was reimbursable to the insured. Modern offerings of basic coverage sometimes contain deductibles or coinsurance requirements, but they both appeared in major medical policies first. We’ll explain each of them in greater detail in a few moments.

In exchange for sharing some of the cost for their health care, patients with major medical insurance get high benefit limits. Instead of the few thousand dollars of coverage available from a basic policy, some purchasers of a major medical health plan have remained covered even after receiving care worth millions of dollars.

At first, major medical insurance was purchased as a separate product to supplement the kinds of basic policies we’ve already discussed. If coverage under a basic policy was exhausted, the major medical policy stepped in to help absorb the rest of the costs. Today, it’s more common for basic and major medical coverage to be combined into one policy. Insurance providing basic and major medical coverage under a single policy is known as “comprehensive major medical insurance.”

Deductibles

A policy’s deductible is the amount of otherwise coverable medical costs a patient must pay out of pocket before insurance benefits become available. The purpose of the deductible is to make the patient responsible for at least some medical costs and to spare the insurer from having to process so many small claims.

There might be a single deductible that applies cumulatively to practically all kinds of care, or there might be a “per-cause” deductible, which would need to be satisfied for each of a patient’s medical conditions. When a single deductible is used, it usually must be satisfied once per calendar year. If a per-cause deductible is used, it might need to be satisfied whenever the insured has gone a specified period of time (such as 90 days) without needing treatment for the same ailment. In either case, a policy can waive the deductible requirement for certain kinds of treatment. Some health insurance products don’t apply a deductible to hospital care. Others might enforce a hospital-related deductible but not one for visits to physicians’ offices.

If a policy calls for a deductible to be satisfied every calendar year, a “carryover provision” usually protects patients whose medical expenses are incurred near year’s end in late autumn and early winter. Under the carryover provision, the insurance company looks at the amount of out-of-pocket expenses that were applied to the patient’s deductible during the last three months of the previous year. Then, those amounts are used to reduce the deductible for the new calendar year on a dollar-for-dollar basis. To better understand this concept, suppose an insured must satisfy a \$500 deductible each year and needs no care until November. In November, she undergoes a

\$400 procedure, all of which is paid out of pocket and credited toward her deductible. If she needs care in January, she can have the \$400 applied to the new year's deductible and have her coverage begin after spending only \$100 more. She won't have to satisfy the same deductible twice.

A few deductible-related consumer protections are commonly built into policies for families. A "common accident provision" generally states that if two or more people who are covered by the same policy are hurt in the same accident, the deductible only needs to be met once. For instance, think of a father and son who are injured in a car crash and have a family policy with a \$500 deductible. If post-accident care ends up costing \$500 for the father and \$300 for the son, the family will only need to spend \$500 to satisfy the deductible. The fact that the son's \$300 of care is below the \$500 deductible amount is irrelevant.

Families covered under one policy also sometimes benefit from there being a "family deductible" in addition to a deductible for each individual. With a family deductible in place, individual deductibles are waived once a certain number of family members have satisfied their own deductible. This feature of family policies can be especially helpful to couples with several children. Let's pretend a family of five has a policy with a \$500 individual deductible and a family deductible that is met when two members have satisfied the \$500 deductible. If both parents have already satisfied their \$500 deductible, individual deductibles will be waived for their three children.

Finally, a "corridor deductible" is common when major medical insurance is used as a supplement to a separate, basic policy. Medical bills that aren't covered by the basic policy but would otherwise be covered by major medical insurance are applied to the corridor deductible. Until the corridor deductible is satisfied, the insured will have no coverage under the major medical portion of a plan.

The presence of a corridor deductible essentially creates a temporary insurance gap for patients who exceed their basic policy's limits. In many ways, this gap mirrors the so-called "doughnut hole" within several Medicare Part D prescription-drug plans. Many Part D plans provide initial coverage up to a certain amount. Then, if a senior's drugs end up costing more than this amount, the insured pays out of pocket until "catastrophic coverage" from the federal government kicks in. Under the Patient Protection and Affordable Care Act, the doughnut hole is scheduled to be eliminated by 2020.

Coinsurance Fees

Once the deductible is out of the way, people with major medical insurance may still need to pay for a portion of their care in the form of "coinsurance fees." Coinsurance provisions in health insurance contracts explain how the cost of covered services will be split on a percentage basis between the patient and the insurance company. The most common coinsurance provision calls for an "80/20" split. In other words, once the deductible has been met, the insurer will pay 80 percent of costs (often based on a fee schedule or on reasonable and customary charges), and the patient will pay 20 percent. This approach differs from the one found in many basic policies, which often cover 100 percent of expenses up to a certain dollar amount.

To demonstrate how coinsurance works, let's imagine a man who undergoes back surgery costing \$10,000. If his major medical policy has a \$500 deductible and an 80/20 coinsurance arrangement, his bills will be handled in the following manner:

- \$500 will be paid by him in accordance with the deductible.
- 80 percent of the remaining \$9,500 (\$7,600) will be paid by his insurance company in accordance with the coinsurance arrangement.

- 20 percent of the remaining \$9,500 (\$1,900) will be paid by him in accordance with the coinsurance arrangement.

The introduction of coinsurance fees was one of the insurance industry's earliest attempts at controlling the utilization of medical services. Presumably, the more patients are required to contribute toward their care, the more likely they'll be to only see a doctor when it's truly necessary. Many forms of managed care—such as some PPOs—will waive coinsurance requirements under some circumstances but will still enforce them when patients use out-of-network providers.

Copayments

They're often confused with one another, but a coinsurance fee and a copayment have some significant differences. Unlike percentage-based coinsurance fees, copayments are expressed as flat dollar amounts per medical visit. Also, whereas coinsurance fees might not be billed to the patient until after an insurance claim has been made, copayments are usually due at the time of service. Even if a policy doesn't require payment of a deductible or coinsurance fees—as is sometimes the case with an HMO plan—a copayment will usually be charged.

Like coinsurance fees, copayments are meant to make patients more responsible for the cost of care and to discourage unnecessary medical visits. The size of a copayment is usually not enough to discourage visits to a primary care physician, but it tends to be bigger for higher levels of care. For instance, a policy calling for a \$10 copayment to see a family physician might have a \$30 copayment to see a specialist and a \$100 copayment to go to the emergency room.

Out-of-Pocket Limits

An insured who has to pay out of pocket in the form of deductibles, coinsurance fees and copayments can end up paying a lot of money for health care despite having insurance. Many major medical insurance policies attempt to take some of the unpredictability out of the equation by including an "out-of-pocket limit." The out-of-pocket limit caps how much an insured will have to pay for otherwise covered care during a calendar year. Money spent on insurance premiums is always excluded from this amount, and coinsurance fees are always included. Whether the out-of-pocket maximum includes the deductible and copayments will depend on the policy.

The Patient Protection and Affordable Care Act will require most health insurance plans to have an out-of-pocket limit for "essential health benefits" beginning in 2014. The limit will include any combination of deductibles, co-payments and coinsurance fees (but not premiums) and will start at roughly \$6,000 for an individual and approximately \$11,000 for a family, with annual adjustments allowed for inflation. Households whose incomes are within 400 percent of the poverty line will qualify for cost-sharing subsidies, which will push their out-of-pocket limits below those amounts. The broad categories of "essential health benefits" to which the out-of-pocket limit will apply are listed below. Each state will be allowed some leeway in setting the specific requirements:

- Ambulatory services.
- Emergency services.
- Hospitalization services.
- Maternity care.
- Newborn care.
- Mental health care.
- Substance abuse services.
- Prescription drugs.
- Rehabilitation services and devices.

- Preventive care.
- Laboratory services.
- Pediatric services, including oral and vision care.

Renewability

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), major medical insurance policies sold in the individual market are “guaranteed renewable.” Guaranteed renewable insurance must remain in force at the policyholder’s option regardless of the person’s claims history or risk potential. It cannot be cancelled or non-renewed by the insurer simply because the insured has become too sick. Some of the few circumstances under which a guaranteed renewable policy can be cancelled or non-renewed are listed below:

- The policyholder had stopped paying premiums.
- The policyholder has committed fraud.
- The policyholder has moved out of the insurance company’s service area. (This circumstance is especially relevant for people in HMOs or other managed-care plans.)

Health insurance premiums for a guaranteed renewable policy can still rise at renewal time. Companies generally can’t increase their price for current policyholders on a case-by-case basis, but they can require higher premiums from broad classes of people who have purchased the same insurance.

It’s important not to confuse a guaranteed renewable policy with a non-cancellable policy. Non-cancellable policies guarantee that premiums won’t rise above amounts that have already been agreed to. They are very rare in today’s insurance market and are practically unheard of in regard to major medical insurance. Assuming they can be found at all, these policies are more common in the market for life, long-term care and disability insurance.

Important Limits and Exclusions

The best health insurance policies can still have significant limits and exclusions. Many of the most important limits and exclusions will be summarized in the next several sections.

Pre-Existing Conditions

We’ve already addressed scenarios in which insurance might be denied outright because of an applicant’s health conditions. Most people with health problems won’t face a flat-out denial of insurance but might still have their current medical issues excluded from coverage.

A medical problem experienced prior to an insurance policy’s effective date is known as a “pre-existing condition.” Policies with an exclusion for pre-existing conditions will have a “look-back” period, such as one or two years. If treatment for the condition was received during the look-back period, the condition will be temporarily excluded. In some jurisdictions, the temporary exclusion will also be enforced if treatment wasn’t received but would’ve been sought by a reasonably prudent person.

By state and federal law (at the time this course was being written), denial of coverage on the basis of a pre-existing condition exclusion is temporary. After a waiting period of anywhere from several months to a few years, treatment for pre-existing conditions will be covered unless the condition was excluded for all policyholders with the same insurance.

For the sake of an example, think of a man who was diagnosed with diabetes three months ago. If he applies for insurance in the individual market, an insurer can refuse to cover any diabetes-related treatment because the problem was diagnosed so close to the policy’s issue date. However, the man will be covered for any new medical problems arising after the effective date, and his diabetes will be covered, too, after a lengthy waiting period.

Keep in mind, though, that the eventual coverage for pre-existing conditions doesn't force insurers to cover all kinds of medical problems. Unless federal or state law says otherwise, a particular kind of care can still be excluded totally and permanently if the exclusion applies equally to people who already have the condition and people who don't. For example, an insurer can exclude vision care on a permanent basis if the exclusion is enforced equally for people who have good eyesight and people who have poor eyesight. People impacted by the vision care exclusion wouldn't be able to have it eliminated after a waiting period.

In most states, insurers have worked around the legal requirements of pre-existing condition exclusions by issuing "exclusion riders." Whereas pre-existing condition exclusions are temporary and can apply to practically any current or recent health problem, exclusion riders can be permanent and are limited to a specified health issue. To understand the difference, think back to the man with diabetes. If his condition is disclosed or otherwise discovered during the medical underwriting process, the insurance company might offer him a choice between expensive coverage with a temporary waiting period for diabetic treatment (per the pre-existing condition exclusion) or affordable coverage that might never cover diabetes at all (per an exclusion rider).

Determining the difference between pre-existing condition exclusions and exclusion riders will be simpler and perhaps unnecessary when the main portions of the Patient Protection and Affordable Care Act go into effect. In 2014, adults will no longer be subjected to exclusions or waiting periods pertaining to pre-existing conditions, and medical underwriting will be eliminated from the individual market. Exclusions and waiting periods were banned for children with pre-existing conditions in 2010. Even before the federal reforms were passed, according to the Department of Health and Human Services, a few states that allowed waiting periods for pre-existing conditions (including California) did not allow exclusion riders.

Much of the information we've mentioned in this section is applicable only to policies in the individual market. The Health Insurance Portability and Accountability Act (HIPAA) and subsequent regulations set many limits regarding pre-existing conditions and waiting periods within group health insurance plans. Here are some of the basics:

- Individual members of a group cannot be denied insurance or charged more because of pre-existing conditions.
- Look-back periods for group plans can be no longer than six months.
- Waiting periods for coverage of pre-existing conditions can be no longer than 12 months for new group members. (18-month waiting periods can apply to people who didn't enroll when first offered the chance.)
- Waiting periods for pre-existing conditions can be reduced by the amount of time a group member had "creditable coverage." Creditable coverage is health insurance (including previous group or individual coverage) that was in effect within 62 days prior to enrollment in the group plan.

Many administrative rules for the Patient Protection and Affordable Care Act hadn't been finalized by the time this material was printed. However, the rules mentioned here about pre-existing conditions in group health plans will probably become even stricter around 2014. The law's general ban on exclusions of pre-existing conditions applies to the group market as well as the individual market.

Skilled vs. Custodial Care

We've focused thus far on care received in hospitals, doctors' offices and outpatient centers. But as practically anyone with an elderly or disabled family member already knows, varying levels of care can also be provided in private residences, nursing homes and assisted-living facilities.

Whether care in those settings will ultimately be covered by health insurance can be difficult to determine.

Major medical insurance will usually pay for “skilled care” at either a nursing facility or a patient’s home. Skilled care is care that can only be performed by a trained medical professional. It doesn’t include “custodial care,” which can often be performed by non-medical professionals. Examples of custodial care include housekeeping chores like cooking, cleaning and doing laundry. Other examples are more personal forms of assistance, such as help with getting dressed, bathing, eating, moving to and from a chair and using the bathroom. Help with these tasks is sometimes paid for when a patient is also in need of skilled care, but custodial care on its own will need to be funded via some other means.

Many health insurance policies make coverage of skilled care contingent upon prior hospitalization. If the patient wasn’t hospitalized for a minimum amount of time prior to needing care at home or in another facility (three days is a common requirement), claims might be denied. Once skilled care has been authorized, it might only last for a certain number of days.

The limits and exclusions involving skilled and custodial care tend to become more important for consumers as they age. Many people who are nearing or already in retirement erroneously think these kinds of care are covered in large part by the federal Medicare program. In fact, Medicare’s position on skilled and custodial care is very similar to the limits and exclusions we’ve mentioned here.

Medicare shouldn’t be confused with Medicaid. Medicaid is the top payer for nursing home care in the United States. Unfortunately, most seniors aren’t eligible for the needs-based program until they have spent down most of their assets. Individuals who are concerned about needing long-term skilled or custodial care and don’t want to rely on Medicaid may want to consider buying long-term care insurance.

Maternity Care

The high cost of childbirth has been a problem for many women, including some who already have insurance. Historically, policies purchased in the individual market didn’t need to cover maternity care, and those offering some coverage would limit it to certain circumstances. Women who delivered via a non-elective caesarian section might have had some insurance protection, but those who had normal vaginal births often had to pay thousands of dollars completely out of pocket. In either case, there frequently were no benefits pertaining to prenatal tests and treatments unless special financial arrangements were made.

Coverage for maternity care has been much more widely available to women in group health insurance plans. In 1978, Congress enacted the Pregnancy Discrimination Act, which clarified that discrimination against pregnant women was an illegal form of gender discrimination under the Civil Rights Act of 1964. As a result, health insurance plans for businesses with more 15 employees must cover maternity care and must do so on a level equal to other medical services. The requirement provides pregnancy coverage to enrolled employees and to their enrolled spouses. The plan doesn’t need to provide pregnancy coverage to other dependants, such as children.

Be aware, too, that even group plans with an exemption from the Pregnancy Discrimination Act must abide by HIPAA and cannot treat pregnancy as a pre-existing condition. Under HIPAA, maternity benefits available in a group plan must be available at the same time as the plan’s other benefits.

The passage of the Pregnancy Discrimination Act has often left employers wondering whether the law requires them to cover some controversial kinds of care. Abortion coverage must be provided, but only to the extent that the procedure is necessary to preserve the life of the mother.

Regulators and courts have gone back and forth regarding whether the law requires plans to cover contraception. In 2000, the Equal Employment Opportunity Commission—which enforces several labor-related laws on the federal government’s behalf—ruled a plan covering other preventive services (such as screenings, immunizations and physicals) must also cover medically prescribed contraception. Similarly, some courts have argued that excluding prescribed contraception is discriminatory because it is used entirely by women and because the health-related effects of contraception disproportionately impact females. More recently, some judges have ruled otherwise, arguing that as long as a plan doesn’t cover male-targeted contraception, it doesn’t need to cover female-targeted contraception.

The requirements we’ve mentioned from the Pregnancy Discrimination Act are from the federal government and only apply to employers with 15 or more employees. Many state governments mandate pregnancy coverage for smaller groups. In 2012, the state of California even extended mandatory pregnancy coverage to plans in the individual market.

The Patient Protection and Affordable Care Act addresses pregnancy issues in several ways. In 2014, the requirement to include coverage of maternity care will be extended to smaller group plans and to policies in the individual market. Federal regulations also now require non-“grandfathered” health plans (including group plans and policies in the individual market) to cover certain kinds of preventive care without applying copayments, deductibles or coinsurance fees to them. (Grandfathered plans, in general, are individual and group health plans that already existed on March 23, 2010, and that haven’t undergone significant changes since then.) FDA-approved contraceptive services for women are considered a form of covered preventive care under the regulations. A limited exemption allows some religious organizations to avoid paying for contraception coverage, but their impacted employees must still be offered the coverage at no cost by their insurance company.

Plans and policies offering maternity-related benefits must also comply with the Newborns’ and Mothers’ Health Protection Act of 1996. This federal law was enacted to eliminate “drive-through deliveries,” in which new mothers and their infants were discharged prematurely from hospitals for insurance reasons. The law applies to practically all kinds of health insurance, including group plans from an insurance company, self-insured plans created by employers, and policies offered to applicants in the individual market.

The Newborns’ and Mothers’ Health Protection Act doesn’t require all plans to cover maternity care, but those choosing to cover it can’t limit benefits beyond the standards set by the law. Insurers covering vaginal births must pay for at least two days of hospitalization for the mother and child. For caesarian births, the requirement is three days. An insurer can still impose deductibles, copayments and coinsurance fees, but cost-sharing can’t differ from day to day. For example, if a policy requires a 20 percent coinsurance fee for the first day of hospitalization for a vaginal birth, the fee can’t increase for the second day. Mothers are entitled to the coverage regardless of whether they’ve had their hospital stay certified or approved in advance by their insurer. However, the insurer is allowed to impose higher cost-sharing requirements if certification or approval is not obtained.

By the time the Newborns’ and Mothers’ Health Protection Act went into effect, most states had already passed similar legislation. Depending on where they live, mothers and their babies might be entitled to additional insurance-related rights.

Other Exclusions

There are many other coverage exclusions deserving of attention in this chapter. Here are some other kinds of care that might be limited or completely not covered by even a fairly comprehensive policy:

- **Cosmetic surgery:** Cosmetic surgery is usually only covered by health insurance when it is performed in connection with treating an injury or illness. For example, a woman will probably be covered for breast reconstruction following a mastectomy, but a claim for elective breast augmentation would probably be denied.
- **Dental care:** Dental insurance is usually purchased separately from major medical insurance. The major medical plan might still cover necessary dental care after an accident.
- **Eye exams and glasses:** Like dental insurance, vision coverage is usually purchased separately. A major medical insurance policy might still cover treatment for eye-related diseases.
- **War injuries:** Injuries sustained in war are usually covered under a government health plan for veterans.
- **Experimental treatments:** New forms of treatment that have undergone little or no testing often won't be covered by insurance.
- **Alternative medicine:** Non-traditional forms of treatment, such as herbal remedies and chiropractic care, might require special authorization or not be covered at all.
- **Injuries or illnesses from the workplace:** Health insurance doesn't pay for treatment if it should be paid for by an employer's workers compensation insurance. If a health insurer ends up paying a claim that should've been paid by the employer's insurance company, it will request reimbursement from the other carrier.
- **Preventive care:** The Patient Protection and Affordable Care Act generally requires preventive care to be covered, but exemptions exist for many plans already in existence on September 23, 2010. Among older plans, preventive care (such as physicals, immunizations and screenings) might not be covered unless the plan is from an HMO.

Health Insurance Claims

The party responsible for filing a claim with the health insurance company will depend, in part, on the kind of policy involved. "Service contracts"—including policies issued by Blue Cross/Blue Shield organizations and managed-care entities like HMOs and PPOs—usually pay medical providers directly. Patients with these kinds of policies typically won't need to fill out claim forms unless they want to be reimbursed for a payment they made in error. If the patient has a "reimbursement policy," (a form of insurance much more common among private insurance companies in previous decades), the patient might need to be the one to initiate the claims process and fill out forms. However, many people with reimbursement policies can "assign" their claims-related responsibilities to their doctor by signing the appropriate paperwork at the medical office, thereby allowing the doctor to receive direct payment. In fact, it is common for patients to be asked to sign these forms regardless of whether their policy is considered a service contract or a reimbursement contract.

Insuring Children and Families

Consumers who want to insure their spouse, children or other family members typically can do it through either the individual or group market. If an adult has a policy from the individual market, the insurance can be converted to a family policy by notifying the carrier soon after having a child or getting married. Likewise, if the new parent or the newly married person has group insurance, the spouse or child can be added to the group plan if proper notification is given.

Under HIPAA, an employee's dependents and spouse can also be added to a group plan during annual open-enrollment periods and when they lose other health insurance.

Most workers with group coverage probably assume it's best to cover their entire family with the same plan. Taking this position can make a family's insurance situation simpler, but it doesn't always translate to savings on premiums. Although employers often pay for a portion of their

employees' health insurance, employer contributions for an employee's family members are usually smaller or not available. If a spouse or child is relatively healthy, it might be a good idea to look into an individual policy for the person before adding him or her to a group.

The Patient Protection and Affordable Care Act contains many important provisions pertaining to children. Under the law, insurers can no longer deny or limit coverage for someone under 19 because of pre-existing health conditions. Also, adult children can now remain on their parents' health insurance plan until age 26. To qualify for inclusion on a parent's plan, adult children don't need to be students, don't need to live with a parent and don't need to be considered a dependent on a parent's tax returns. Children under 26 can even be married without losing their eligibility. Until 2014, grandfathered groups don't need to make insurance available to an adult child if the person is eligible for other group coverage from an employer.

Sources of Insurance

We've touched on the differences between individual policies and group plans, and we've gone into detail about the characteristics of basic and major medical insurance products. But the categorization of health insurance options doesn't end there.

Even if we assume the vast majority of people with health insurance have major medical or comprehensive coverage through a group plan (as is indeed the case), there are still several different options to choose from. These options include reimbursement policies from private insurance companies, service plans from Blue Cross/Blue Shield organizations, and myriad types of managed-care arrangements from many different entities. Each option has its own set of positives and negatives for patients, although the distinctions among them are becoming increasingly blurry. The basics of each will be explained over the next several pages.

Reimbursement Policies

Arguably the most traditional form of major medical insurance is a reimbursement policy. Reimbursement policies have been sold mainly by for-profit insurance companies rather than by Blue Cross/Blue Shield or independent managed-care organizations. Many for-profit insurers selling life insurance also sell health reimbursement policies.

Reimbursement policies tend to give policyholders the greatest level of choice regarding which medical providers they can see. Patients aren't limited to an insurer-approved network of physicians, and they don't need a referral to see specialists. What matters is that the kind of care received from a provider isn't excluded from the policy. The freedom to go to practically any doctor might help explain why these policies tend to be more expensive than other insurance options. The higher cost might explain why they usually aren't the first option for the average consumer or small businesses.

Since reimbursement policies lack an organized network of providers, patients might need to pay their doctor for services themselves and then personally file a claim for reimbursement. Still, as was mentioned previously, it's possible for the patient to complete necessary paperwork at the physician's office and allow the provider to make a claim on the patient's behalf. Through this process, known as "assignment," money normally sent to the insured will instead be sent directly to the provider.

As a side note, be aware that some people use the term "indemnity" instead of "reimbursement" when discussing these classic kinds of health insurance contracts. We have chosen not to do so in order to distinguish them from the basic policies that don't take the cost of received care into account (hospital indemnity, dread-disease, etc.). For a review of these basic policies, refer back to the section "Health-Related Indemnity Policies."

Service Plans

Most major medical insurance policies covering groups or individuals today have at least some elements of a “service plan” in them. In a service plan, insured individuals don’t pay premiums in exchange for future reimbursement. Instead, they pay premiums in exchange for future medical services. This difference helps explain why patients in service plans are often called “subscribers” instead of “policyholders.”

The seemingly subtle distinction between reimbursement plans and service plans impacts how insurance claims are handled. Unlike situations involving reimbursement policies, patients in service plans generally don’t need to pay doctors on their own and then wait to be paid back by their insurer. Instead, claims are usually handled automatically by the health care provider, and the insurer pays the provider directly. A patient with a reimbursement policy can sign forms to make sure a provider is paid directly, but this extra step of written authorization usually isn’t necessary in a service plan. Direct payment from the insurer to the provider will have already been agreed to as part of a contract. So, by default, reimbursement policies reimburse the patient, and service plans reimburse providers.

Medical providers who have contracted with insurers to treat subscribers are part of a plan’s “network.” In exchange for direct payments and other incentives, providers in a network typically agree to bill for no more than what’s in the plan’s fee schedule or what the plan believes is “reasonable and customary.” Patients who see network providers might still have to pay deductibles, coinsurance fees and copayments, but they won’t need to pay any additional fee just because the insurer and the provider don’t agree on what something should cost.

Telling the difference between reimbursement plans and service plans can be difficult and, frankly, unimportant to a certain extent. Today, it’s common for a health insurance product to feature characteristics of both a reimbursement policy and a service plan. For example, a service plan might act more like a reimbursement policy when a patient sees a doctor who isn’t in the plan’s network.

The classic example of a service plan is a Blue Cross/Blue Shield plan. At a basic level, the many kinds of managed-care plans (HMOs, PPOs, etc.) can be considered service plans as well.

Blue Cross/Blue Shield

Blue Cross/Blue Shield plans have been leaders in the market for service plans for several decades. Originally, these plans were separate, with Blue Cross plans handling hospital expenses and Blue Shield plans handling physician expenses. Eventually, it became more practical for the two types of plans to merge. Each Blue Cross/Blue Shield plan serves its own geographic area and is run by its own set of directors, but they all follow standards from the same national association.

Historically, one of the distinguishing characteristics of Blue Cross/ Blue Shield entities has been their non-profit status. As non-profits, the plans receive major tax exemptions in exchange for following certain rules. They’ve generally been known to spend more of their money on providing services than for-profit insurers, and they’ve often been quicker to accept less-healthy applicants and small groups. That reputation, though, has become somewhat diluted over the years. Many Blue Cross/Blue Shield plans have re-organized themselves as for-profit entities. Meanwhile, some of the consumer protections offered originally by Blue Cross/Blue Shield plans have since become mandatory for for-profit insurers.

Managed Care

Since you now have an understanding of service plans and Blue Cross/Blue Shield, we can address the important issue of “managed care.” Managed care has many definitions, with its

meaning dependent upon who is using the term and in which context. Many people assume managed care is synonymous with an HMO or that it's completely separate from the kinds of insurance available from major insurance companies. In fact, managed care can be viewed more as an approach to health insurance rather than an alternative to it. It's been adopted to varying degrees by private insurance companies, Blue Cross/Blue Shield plans, service plans and (to a lesser extent) providers of reimbursement policies.

For our purposes here, we'll define managed care as an approach to health insurance that attempts to control how covered care is actually provided. Examples of managed care in action include instances in which an insurer requires pre-authorization for an operation and cases in which an insurer limits a patient's choice of physicians. If a patient is asked to choose among the physicians in an insurer's network, at least some level of managed care is being practiced.

The amount of managed care in a health insurance plan can be anywhere from relatively minor to very high. An insurer practicing a relatively minor amount of managed care might simply try to influence patient behavior by offering certain financial incentives. For instance, it might cover 50 percent of services received from out-of-network providers, but offer to pay 80 percent if the patient gets care within the network. Conversely, an insurer practicing a lot of managed care might essentially force a patient to receive care from a network provider by refusing to cover any out-of-network treatment.

If a patient stays in network, access to providers can be restricted in other ways. A strict approach to managed care might require a referral from a primary care physician before a patient is allowed to visit a specialist. A more flexible approach might waive the referral requirement but impose smaller copayments if treatment is received from the primary doctor instead of a specialist.

Proponents of managed care believe it can be an effective way of controlling health-care costs. Because of the disincentives to go out of their network, patients have good reasons to only seek treatment from providers who have already agreed to accept pre-negotiated payment amounts from the insurance company. The restrictions relating to specialists can sometimes make care more efficient. Depending on a primary care physician's expertise, he or she might be able to solve a patient's problem and thereby eliminate the need to see a usually more expensive specialist. If the primary care doctor can't solve a problem, he or she can usually guide an uninformed patient to the appropriate expert. For these and other reasons, consumers who are willing to accept a higher level of managed care usually pay less for their insurance.

Still, managed care is routinely criticized for its influence on choice and the doctor-patient relationship. Managed care attempts to make comprehensive health services available to patients, but a patient's favored physician isn't always part of an insurer's network. And even if a patient is satisfied with his or her current doctors, there's no guarantee those doctors will remain in the network forever. Meanwhile, doctors in an insurer's network sometimes complain that rules regarding insurer authorization are too narrow and prevent them from implementing patient-specific treatment plans.

Over the last few decades, insurers have tried to find ways to balance cost against freedom of choice and have come up with several different managed-care arrangements. Among the most recognized arrangements are HMO plans, PPO plans, and POS plans.

HMOs

An HMO (or "health maintenance organization") is probably what most people think of when the term "managed care" is used. This makes sense because even though many other sources of health insurance have elements of managed care in them, the use of managed care within HMOs is especially high.

Compared to other health insurance arrangements, an HMO features a relatively tight relationship between the physician and the insurer. The closeness of the relationship can be reflected in several ways, including how medical providers are paid, who physicians work for, and how carefully a physician's procedures are monitored.

In perhaps the closest kind of relationship, individual physicians can be employed on an exclusive basis by the HMO to staff its own medical facilities. Alternatively, an HMO can contract with one or more medical groups, and the groups' employed physicians will serve the HMO's patients. An HMO also has the option of contracting with individual physicians who will treat the HMO's subscribers in addition to treating other patients.

Compared to other examples of managed care, an HMO is less likely to compensate medical providers through a "fee-for-service" arrangement. In a fee-for-service system, compensation for providers is based on the number and type of specific services they actually perform. By contrast, providers in an HMO are often paid a pre-determined amount every year or every month based on their total number of patients. This pre-determined amount might be paid directly to a physician, or it might be paid to the physician's medical group, which will have its own method of compensating individual doctors. Either way, the movement away from a fee-for-service system is meant to eliminate financial incentives for providing supposedly unnecessary treatment. Of course, whether certain services are truly unnecessary is often a serious area of disagreement between doctors and insurers.

Even in cases where an HMO uses a fee-for-service model, it will monitor a provider's decisions to make sure care is being provided in a cost-effective manner. For example, if a provider orders tests at an unusually high rate, the HMO might request clarification or a change in behavior.

Primary Care Physicians

A patient in an HMO will have all of his or her care coordinated by a "primary care physician." A primary care physician is the patient's first point of contact for help with a medical problem. The physician might be a general practitioner, a family practitioner, an internist (if the patient is an adult) or a pediatrician (if the patient is a child). Each HMO will have a list of eligible primary care physicians for patients within a designated geographic area. A patient who has a bad experience with a primary care physician can switch to another provider on the list. If a primary care doctor leaves the HMO, patients might be able to continue seeing the doctor for a short period of time.

In an HMO, the primary care physician acts as a "gatekeeper" who controls a patient's access to specialists. Before a patient can receive covered care from a specialist, the primary care physician must be consulted to determine if a specialist is actually necessary. If the patient's problems aren't treatable by the primary care physician, a formal referral often must be made to the specialist.

The Patient Protection and Affordable Care Act requires non-grandfathered plans to waive referral requirements for treatment from doctors practicing obstetrics and gynecology (OB/GYNs). Again, a grandfathered plan is health insurance that was already in place on September 23, 2010, and has not undergone significant changes since then.

Preventive Care

One of the attractive features of an HMO is its emphasis on preventive care. HMOs have long believed that addressing health issues as soon as possible ends up saving them money over the long run. As a result, they've typically covered physicals, screenings, immunizations and other forms of preventive medicine at a higher rate than other kinds of health insurance. This is likely to become less of a distinguishing characteristic as more health plans become compliant with the Patient Protection and Affordable Care Act. Through the law, non-grandfathered plans must cover

certain forms of government-recommended preventive care without imposing a deductible or requiring any additional copayments or coinsurance fees.

Cost Sharing in an HMO

Another attractive feature of an HMO is cost. Since there are more restrictions on access to providers, subscribers tend to pay comparatively lower premiums. The cost of receiving covered care is usually lower, too. Patients usually don't need to satisfy a deductible before their benefits kick in, and they tend to only be responsible for a small copayment for each medical visit. Coinsurance fees are usually not required.

PPOs

Consumers who want insurance with more flexibility than an HMO and are willing to pay a little more might be interested in a "PPO." A PPO (or "preferred provider organization") has contracts with a wide variety of medical providers and pays those providers on a fee-for-service basis. The size of the fee might be pre-determined as part of a fee schedule or might be based on what's reasonable and customary in the area.

In exchange for accepting pre-negotiated fees from the PPO, affiliated providers are more likely to receive business from the PPO's subscribers. Patients in a PPO aren't prohibited from receiving care beyond the insurer's network, but financial incentives exist to keep them from going elsewhere. For example, while a PPO might cover 60 percent of care received beyond the insurer's network, care inside the network might be covered up to 80 percent. Similarly, a PPO might reduce the deductible (or waive it entirely) if care is received from network providers.

Unlike an HMO, PPOs generally don't require the use of primary care physicians as gatekeepers. If they want to see a specialist, patients can do so without first receiving a referral. There will be financial incentives to choose a specialist within the PPO's network, but seeing an out-of-network specialist is still permissible.

POS Plans

A "point of service" (POS) plan is commonly considered a combination of an HMO and a PPO. Just as they would in an HMO, patients choose a primary care physician, who will coordinate their care and issue the necessary referrals. Just as they would in a PPO, patients have the option of going out of network. But compared to a PPO, the difference in coverage for in-network care vs. out-of-network care in a POS plan tends to be more significant.

HSAs, MSAs and FSAs

Managed care isn't the only popular method of controlling costs in the health insurance community. Many health policy experts believe certain ways of paying for care—when coupled with favorable tax treatment—can make insurance affordable and reduce unnecessary treatment. Proponents of this idea often encourage broader use of "health savings accounts" (HSAs)

A health savings account is an individually owned tax-favored account containing money for medical expenses. The account can be offered in conjunction with an individual health insurance policy or a group plan, and it can be for the benefit of one person or a family. Contributions—which are capped by the Internal Revenue Service at a certain dollar amount each year—can come from the account holder or from an employer.

A health savings account must be paired with a high-deductible health insurance plan. The deductible can be anywhere from roughly a few thousand dollars for an individual to several thousand dollars more for a family. Until the deductible has been satisfied, a patient's medical expenses can be paid with money from the person's account. In fact, money from the account can sometimes be used to fund medical expenses not covered by the high-deductible insurance plan. Examples might include the cost of eyeglasses, preventive dental services and custodial

care. While making an exception for insulin, the Patient Protection and Affordable Care Act eliminated over-the-counter medicines from the list of eligible expenses. (For an in-depth look at eligible expenses, see IRS Publication 502.)

In general, contributions to health savings accounts are tax-deductible and can grow on a tax-deferred basis. Withdrawals for payment of eligible medical expenses are free from federal taxation, but money spent for other purposes will be taxed as income. Barring special circumstances, such as a disability, withdrawals made prior to age 65 for non-medical purposes will also be subjected to a flat, percentage-based penalty. On January 1, 2011, the penalty increased to 20 percent in accordance with the Patient Protection and Affordable Care Act.

The push for greater use of health savings accounts is based partially on the theory that the high deductible in the accompanying plan will force people to make responsible decisions about their health care. It's also been argued that the high deductible can make insurance an option for people who wouldn't otherwise be able to afford it. On the other hand, some critics believe a movement toward more health savings accounts wouldn't benefit households in low tax brackets and would discourage unhealthy people from seeking important treatment.

Be careful not to confuse a health savings account with a "flexible spending account" (FSA) or a "medical savings account" (MSA). A flexible spending account lets employees use pre-tax dollars to pay for various medical expenses. Unlike money in a health savings account, unused funds in a flexible spending account generally cannot be carried over from one plan year to the next.

A medical savings account is very similar to a health savings account but is only available to self-employed people and employees of small businesses. Since health savings accounts are available to a broader portion of the population, they've essentially replaced medical savings accounts in today's market.

High-Risk Pools

If medical underwriting disqualifies someone for health insurance, a "high-risk pool" is an option. In 2009, roughly 30 states gave otherwise uninsurable residents the chance to gain coverage through a high-risk pool. The kind of coverage made available and the requirements to join the pool differed by state.

The Patient Protection and Affordable Care Act made high-risk pools available in all states and set federal standards for them. The pools required by the law can't have a waiting period for coverage of pre-existing conditions, and premiums must be based on the standard rate for non-group coverage in the area. Unlike some of the earlier state pools, the federally mandated pools are only accessible to individuals who've been uninsured for at least six months.

Although pre-existing pools that were started by the individual states continue to exist, the pools required by the Patient Protection and Affordable Care Act stopped enrolling people in March 2013. (Despite unexpectedly low enrollment, the cost of covering the thousands who did enroll was still higher than what the federal government had predicted.) However, individuals who had already enrolled in one of the pools will continue to be covered until 2014. At that point, the ban on medical underwriting will go into effect, and those in the pools will become eligible for a policy in the individual market.

Group Health Insurance

Most people who have health insurance didn't get it in the individual market. Instead, they receive group coverage as an employee benefit through their job. The use of health insurance as an important employee benefit grew out of the World War II era. Labor shortages caused businesses to compete for the best workers, but government freezes on wages meant those companies often couldn't attract new employees by simply offering more money. Since the freezes weren't

applicable to fringe benefits, group health insurance was used as a recruiting tool and as a way to satisfy organized labor. The wage freezes eventually ended, but the popularity of employer-sponsored health insurance continued to grow.

We'll conclude our study of health insurance by reviewing topics specific to group health plans. But despite a few significant differences, the majority of the information already provided in this chapter is relevant on a nearly equal basis to the individual market and the group market. Like most policyholders in the individual market, enrolled group members almost always have a form of major medical insurance covering hospital expenses, surgical expenses and physician expenses. Like shoppers in the individual market, covered employees often must accept a certain level of managed care. And like applicants who get their insurance outside of work, members of group plans might have coverage through a for-profit insurer, Blue Cross/Blue Shield, an HMO, a PPO or some combination of those sources.

Applying for Group Health Insurance

Group health insurance covers several people through a single insurance policy. In most cases, the link between all members in the group is their employer. Employer-sponsored group health insurance is usually available to all of a company's full-time employees. Most plans will also insure an enrolled employee's spouse and children. Although the Patient Protection and Affordable Care Act doesn't force all group plans to cover employees' children, those already covering children must continue to do so until a child turns 26. Eliminating coverage for children because they are no longer students, no longer single or no longer dependents on an employee's tax returns is prohibited until they reach this age.

Insurance options in group plans tend to be less clear for retirees, working senior citizens and same-sex partners. Health insurance for retirees used to be a popular benefit, but it's become increasingly uncommon as businesses have tried to reduce costs. Working people who are nearing Medicare eligibility should contact their insurer to see how their current plan coordinates with the federal plan. This is especially important for people at companies with less than 20 employees because those businesses sometimes have the right to offer reduced coverage to workers over 65. Same-sex couples who are married generally have the same federally imposed insurance rights as married opposite-sex couples. Similarly, same-sex couples in civil unions generally have the same state-level insurance rights as married couples in their state. An increasing number of employers are also making enrollment an option for unmarried couples in domestic partnerships.

The option to enroll in an employer-sponsored group plan typically exists when the employee is hired or during a month-long "open-enrollment" period each year. Under HIPAA, employees, spouses and dependents who initially declined group coverage don't need to wait for an open-enrollment period following marriage, the birth or adoption of a child or the loss of other health insurance.

Circumstances in which an employee, a spouse and dependents can bypass a group plan's open-enrollment period because of a loss of other coverage include the following:

- Coverage existed under a spouse's or dependent's plan, and the spouse or dependent has become unemployed.
- Coverage existed under a spouse's or dependent's plan, and the spouse's or dependent's employer has discontinued the plan.
- Coverage existed under a spouse's or dependent's plan, but the spouse's or dependent's employer has shifted the cost of the plan entirely to employees.
- Coverage existed under a spouse's or dependent's plan, and the plan's lifetime benefit limit has been reached.

- Coverage existed under a spouse's or dependent's plan, but the spouse or dependent has lost coverage due to a reduction in work hours.
- Coverage existed under a spouse's or dependent's plan, and the spouse or dependent has died.
- Coverage existed under a spouse's or dependent's plan, but the spousal or dependent relationship has ended. (This includes cases of spouses getting divorced and children reaching adulthood.)

Marriage is one of the few events that lets families bypass an open-enrollment period and join a group plan without needing to have lost other coverage. An employee who is already covered by a group can add his or her spouse within 30 days of marriage. If the employee hasn't enrolled, he or she can join within those same 30 days.

Birth or adoption is another event that lets families join group plans outside of normal open enrollment. Children can join within 30 days of being born or adopted. When they do, coverage is retroactive and dates back to their date of birth or adoption. Parents to the child who haven't enrolled can do so during those same 30 days.

One drawback to group coverage is that eligible employees are limited to the options presented to them by the sponsoring employer. For example, if the employer only offers insurance through an HMO, the employee must decide whether to accept it or go without group coverage. If the employer offers multiple options but the employee is still unhappy with a particular aspect of a plan, the employee can't negotiate a change with the insurance company.

Despite allowing for less personal choice than the individual market, group insurance is usually preferred by eligible employees. The main reasons for this pertain to access and affordability. Although a group as a whole might be charged more because of the overall health status of its members, group plans can't deny enrollment to a particular person because of health or charge the person more for being a higher risk. And although most employers won't help pay premiums for spouses or dependents, many businesses continue to pay for at least a portion of the insurance covering their employees.

Pricing Group Health Insurance

Since insurance companies can't discriminate against a particular person in a group plan, characteristics of the group as a whole can be very important. The composition of the group and the amount charged per member will need to be enough to balance out the risk of insuring unhealthy members. In most cases, the insurance company will be more confident (and more willing to offer affordable coverage) when enrollment in the group is high and when the average age of the members is low.

If the number of people in a group is very large, the group might be viewed as its own pool for the purpose of pricing and will be subjected to "experience rating." Experience rating is a method of calculating the cost of insurance in which emphasis is placed on the applicant's previous losses. If claims made by an experience-rated group are relatively high, the group should expect to pay a relatively high amount for its insurance. If an experience-rated group has a major shift in its claims history from one year to the next, the amount charged by the insurer for the following year will reflect the change.

Due to their size, smaller groups either aren't subjected to experience rating or are only impacted by it to a limited extent. Instead, greater emphasis is put on community rating. Community-rated groups can still experience significant increases in the cost of their insurance, but it won't be because claims for the group are especially large. Rather, it will be influenced more by changes in the group's demographics and the overall claims history of all similarly insured businesses in the area.

As was mentioned earlier, the Patient Protect and Affordable Care Act will require insurers to engage in a modified form of community rating in 2014 when pricing coverage for small groups. Presumably, this will prevent these groups from being experience-rated in any way when they apply for or renew coverage. (Specific rules had not been issued by the time this course was finalized.) The law also calls for community rating among larger groups, depending on how other portions of the law are implemented at the state level.

Self-Insured Plans

Over the past few decades, many employers have abandoned traditional relationships with insurance companies and covered their employees through a “self-insured plan.” In a self-insured plan, the money for an enrolled person’s medical treatment comes out of an employer’s own funds. This differs from a “fully insured plan,” in which insurance for employees is funded entirely by paying premiums to an insurance company. Both types of plans can require financial contributions from enrollees, but the difference relates to how much responsibility an employer must accept when those contributions are too small to pay claims. In a fully insured plan, the employer is not financially liable if premiums from group members aren’t enough to pay claims. In a self-insured plan, claims exceeding collected premiums will need to be paid by the employer unless special legal arrangements have been made.

For a self-insured plan to be successful, the employer’s annual health care costs need to be steady or, at least, predictable. To an extent, this helps explain why self-insured plans are more commonly implemented by companies with several hundred workers than by smaller businesses. Whereas a few employees having catastrophic health problems are unlikely to skew a large employer’s annual costs very much, having the same thing happen at a small company could bankrupt the business.

The financial responsibilities involved with a self-insured plan are sometimes worth taking if the employer wants to customize its health plan to make it more efficient and less costly than a fully insured plan. Unlike fully insured plans, self-insured plans generally aren’t regulated by state insurance departments and can therefore ignore many of the mandatory benefits insurance companies must provide. However, self-insured plans generally must comply with the majority of the federal requirements mentioned in this chapter, including most of those pertaining to HIPAA and the Patient Protection and Affordable Care Act.

Since health plans can be very complex, an employer with a self-insured plan will usually still maintain some kind of relationship with a health insurance company or another business specializing in employee benefits. For example, an employer might provide all the money needed to pay claims but contract with a third-party administrator (TPA) to handle enrollment, billing and other administrative tasks. When these tasks are offered to self-insured plans by a health insurance company, the acronym “ASO” (for “administrative services only”) is sometimes used.

If a self-insured plan wants to manage the risk of unexpectedly large claims, it can purchase “stop-loss insurance.” Stop-loss insurance will reimburse the self-insured employer for medical payments above a set amount. It might go into effect when claims for an individual reach the amount or when claims for the group as a whole have reached it. A similar arrangement known as a “minimum premium plan” is sometimes used by fully insured plans that are willing to share some medical bills with insurers in exchange for lower premiums.

Coordination of Benefits

It’s possible for people to be covered by more than one health insurance plan. This might occur if an employee works for multiple employers, each of which has its own plan. More commonly, it happens when both members of a married couple have insurance through their employers and decide to cover each other or their children under both plans.

If someone has health insurance from multiple sources, it's important to examine a plan's "coordination of benefits provision." The coordination of benefits provision serves two important purposes. First, it stops someone who is covered by multiple insurance policies from "double-dipping" and being compensated for more than the cost of their care. Second, it explains how the cost of care will be shared among the different insurance plans. Usually, one plan is "primary" and pays for care as if the patient were covered under no other plans. Then, the other plan (considered "secondary") pays for some or all of the costs not covered by the primary plan. In general, the rules about which plan is primary and which one is secondary are as follows:

- If someone is covered as an employee in one plan and as a spouse in another, the employee coverage is primary.
- If a child is covered by plans from two parents who have joint custody, the coverage from the parent whose birthday falls earliest in the calendar year is primary.
- If a child is covered by plans from two parents who don't have joint custody, the coverage from the parent with custody is primary.
- If a divorce decree specifies which parent will be responsible for a child's health insurance, the insurance arranged by that parent will be primary.
- If someone is covered by a employer-sponsored group plan and Medicare, several factors (including the size of the employer and whether the person is retired) will determine which insurance is primary. Interested readers should contact the Department of Health and Human Services or visit the department online for details.

Mental Health Parity

As mental health has become less of a stigmatized topic, the insurance-related rights for individuals with mental health problems have grown. In 1996, Congress passed the Mental Health Parity Act, which required lifetime and annual dollar limits for mental health care to be equal to the dollar limits for physical health care. The law didn't require coverage for mental health care, and those providing such coverage could still have different limits for mental health if they weren't based on annual or lifetime dollar limits. For example, a plan could still have different copayments or coinsurance fees for mental health and could put different limits on the number of covered visits. The law applies to group plans with more than 50 members.

The Mental Health Parity and Addiction Equity Act of 2008 expanded upon the requirements of the earlier law. Under the act from 2008, plans covering mental health care must have substantially the same limits for mental health care and physical health care in regard to most aspects of coverage, including deductibles, coinsurance fees, copayments and number of visits. As with the earlier law, it doesn't force plans to cover mental health care in the first place, and it only applies to group plans for more than 50 people.

Many states require coverage of mental care in some plans. For example, Illinois requires group plans for more than 50 employees to cover "serious mental illnesses." Insurers offering plans to smaller groups in the state must offer mental health coverage to the employer, but the employer can decline it.

The Family and Medical Leave Act

The Family and Medical Leave Act preserves employees' jobs and their health insurance when they take a leave of absence to care for themselves or a family member. Employees covered by the law are entitled to 12 weeks of unpaid leave (and continued health insurance) per year under any of the following circumstances:

- They need time off to become acquainted with a newborn, a newly adopted child or a newly placed foster child. (Men who take leave for this reason are entitled to the same rights as women.)

- They need time off to care for a seriously ill child. (The child doesn't need to legally or biologically be their son or daughter. However, an employee must have assumed some kind of parental role.)
- They need time off to take care of a seriously ill spouse.
- They need time off to take care of a seriously ill parent or guardian. (The parent or guardian doesn't need to legally or biologically be their mother or father. However, the ill person must have assumed some kind of parental role when the employee was a minor.)
- They need time off to manage their own serious illness.
- They need time off for reasons relating to a family member's membership in the National Guard or Reserves. (In addition, family members may take 26 weeks of unpaid leave to care for a seriously ill service member.)

Serious medical conditions that would trigger an employee's rights under the Family and Medical Leave Act generally include a sudden medical problem requiring hospitalization or a chronic condition that prevents a person from working. Requests for medical leave generally must be granted, but an employer can require medical proof before authorizing an absence.

Not all businesses are impacted by the Family and Medical Leave Act. For the law to apply, all of the following statements must be true:

- The employee has worked for the employer for at least a year.
- The employee has worked at least 1,250 hours for the employer over the past 12 months.
- The employer employs at least 50 people within 75 miles of the employee's workplace. (This requirement attempts to address situations in which an employer has multiple offices.)

The insurance-related rights under the Family and Medical Leave Act don't excuse employees from having to pay their portion of insurance premiums. Also, if an employee takes leave and never returns to work, the employer might be able to recoup any premiums it paid toward the person's coverage during the absence.

Continuation Coverage

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) gives people who would otherwise lose group coverage a chance to maintain their insurance. Circumstances under which COBRA rights can be triggered are as follows:

- An employee, the employee's spouse and the employee's children can keep their group coverage for 18 months if the employee leaves the employer. (This includes being laid off or leaving voluntarily, but it doesn't include cases in which someone is fired for gross negligence.)
- An employee, the employee's spouse and the employee's children can keep their group coverage for 18 months if the employee loses coverage because of a reduction in work hours.
- An employee, the employee's spouse and the employee's children can keep their group coverage for 29 months if the employee becomes disabled within 60 days of the events listed above.
- An employee's spouse can keep his or her group coverage for 36 months following a divorce or separation.
- An employee's spouse and children can keep their group coverage for 36 months following the employee's death.
- An employee's spouse and children can keep their group coverage for 36 months if the employee's coverage is cancelled because of Medicare eligibility.

- An employee's children can keep their group coverage for 36 months if they become too old for the plan or become ineligible for other reasons.

COBRA rights apply to group health insurance, group dental insurance and group vision insurance. They don't apply to group life insurance, group disability insurance or group long-term care insurance. Regardless of the timeframes mentioned above, coverage extended through COBRA can end prematurely if any of the following events occur:

- The employer ends the group plan.
- The insured stops paying premiums.
- The insured joins another group plan. (Someone who becomes eligible for another group plan can decline enrollment in it and continue COBRA benefits.)

Although COBRA allows eligible employers and their families to temporarily keep their insurance, those who exercise their COBRA rights will usually end up paying more than what they're accustomed to. An employer who pays for a portion of an employee's insurance is not required to do the same for people on COBRA. In fact, an individual can be charged the same amount as current employees, plus the amount normally paid by the employer, plus an extra 2 percent to cover administrative costs. If COBRA rights are extended because of disability, the extra 2 percent can be increased to 50 percent for months 19 through 29.

The aforementioned federal rules about COBRA are for group plans at businesses with more than 20 employees. Some states (including California, Illinois and several others) give similar rights to workers at smaller businesses.

Conclusion

Health insurance is an incredibly important topic for consumers and for the producers who help them. The next several years will feature several important changes in the way this insurance is offered. Undoubtedly, other major changes will occur in later years as society tries to deal with evolving health-related concerns. Keeping up with all the changes will be a challenge for anyone connected to the health insurance industry. Still, the task is likely to be less burdensome on professionals who have a firm grasp on the way coverage currently works.

CHAPTER 6: RECOVERING FROM SHUTDOWNS

Pretend for a moment that you are a business owner who receives a phone call earlier than usual one morning. The frantic voice on the other end of the line belongs to your office manager, who hurriedly informs you there is a fire ripping through your premises. As you arrive on site, you're relieved to learn no one was hurt. Your building, though, wasn't nearly as lucky. A bustling fire crew blocks you from inspecting the damage up close, but you could tell all the way from the road this wasn't just a small fire that relegated itself to your company's small kitchen. Based on what you see, getting your business back to where it was will require several months of rebuilding. Your property insurance will help pay for repairs to the building and for replacement of contents, but what about your income? How will you pay bills while your doors are closed? How will you continue to pay your workers? What you do while you wait for your post-fire income to catch up with your pre-fire income?

While business owners can't control the forces of nature or prevent all serious accidents from happening, they can cushion the financial blow of a possible shutdown by purchasing adequate "business interruption insurance." This kind of insurance typically reimburses policyholders for lost income and any expenses they incur during a break in normal business operations.

Kinds of Insurable Properties

Although business interruption insurance reimburses policyholders for lost income and not for property damage, coverage is still usually linked to an insured's physical place of business. In

order for an interruption at a particular business property to be covered, the property often must be named in the insurance contract.

The kinds of properties that can be named in a business interruption contract are seemingly unlimited. A policy might name one building, an entire industrial complex, a rental property or a single office within a bigger building. A single policy form can be made to cover interruptions at one location, or it can be made to cover multiple properties regardless of their proximity to one another.

Coverage is available to businesses renting their commercial space, as well as to those who own and operate their own buildings. Business tenants can insure themselves against interruptions that are caused by damage to their section of a building or to any public area that is used to access that part of a building.

Coverage also extends to interruptions caused by damage to personal property, such as important equipment or machinery. In these situations, the damaged personal property usually needs to have been within 100 feet of the named premises.

ISO forms permit owners of commercial properties to choose among three kinds of business interruption coverage. Those who operate a business out of their property but do not rent out space to tenants will probably opt for “non-rental value only” coverage. Owners who rent out space to tenants but do not operate their own business out of their property will probably opt for “rental value only” coverage. Owners who operate a business out of their property and rent out space to tenants will probably opt for “business income with rental value” coverage.

In the context of the three preceding terms, “rental value” means the amount of money commercial tenants pay to building owners, plus any operating expenses that are normally paid by tenants but would be incurred by owners during an interruption.

Tenants should keep in mind that they are probably not covered by their landlord’s business interruption insurance, assuming such coverage has even been purchased by the property owner.

Regardless of the location, business interruption insurance is a combination of “business income insurance” and coverage of assorted business expenses. Let’s look at the kinds of benefits that are commonly available.

Business Income Insurance

Business income insurance pays business owners the amount of money they would have earned if a covered peril had not forced them to suspend normal operations. It reimburses business owners for their lost net profits before taxes. Not surprisingly, since these insurance benefits are meant to replace lost taxable income, they must be declared as income for tax purposes.

Business income payouts are determined by the actual loss a business has suffered during an interruption. Essentially, benefits are calculated by estimating the profits that would have been produced without the interruption and by subtracting the company’s actual income from that hypothetical figure. Income sources not affected by the interruption, such as investment income, will also be deducted.

Continuing Expenses

If a business owner plans on ever reopening after an interruption, there will be several bills and other financial obligations to take care of in the meantime. Luckily for that business owner, business interruption insurance includes coverage of “continuing normal operating expenses.” Continuing normal operating expenses are those expenses the insured would face regardless of damage to named property. Examples of these expenses include rent, commercial mortgage

payments, commercial insurance premiums, utility bills and some taxes. If the insured wishes to lower premiums, the cost of heat, power and refrigeration can be excluded by means of an endorsement.

A normal continuing operating expense is not covered if the interruption has eliminated it. The cost of electricity, for example, is usually considered a normal continuing operating expense, but it would not be covered if business is interrupted by a blackout. After all, the business would not be using any power during that kind of interruption.

Payroll Coverage

Choosing to pay employees during a business interruption does more than create good will between labor and management. It helps the business owner by making it less likely that valuable workers will leave the company out of financial necessity.

By keeping their experienced employees on the payroll during a suspension of operations, businesses set themselves up for quicker recovery. Their reopening will not be delayed by a shortage of staff, and their productivity will not be hampered by newly hired personnel with inadequate training.

Insurers understand how employee continuity can reduce business interruption losses, and they make it a point to list payroll as a covered continuing expense. Along with wages and salaries, business interruption insurance pays for union dues, workers compensation premiums, some employee benefits and the business's required contributions to Social Security and Medicare under the Federal Insurance Contribution Act (FICA). Insurance benefits will be reduced appropriately if an employee is laid off during an interruption.

Extra Expenses

Most but not all forms of business interruption insurance reimburse businesses for the extra expenses they incur during a suspension of normal operations. In order to be covered by an insurer, these costs must, in some way, either reduce the duration of the interruption or help eliminate the interruption altogether.

Each insurer may have its own idea of what constitutes a legitimate extra expense. That said, the insured could probably make a strong case for coverage of the following expenses:

- The cost of renting a temporary place of business.
- The cost of equipping a temporary place of business with necessary machinery and supplies.
- The cost of making a temporary place of business physically presentable to the public and serviceable for business operations.
- Expedited shipping costs for necessary machinery and supplies.
- Moving costs.
- Overtime pay for employees who assist in the relocation process.

Unlike business income insurance, which usually features a three-day waiting period before coverage can begin, coverage of extra expenses starts at the very beginning of an interruption. Benefits can continue throughout the "period of restoration," which will be the subject of the next section.

In spite of the difference in waiting periods, insurance for extra expenses and coverage of business income are linked to each other in several ways. They are often both subject to the same benefit limit, which means any claim made for an extra expense is likely to reduce the amount of money that will be available for a business income claim.

There is no difference between the perils covered by the business income side of a policy and the perils covered by the extra-expense side of a policy. Both parts of the contract require that all claims relate to physical damage at a named property. Therefore, a business will not be covered for the extra expenses it incurs when it loses its lease and must relocate, and it will rarely be covered for the expenses it incurs during a strike.

Period of Restoration

Coverage of business income and expenses lasts until insured losses exceed the policy's dollar limit or until the end of the "period of restoration," whichever occurs sooner. In the case of business income, the period of restoration usually begins a few days after the start of an interruption. In the case of extra expenses, it starts at the same time as the interruption. In both cases, the period of restoration ends on the earlier of the following dates:

- The day when the damaged premises should have reasonably been repaired, rebuilt or restored.
- The day when the business has reopened at a different, permanent location.

A business interruption coverage form may also feature a chronological limit of liability that caps the period of restoration at a year. But since interrupted businesses rarely take longer than one year to resume normal operations, the cap is often not a factor at claim time and was often absent from insurance contracts prior to 9/11.

Limits to the Period of Restoration

While a business technically has the right to suspend operations and take all the time in the world to reopen, the insurance company will only pay benefits during what it believes to be a reasonable timeframe for repairs and rebuilding projects. This reasonable timeframe lasts only as long as it would take to make the property as serviceable as it was before the interruption. If business owners decide they want to expand their property as part of their rebuilding plans, lost business income and extra expenses will not be covered during the expansion.

Covered Perils and Benefit Triggers

For a loss to be covered, operations usually need to have been interrupted at a covered premises by a covered peril. We already know a "covered premises" can be seemingly any building, complex or office named in the insurance policy. But we have not yet specifically explained the perils that can lead to a valid claim.

The perils covered by business interruption insurance are usually identical to the perils in the business's commercial property insurance policy. This link between property insurance and business interruption insurance usually ensures that interruptions are covered when they are caused by fire, wind, lightning, burst pipes, vandalism and explosions, among other perils. In most cases, it also ensures that interruptions are not automatically covered when they are caused by a flood or an earthquake. An insurer might agree to cover those commonly excluded perils for an additional premium.

With a few possible exceptions, an interruption will only be covered if a peril has done physical damage to a business's premises. In practical terms, this means a restaurant would not be covered if it shuts down temporarily because of a food-poisoning scare. It also means a business would not be covered if it voluntarily closed its doors in anticipation of a covered peril (such as a windstorm) without sustaining any actual damage to its property.

Waiting Periods

Even if a covered peril has clearly caused an interruption, the insured will still have to endure a waiting period before coverage of business income and continuing expenses can apply. Typically, this waiting period ends when a business has been interrupted for 48 or 72 hours. Though not

mentioned in all policies, it is assumed that these hours must occur consecutively. So if a business closes, briefly reopens and then shuts down again, it will probably be subjected to a new waiting period. Waiting periods tend not to apply to coverage of extra expenses.

Excluded Perils

Perils commonly excluded from business interruption coverage include earthquakes, floods, radiation and acts of war. However, exceptions are possible. Insurers did not invoke the war exclusion after the events of 9/11, and the subsequent Terrorism Risk Insurance Act ensured that any business owner who was willing to pay a premium could be covered for similar kinds of attacks.

Loss-of-Market Exclusion

Claims may also be denied on the basis of a “loss-of-market exclusion.” In general terms, this exclusion prohibits coverage when demand for a business’s goods or services is reduced or becomes non-existent. For the purpose of an example, consider a business impacted by Hurricane Katrina. Suppose the business avoided significant damage during the hurricane but had to close when most its customers in New Orleans evacuated. Depending on the language of the business’s insurance policy, claims for this kind of interruption may be denied.

It is worth noting, however, that the loss-of-market exclusion can be one of the most ambiguous elements in a business interruption contract. To a court or even to an insurance company, the exclusion might not apply when the loss of market is caused by a covered peril.

Computer Interruptions

The basic business interruption form authored by the Insurance Services Office specifically excludes coverage of computer interruptions. In this context, a computer interruption means a break in operations that is caused by “destruction or corruption of electronic data, or any loss or damage to electronic data.”

Additional coverage is available that reimburses policyholders for income and expenses when a virus or some other pest is introduced into a network or computer system. The additional coverage excludes cases in which the damage has been inflicted by an employee or by any third party who has been entrusted with the computer system.

Power Outages and Service Interruptions

Power outages and service interruptions used to be commonly covered under commercial insurance policies, but that has changed as businesses have become more and more dependent upon their phones, fax machines, email accounts and Web sites. A basic business interruption contract offers no benefits when businesses are shut down by a failure at a utility company, a breakdown of an offsite transformer or deterioration of power lines.

Benefit Limits

No matter how well a business has documented its earnings, policyholders can never know for certain how much they might lose during a suspension of their operations. Even if they could arrive at a solid figure that represents the expected loss for a typical day, they would still lack the ability to conclusively determine how long an interruption might last. While there have been plenty of cases in which businesses reopened quickly and didn’t come close to using up all their insurance benefits, events like 9/11 and Hurricane Katrina brought about instances in which businesses were closed for a year or more and lacked enough coverage to survive.

In the next several sections, we will note one method that businesses and insurance professionals have used to quantify adequate coverage. We will also explore various clauses in business interruption contracts and go into detail about how dollar limits are impacted by them at claim time.

Probable Maximum Loss

Though buyers may choose to over-insure or underinsure themselves for various reasons, they are probably best served by a dollar limit that is at least somewhat comparable to their “probable maximum loss.” Often, this number is calculated by determining a business’s probable income for a 12-month period and then estimating the length of an interruption in a worst-case scenario.

Suppose, for example, that a business expects to bring in \$12 million over the next year and believes that in a worst-case scenario (usually thought of as the total destruction of the business premises), it will need no more than nine months to reopen. In this case, the probable maximum loss can be calculated by multiplying the expected yearly income by the expected length of the interruption. By multiplying \$12 million by 0.75 years (or nine months), we arrive at a probable maximum loss of \$9 million.

To arrive at a suitable dollar limit for business interruption insurance, the business must then develop an estimate of probable extra expenses and add that number to the probable maximum loss. So, if the aforementioned business expects to incur up to \$1 million in extra expenses during its nine-month interruption and wants losses to be covered in full, the dollar limit for its business interruption insurance should probably be at least somewhere around \$10 million.

We must state, however, that all of these calculations have been simplified. In a real-life situation that requires more than a ballpark figure, readers are strongly advised to use a more exact method of calculating probable maximum loss. Many insurers have developed a multi-page “business interruption worksheet” in order to help their producers determine probable maximum losses.

Coinurance Clauses

Pretend a business purchased \$50,000 of business interruption insurance and has lost \$45,000 during a suspension of operations. Waiting periods aside, that means the business ought to be reimbursed for the entire loss, right? Well, maybe. Then again, maybe not. The answer will depend on whether the business’s policy contains a “coinsurance clause” and whether the business bought enough insurance to overcome the impact of this clause.

The coinsurance clause can make a business responsible for a portion of any business interruption loss, even when the loss is far smaller than the policy’s dollar limit. The clause exists to protect the insurance company in cases where a business has underreported or underestimated its expected “net income” (net profit or loss before taxes) and operating expenses. It ensures that the insurance company will be paid fairly for absorbing risks and that a short interruption will not come close to exceeding the policy’s dollar limit.

The coinsurance clause states that the insurer will not honor a claim in its entirety if the policy’s dollar limit is less than the policy’s coinsurance percentage, multiplied by the business’s expected net income and operating expenses for the 12 months following the policy’s inception. When the insurance is renewed, its anniversary date will serve as the beginning of a new 12-month period.

The applicability of the coinsurance clause will be determined at the time of a loss. If, for example, insurance is purchased in January and an interruption occurs at the end of September, the insurance company will look at the business’s actual net income and operating expenses from January through September and will estimate the net income and operating expenses that would have been expected for the rest of the year. The hard numbers and the hypothetical numbers are then added together and multiplied by the coinsurance amount, which can be as low as 50 percent and as high as 125 percent. The result is then compared to the policy’s dollar limit.

Coinsurance Examples

The coinsurance clause and its corresponding formulas are probably best understood when they are accompanied by some concrete numbers. With this in mind, let's look at three examples.

Company A chose to purchase business interruption insurance with a \$100,000 limit and a 50 percent coinsurance requirement. After a loss, it was determined that the company's net income and operating expenses for the year following the policy's inception was going to equal \$200,000. Since the policy's dollar limit (\$100,000) was equal to 50 percent of expected net income and operating expenses ($\$200,000 \times 50\% = \$100,000$), the coinsurance requirement was met. Therefore, after any applicable waiting period, Company A was entitled to full coverage up to the policy's dollar limit.

Company B purchased business interruption insurance with a \$100,000 limit and an 80 percent coinsurance requirement. After a loss, the company's expected net income and operating expenses for the year following the policy's inception was going to equal \$100,000. Since the policy's dollar limit (\$100,000) was greater than 80 percent of net income and operating expenses ($\$100,000 \times 80\% = \$80,000$), the coinsurance requirement was met. Therefore, after any applicable waiting period, Company B was entitled to full coverage up to the dollar limit.

Company C bought business interruption insurance with a \$200,000 limit and a 50 percent coinsurance requirement. After a loss, the company's expected net income and operating expenses for the year following the policy's inception was going to equal \$600,000. Since the policy's dollar limit (\$200,000) did not equal or exceed 50 percent of the expected net income and operating expenses ($\$600,000 \times 50\% = \$300,000$), the coinsurance requirement was not met. Therefore, Company C was only covered for a portion of all its claims.

The following two tables list the minimum amount of coverage that a business would need to purchase if it wanted to comply with an insurer's coinsurance requirement. The first table assumes a 50 percent coinsurance requirement. The second one assumes an 80 percent requirement.

<i>With 50% Coinsurance Requirement</i>	
<i>Expected Net Income and Operating Expenses</i>	<i>Minimum Coverage Needed</i>
\$100,000	\$50,000
\$200,000	\$100,000
\$300,000	\$150,000
\$400,000	\$200,000
\$500,000	\$250,000

<i>With 80% Coinsurance Requirement</i>	
<i>Expected Net Income and Operating Expenses</i>	<i>Minimum Coverage Needed</i>
\$100,000	\$80,000
\$200,000	\$160,000
\$300,000	\$240,000

\$400,000	\$320,000
\$500,000	\$400,000

Figuring the Covered Portion of a Claim

When a business has not satisfied its coinsurance requirement, an insurance professional can look at the coinsurance clause and—using the appropriate numbers—determine the amount the insurer will actually pay to the policyholder.

To determine the covered portion of a loss, we must first determine the size, in dollars, of the coinsurance requirement. As shown in the two preceding tables, this is accomplished by multiplying the coinsurance percentage by the business's expected net income and operating expenses for the year following the policy's inception. For the aforementioned Company C, we would multiply 50 percent by \$600,000 and get a result of \$300,000.

In the next step, we need to divide the policy's dollar limit by the size of the coinsurance requirement in dollars. For Company C, we would divide \$200,000 by \$300,000 and get a result of 0.66. That means a business like Company C would be covered for no more than 66 percent of each business interruption loss.

Now all we have to do is multiply our answer from the previous step by the actual loss. If a business like Company C were to lose \$30,000 due to an interruption, the insurer would multiply \$30,000 by 66 percent and get a result of \$20,000. This result would be the amount that the business would receive from the insurance company. The remaining \$10,000 would go down as an uninsured loss.

If company C were to lose \$100,000 due to an interruption, we would generally follow the same steps. However, instead of multiplying 66 percent by \$30,000, we would multiply 66 percent by \$100,000. The result (\$66,000) would be covered by the insurance company, and the rest would be considered an uninsured loss.

No matter the actual size of a loss and a policy's actual coinsurance requirement, the preceding steps can be summarized in the form of the following equation:

- Covered Portion of Loss = [Policy Limit ÷ (Coinsurance Percentage × Expected Net Income and Operating Expenses)] × Actual Loss

Conclusion

Business interruptions can create major problems for owners and their employees. Along with other forms of risk management, business interruption insurance may minimize some of those problems. While not as popular or as widely understood as coverage for tangible property, it is a product that can be useful to all kinds of companies, regardless of their size or specialty.

CHAPTER 7: GROUP LIFE INSURANCE

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

In some cases, having a group life insurance plan might simply seem like the decent thing to do. Workers are likely to mention their spouses, children or other family members to their bosses at

some point and may even invite members of their household to company functions. If management gets to know these family members, the employer may develop deep sympathy for them after an employee's death. The feeling can be even more intense if the company knows that the family was living paycheck to paycheck and relied on the deceased to pay the bills. The money made possible through group life insurance is rarely enough to eliminate anyone's long-term financial concerns, but it's usually capable of covering immediate expenses while survivors take a deep breath. It's a great way to express appreciation for the employee's loyalty.

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

Group Plan Basics

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

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

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

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

Group Underwriting and Premiums

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

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

Plans requiring premium contributions from participants sometimes charge employees more as they age, but the individual's personal health history will either be irrelevant or a minimal factor. The minimal or lack of emphasis on a participant's own medical history is made possible by the

concept of “pooling.” In pooling, risks are shared among all group members in a way that is meant to keep premiums relatively stable for everyone. The bigger the pool of participants, the less likely it will be that a particular employee’s health status will impact everyone else’s costs.

At large employers, covered employees might represent the entire pool that will be used to set premiums. Smaller companies, on the other hand, are often added to a pool of several similarly sized businesses and charged an amount based on the characteristics of the larger pool. Depending on the insurer’s preference and state law, a group might be subjected to only one or a combination of these pooling methods. For example, a small employer might be pooled together with similar businesses for the purpose of determining an initial price and then have the price lowered or increased based on the particular employer’s loss history.

Terms and Renewals

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

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

Eligibility and Enrollment

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

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

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

Benefits provided under a group life plan will occasionally be different for employees beyond a certain age or for high-ranking executives. For instance, death benefits might decrease once a

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

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

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

Common Death Benefits

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

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

Analyzing Needs

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

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

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

- How much money will my dependents need in order to maintain their current standard of living and keep up with inflation?
- How much money will my children need for school tuition and basic necessities?

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

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

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

Is Group Coverage the Best Deal?

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

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

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

Portability and Conversion

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

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

employee with portable coverage will be able to keep the insurance regardless of his or her health.

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

Unlike term life insurance, permanent life insurance is designed to keep somebody insured for the rest of their lifetime. It also has an investment feature that gives the policy a "cash value." A policy's cash value grows over time and can be used in a number of ways. The policyholder can borrow money against it, use it to offset future premiums or even receive a portion of it in a lump sum if coverage is ever cancelled. In many cases, term life insurance that's converted to permanent coverage will have level premiums that are based on the person's age at the point of conversion.

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

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

Tax Issues for Group Life Insurance

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

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

Taxation of Death Benefits

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

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

the received installments. IRS formulas determine how much of each installment will count as income.

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

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

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

Estate Taxes

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

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

Since they usually can pick their own beneficiaries, people who die with group life insurance will have the insurance’s death benefits included as part of their estate. However, most estates aren’t worth enough for the estate tax to apply to them. The 2012 exemption for estates worth less than \$5 million means the tax is usually only a concern for people with very valuable assets. One group of employees who are often more susceptible to estate taxes are “key employees.” You’ll read more about these highly compensated individuals in a later section.

IRS Rules for Group Term Life Plans

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

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

According to IRS rules, benefits that would otherwise be considered imputed income don’t apply to group term life insurance if the death benefit doesn’t exceed \$50,000. This exemption is

intended mainly for groups with at least 10 people in them, but smaller groups are eligible if they follow certain guidelines.

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

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

Voluntary Group Plans and the \$50,000 Rule

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

In order to avoid taxation of imputed income in a voluntary group plan for term life insurance, a number of rules must be obeyed. According to various tax advisors, some of the more important rules and recommendations to follow include the following:

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

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

Key Employees and the \$50,000 Rule

The \$50,000 exemption for imputed income and group term life insurance doesn't extend to key employees when a plan favors them on a discriminatory basis. According to rules from 2012 by the IRS, a key employee is any of the following individuals:

- An officer of the employer whose annual pay exceeds \$165,000.
- An owner of at least 5 percent of the business.
- An owner of at least 1 percent of the business whose annual pay exceeds \$150,000.

In order to preserve the \$50,000 exemption for key employees, the group term life plan must be non-discriminatory toward other employees in regard to participation and benefits. To be non-

discriminatory in regard to participation, a group term life insurance plan must satisfy at least one of the following requirements:

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

To be non-discriminatory in regard to benefits, the plan must offer the same benefits to key employees and other participants. This rule doesn't prevent a plan from basing death benefits on a multiple of a participant's income. In other words, a plan that offers a death benefit equal to two years of salary to someone making \$160,000 and someone making \$50,000 isn't necessarily a discriminatory plan.

Other rules apply to cafeteria plans and insurance for shareholders at S corporations. They are beyond the scope of this course.

Taxation of Permanent Life Insurance

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

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

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

Conclusion

Group life insurance can be a valuable employee benefit, but it shouldn't be offered or accepted without some careful planning. While you encourage an employer to implement a plan, you'll want to make sure the right tax questions are asked and that administrative requirements are considered. While marketing a plan to eligible employees, you'll want to stress the ways in which the death benefit might fit into their financial goals. By knowing what's available and analyzing the group's situation, you should be able to help people find attractive coverage at an affordable cost.

CHAPTER 8: COVERING VEHICLES

The need for auto insurance should be examined carefully by every business. This basic yet important advice applies to commercial entities that have their own vehicles and even to businesses that don't have any autos in their name.

Many companies decide to purchase their own cars for tax reasons, as employee perks or as a way of simplifying matters for workers who are constantly on the road. In these cases, the need for insurance will be absolute. In order to be operated on public roads, company cars will need to at least be covered by the minimum amount of liability insurance set by state law.

Businesses that don't own any vehicles might not need auto insurance as a matter of law, but they should at least consider the amount of auto-related risks they are willing to absorb. If an employee is sent out on a company errand in his own car and causes an accident, there is at least a chance that his employer will be sued. The employee's personal auto insurance will usually cover him in this scenario, but determining whether there is any or enough coverage under that same policy for the employer can be tricky.

Unfortunately for business owners, auto risks are almost never covered by other kinds of commercial insurance. The standard commercial general liability policy has an auto exclusion that usually prevents it from paying damages to victims when an accident involves a vehicle that's owned, hired, borrowed or leased by a business. Meanwhile, the typical commercial property policy won't cover damage to a policyholder's own vehicle. If a business wants to prepare itself financially for losses caused by auto accidents, its options are generally limited to buying commercial auto insurance or following a self-insurance strategy.

The most popular variety of commercial auto insurance is based on a document called the "Business Auto Coverage Form." The document was created in the late 1970s by Insurance Services Office, Inc. and has been revised several times since then. Policies based on that document are known as "Business Auto Policies," BAPs" or "BACs." For simplicity's sake, we'll use the term "BAP" from this point forward.

Because BAPs are so common and applicable to most businesses, we will use them as the main reference point in our explanation of commercial auto insurance. Still, it's important to realize that there tends to be far less standardization in commercial insurance than in personal lines. A policy issued by one carrier won't necessarily match one issued by a competitor in every important way. There may also be cases in which a standard BAP might be inappropriate or unobtainable for a particular entity. For instance, if a business commonly carries other people's goods on its vehicles or transports people for a fee, additional insurance options are worth exploring.

Wherever possible and appropriate, we'll also draw your attention to the similarities and differences between auto insurance for individuals and auto insurance for businesses. Indeed, there's some overlap that allows certain parties to remain insured when business vehicles are driven for personal use or vice versa. But whether your customers are mainly businesses that have their own cars or individuals who occasionally use their family's minivan for work, it's important to know where the overlap begins and ends.

Covered Vehicles

Commercial auto insurance is technically capable of covering any vehicle designed for use on public roads. However, the specific vehicles insured under a BAP will be indicated by numbers checked on the policy's declarations page. There are nine different numbers for nine different groups of vehicles. The significance of each number is summarized in the list below:

- **Symbol 1:** When this symbol is chosen, coverage applies to any vehicle designed for use on public roads, regardless of who owns it. For example, if it's used with regard to liability coverage, the business will be insured if it's sued in connection with practically any auto accident. The only things that would prevent the business from being covered would be either a specific exclusion written into a policy or a previous claim that exhausted the policy's dollar limits. It represents the broadest form of coverage.
- **Symbol 2:** When this symbol is chosen, coverage only applies to autos owned by the "named insured." (In most cases, the named insured is the business.) Unless special arrangements are made, it won't provide coverage for vehicles owned by someone else, such as an employee. It also won't make coverage applicable to vehicles that the business leases or borrows.

- **Symbol 3:** When this symbol is chosen, coverage only applies to private passenger vehicles owned by the named insured. It won't provide coverage for other people's private passenger vehicles, and it won't cover large trucks. It might only provide coverage for trailers under certain circumstances.
- **Symbol 4:** When this symbol is chosen, coverage only applies to vehicles that are owned by the named insured and aren't private passenger vehicles. In other words, it can make insurance applicable to a business's large trucks but not its cars.
- **Symbol 5:** When this symbol is chosen, coverage only applies to vehicles that are registered or stored in states where no-fault auto insurance is mandatory.
- **Symbol 6:** When this symbol is chosen, coverage only applies to vehicles that are registered or stored in states where uninsured motorist coverage is mandatory. You'll read more about uninsured motorist coverage in a later portion of this chapter.
- **Symbol 7:** When this symbol is chosen, coverage only applies to the specific, individual vehicles listed on the policy's declarations page. It's ideal for businesses that own or have access to multiple vehicles but only want to insure certain ones.
- **Symbol 8:** When this symbol is chosen, coverage only applies to vehicles that are leased, borrowed, rented or hired by the named insured. It doesn't provide coverage for vehicles owned by employees or by owners of the business or their families.
- **Symbol 9:** When this symbol is chosen, coverage only applies to vehicles that aren't owned, leased, borrowed, rented or hired by the named insured. For example, it might protect the employer if a worker causes an accident in her own car, but it won't cover the employer if that same worker causes an accident in a company car.

A business can request different symbols for each main kind of coverage. For instance, it may want Symbol 1 in regard to liability coverage but only Symbol 7 for property damage to its own vehicles. It's also possible to use multiple symbols at once. So if a business knows it will be using its own vehicles and an employee's vehicle but will never rent, lease, borrow or hire any others, it might want liability protection with symbols 2 and 9 selected.

Not every insurer will let businesses choose from all nine symbols under every circumstance. A carrier that's willing to offer Symbol 1 coverage for liability might not make Symbol 1 an option for covering damage to a business's own vehicles. It's also important to read coverage forms carefully instead of immediately assuming that the symbols correspond with the descriptions listed here. Particularly when not all nine symbols are available, an insurer might renumber the symbols on its forms. For example, if an insurer is not interested in offering coverage for all autos to anyone, it might designate Symbol 1 to mean something else, such as coverage only for owned vehicles.

Obviously, symbols should be chosen and indicated with care. If the wrong symbol is marked—or if no symbol is indicated at all—the business could have a significant coverage gap.

Who's an Insured?

In the previous section, we mentioned the term "named insured." The named insured is the main party who is protected by the commercial auto insurance policy. Unless the policy contains an exception, no one else will be covered for liability if an auto accident causes property damage or bodily injury. And unless the appropriate symbol is chosen (such as symbols 1, 8 or 9), no one else's vehicles will be covered for repairs.

In the vast majority of cases, the named insured in a BAP is the business. Most BAPs will also cover people besides the named insured, but only when certain conditions have been met.

Coverage under a BAP will usually extend to anyone driving a covered auto with the named insured's permission. In a hypothetical example, let's assume Jane is given access to a car that's

owned and insured by Real Good Paper Company. Jane causes an accident while driving Real Good Paper Company's car. Since Jane had permission to drive the car, she will likely be covered for liability along with Real Good Paper Company if an accident victim ever sues. This would likely be true even if Jane doesn't have personal auto insurance of her own.

But as was mentioned in the previous section, the vehicle needs to have been properly listed on the policy's declaration page, either by name or by symbol. In other words, if Real Good Paper Company chose a symbol that doesn't include rental cars, Jane won't be insured under Real Good Paper Company's policy if she rents a car for business.

Who's Not an Insured?

Even when a business allows someone to use one of its vehicles, a few additional exceptions can stop coverage from extending to that individual. Perhaps most significantly, insurance won't apply to employees or business owners when they drive their personally owned vehicles. Suppose Gary is sent by Real Good Paper Company on business trips and uses his own vehicle. If Gary causes an accident on one of these trips and is held personally liable, the BAP usually won't cover him. He will probably have to seek protection under his personal auto policy.

There's also no protection for the owner of a vehicle that's borrowed, rented or hired by the named insured. In other words, if Real Good Paper Company decides to rent a van to take several employees to a seminar, the owner of the van might not be able to share coverage with Real Good Paper Company after an accident.

Finally, even when permission is granted, no one operating a covered vehicle will be covered if they're in the business of parking or servicing it. If Real Good Paper Company takes one of its vehicles to a mechanic who hits a pedestrian during a test drive, the mechanic cannot rely on Real Good Paper Company's insurance for protection.

Realize, though, that the exclusions we've just mentioned don't stop the named insured from being covered by its own policy. A business that's sued after an employee has an accident in his own car can still be covered for liability even when its employee can't. And a business that is sued after an accident in a rented vehicle can still be covered even when its owner can't. (This assumes, of course, that the appropriate symbol was used on the declarations page.)

To better understand these points, think about some of the examples you've just read about. In the example in which Gary caused an accident in his own vehicle, Real Good Paper Company would still have coverage for itself (but not for Gary) if Symbol 1 or Symbol 9 was selected. In the example in which Real Good Paper Company rented a van to take employees to a seminar, Real Good Paper Company would still have coverage for itself (but not the owner of the van) if Symbol 1 or Symbol 8 was selected.

If the business believes the requirements for being an insured party under the BAP are too narrow, changes can usually be approved. An employer may decide, for example, that it wants to insure a worker while he's driving his own car for business. Similarly, companies leasing vehicles to other businesses might demand that they be given additional protection under their customers' insurance. Of course, these changes and additions should be addressed as soon as possible and before an accident occurs.

Liability Coverage

While BAPs and personal auto policies aren't intended for the same audience or the same vehicles, the liability protection they provide to drivers is very similar. Both kinds of insurance can be used to manage liability for bodily injury or damage to someone else's property. They also help potentially liable parties pay to defend themselves.

Bodily Injury and Property Damage Liability

Bodily injury pertains to practically any kind of physical harm inflicted on another person as a result of an auto accident. It can mean an illness, temporary or permanent damage to a particular part of the body or even death. Because the severity and cost of bodily injury can be very high, having enough insurance for this risk should be one of a business's top priorities.

Property damage losses have a reputation for being less severe than losses for bodily injury, but it's easy to picture them happening at a higher rate. Even if an accident leaves a victim physically unscathed, the at-fault driver will usually still be legally responsible for compensating the other person for repairs. Property damage can also result when a driver hits something other than a vehicle, such as a building, an animal or a tree.

Many businesses opt not to purchase insurance for harm to their own vehicles, but forgoing liability insurance for bodily injury and property damage isn't an option. Vehicles must be covered by at least the minimum amount of liability insurance set by state law. States might have one minimum requirement for bodily injury and another minimum limit for property damage. There may also be mandatory minimum amounts of insurance per accident or per victim.

Because mandatory minimums differ among states, coverage automatically adjusts when a vehicle that's registered or normally garaged in one state is being operated in another state. Despite the minimums, businesses are often wise to purchase additional liability coverage. Questions worth asking when choosing a dollar limit for liability include:

- How much will extra coverage cost?
- Are we financially strong enough to withstand a major accident?
- Do we have an ethical responsibility to ensure that accident victims receive appropriate compensation?

Defense Costs

If legal action is taken or threatened against an insured party, the liability portion of the BAP will cover defense costs. The insurer's duty to defend is generally greater than its duty to pay for damages. Even if there's only a small possibility that an accident is covered by the policy, the insurance company might still need to provide a defense.

The cost of defending the insured party won't impact the amount of money available for bodily injury or property damage. However, the carrier is allowed to stop defending the insured once the policy's dollar limits have been met through any judgments or settlements. For example, imagine a policy covers a company for \$200,000 per accident in the event of bodily injury. One of the company's covered employees caused an accident, and the victim claimed to suffer damage to her back and leg. The company's insurer settled with the victim in regard to her back injury for \$200,000, but the parties couldn't agree on an amount for the foot problem. Since the insurer already paid out the full \$200,000 limit for bodily injury, it won't be obligated to defend the business anymore if the victim sues.

Liability Exclusions

No matter the people or vehicles involved, some injuries and damages won't be covered by the BAP. Many of the exclusions mirror those found in personal auto policies for individuals. Some of the most important exclusions are listed here, and a few will be given more attention in later sections:

- There's no coverage for punitive damages. (Punitive damages are extra court penalties that are designed to punish people for especially egregious behavior. Covering these damages is usually prohibited by law.)

- There's no coverage for intentionally injuring someone or damaging their property on purpose.
- There's no coverage for property damage or bodily injury caused by pollution. (A possible exception exists when an auto accident releases a pollutant that wasn't on the business's premises and wasn't in a vehicle.)
- There's generally no coverage for damage to property in an insured party's care, custody or control. (If a business transports other people's property in its vehicles, it may want to purchase inland marine insurance.)
- There's no coverage if a vehicle is being used as part of an organized racing event or stunt.

Property Damage

If damage to a covered vehicle can't be blamed on someone else, repairs might be covered under the BAP's property damage section. Unlike liability coverage, property damage coverage is usually not required by law. Businesses might only need to purchase it if they rent or lease a vehicle or purchase one with borrowed money. Otherwise, they can opt to pay for damage out of their own pocket.

Another difference between coverage for liability and coverage for property damage is that the latter usually has a "deductible." The deductible is the amount of each loss the insured must pay before the insurance company will start paying. Depending on the policy, there might be one deductible per accident, per vehicle or per policy period.

By default, property damage coverage for covered autos is based on a vehicle's "actual cash value." A vehicle's actual cash value is its value immediately prior to an accident, including depreciation. Vehicles tend to depreciate almost immediately after they're purchased, so even a driver whose car is totaled in an accident is unlikely to receive enough insurance money for a brand-new, identical car. Businesses that want to insure their vehicles for more than actual cash value will need to make a special request and pay a higher premium.

Collision, Comprehensive and Other Coverages

Businesses that want to insure vehicles for property damage will usually choose "collision coverage," "comprehensive coverage" or both. These two kinds of coverage are also the main options in the market for personal auto insurance.

Collision coverage pays to repair or replace a driver's vehicle if he or she hits another object. That object is usually another vehicle, but it might be a tree, a road sign, a building or something else. Collision coverage is also for situations in which a vehicle is turned on its side.

Comprehensive coverage pays to repair or replace a vehicle when damage is caused by something other than a collision. It can also compensate the owner if a vehicle is stolen. By purchasing both collision and comprehensive coverage, an insured can be covered for practically any kind of physical damage that isn't specifically excluded in the policy.

A very basic third option might also be available to some applicants. This coverage, which goes by different names, only insures businesses against the perils specifically listed in the policy. Under this option, an insured can be covered for the following perils:

- Fire.
- Lightning.
- Explosion.
- Theft.
- Windstorm.
- Hail.

- Earthquake.
- Flood.
- Mischief or vandalism.
- Sinking, burning collision or derailment of any object transporting the vehicle.

Property Damage Exclusions

Regardless of which option the business ultimately chooses, some kinds of damage typically won't be covered by a BAP. Like the liability exclusions, many of these will be familiar to people who sell personal auto insurance. Some common exclusions are as follows:

- There's no coverage for losses caused by war or terrorist attacks.
- There's no coverage for damage from wear and tear.
- There's no coverage for damage from nuclear accidents.
- There's no coverage for lost or damaged media used in the vehicle for enjoyment (such as cassettes or compact discs).

Uninsured Motorists Coverage

Whether we like it or not, there will always be people who believe the law doesn't apply to them and who will drive without liability insurance. So what can people do if an uninsured driver hits one of their vehicles? They could, of course, sue the person. But that would probably involve finding a lawyer and rearranging their lives around court dates and other hassles. And even if they take legal action, an accident victim might discover that the at-fault driver lacks enough assets to pay for damages.

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

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

- A covered auto is hit by someone who has no insurance.
- A covered auto is hit by someone who has less insurance than the law requires.
- A covered auto is hit by a hit-and-run driver.
- A covered auto is hit by someone whose insurer becomes insolvent.

Uninsured motorists coverage is mandatory in some parts of the country, and most states at least force insurers to offer it. Historically, those mandates have been restricted to bodily injury coverage, but coverage for property damage isn't entirely uncommon.

Uninsured motorists coverage is often beneficial to drivers of personal autos, but questions have arisen regarding its role in commercial lines. For instance, since the coverage is mainly designed to compensate people for bodily injury, logic suggests that it insures real, live people. Yet ambiguous language in some policies (and inconsistent rulings among some courts) have sometimes suggested that uninsured motorist coverage only insures the business and not an actual person.

Even if a carrier or a court makes it clear that the coverage can be used to insure real people (such as employees), many companies decide not to purchase it. These businesses often make the assumption that anyone who is injured in a covered auto will be an employee, who will have his or her medical expenses covered by workers compensation. This line of reasoning, while generally sound, might still create an insurance gap for the occasional passenger who doesn't work for the business. For instance, a covered auto might be involved in an accident while an independent contractor is driving it or while a customer is in the passenger seat.

Renting Vehicles

Coverage for rented vehicles can be obtained by choosing Symbol 1 or Symbol 8. In most cases, the coverage extends to the business and to the driver. However, if a vehicle is rented by an employee and not by the business, the employee might not be protected by the BAP.

Employees who rent their own vehicles (for business or pleasure) should already have coverage under their personal auto policy. If they don't have their own car and consequently don't have a personal auto policy, vehicles they rent can be covered by attaching a "drive other car" endorsement to the BAP. You'll read more about this endorsement later.

If a vehicle that's covered for liability is stolen, broken down or undergoing repairs, liability coverage is automatically extended to a borrowed temporary replacement. This protection applies regardless of which symbol appears on the declarations page.

Personal Use

Even if a vehicle is driven primarily for business, people with access to company vehicles are likely to also drive them for personal use. Assuming the appropriate symbol is marked on the declarations page, a business will remain covered for liability even if one of its owned or rented vehicles is being used for non-business purposes. But liability protection for the person driving the vehicle doesn't always exist.

In order for a driver to drive a company vehicle for personal use and still be covered for liability under the BAP, permission must have been granted by the business. In other words, if a company makes it clear that one of its cars is only to be used for conducting business, drivers won't be covered while driving to and from personal errands. Similarly, even if a business allows vehicles to be driven for personal use by an employee, permission might not extend to the employee's spouse, other family members or friends. If anyone besides the permitted driver uses a business's vehicle, the insurance company might not have to cover anyone for liability except the business.

Permission to drive a company-owned or company-borrowed car for personal use won't give drivers any protection when they use other vehicles. For example, even a vehicle rented on a personal credit card for use on a business trip can be a problem. In this scenario, the driver's personal auto policy would be relied on for coverage.

If a business wants to be generous, it can protect employees using non-business vehicles by specifically having them as named insureds in the policy. A more likely solution for workers who don't have their own auto insurance is "drive other car" (DOC) coverage. You'll read more about this endorsement to the BAP shortly.

Employees' Own Vehicles

Based on what you've already read, you should understand that businesses can be covered under the BAP for their own liability when an employee causes an accident in his or her own car. You should also understand that the employee is usually covered for liability when he or she causes an accident in a company car. But what about liability and property damage coverage for employees when they're driving their own vehicles?

Many workers are asked to perform short errands for their employer in their own car. Those workers might assume that if an accident occurs, their employer will step in and pay for any damage. In most cases, this assumption is incorrect.

Although the BAP covers employees for liability while they drive company cars, workers are excluded while operating their own vehicles. Liability protection after an auto accident will usually need to come from their personal auto policy.

Property damage to an employee's vehicle will also usually only be covered by personal auto insurance. Many insurers that let businesses insure all vehicles for liability (by selecting Symbol 1) don't let them do the same in regard to property damage.

In cases where there's some overlap in coverage between an employee's personal policy and an employer's BAP, claims will be made first against the vehicle owner's insurance. (This includes any liability claims against the business.) If the limits of the owner's policy have been exhausted, the employer's BAP will be next in line. Again, the BAP often provides excess liability protection for the employer but rarely any excess coverage for the employee.

A handful of businesses choose to add an endorsement to their policy that specifically names employees as insureds. This strategy eliminates liability and property exclusions for named employees who have accidents in their own vehicles, but it often inadvertently gives employees more coverage (and more control over the insurance) than the employer intended. Due to the costs and complications associated with that option, many employers prefer alternative strategies. One option is to provide money to employed drivers so they can purchase better personal auto insurance.

Drive Other Car Coverage

Some business owners and employees rely on company cars and don't actually own a vehicle. Not owning a vehicle usually means they don't have a personal auto insurance policy either. This lack of insurance can create problems if they're ever involved in an accident with a car they rent or borrow for personal use.

Although the owners of rented or borrowed vehicles are likely to have some auto coverage that the otherwise uninsured driver can rely on, there are no guarantees. The owner of the rented or borrowed vehicle might only have a minimum amount of liability insurance or perhaps no insurance at all. In either of those cases, the driver using the vehicle could have a major liability exposure.

Businesses that already furnish company cars to people can help alleviate this problem by purchasing "drive other car" coverage. Drive other car coverage is added to the BAP for an additional cost and is designed for drivers who don't normally use any other vehicles and don't have personal auto insurance. It covers workers who are held liable for an accident involving practically any vehicle (other than one they own), regardless of whether they're driving for business reasons or personal ones.

A drive other car endorsement covers the individual specifically named in the policy and also extends to the person's cohabitating spouse. Unless requested, it won't cover non-spouses who live with the named driver, and it won't cover a spouse who lives at another location. The endorsement is usually purchased solely for the purpose of covering the driver for liability, but uninsured motorist, physical damage and other coverages may also be available.

Employee Injuries

A BAP usually won't help pay for bodily injuries to workers who are hurt while doing their jobs. If an injured worker is considered an employee, benefits should be available through the business's workers compensation insurance. If the injured worker is considered an independent contractor, coverage might exist under employers liability insurance. The BAP might make an exception if the injured worker is a domestic employee (such as a housekeeper) who is not required to be covered by workers compensation. The rules for covering employees for workers compensation differ from state to state.

Moving Property to and From Vehicles

Businesses that transport goods need to be aware of where coverage under a BAP starts and stops. Essentially, the BAP provides no coverage when property being transported or delivered is damaged. These businesses should also be aware that it only provides a limited amount of liability coverage if other property or a person is injured while a delivery is underway.

Liability coverage exists under the BAP while property is being moved to a covered auto and while it is being moved from the auto to the point of delivery. There is no liability coverage for accidents that occur after property has been delivered.

For the sake of an example, think of a furniture store that's delivering a sofa to a customer. If the store's employees accidentally knock down an antique vase while carrying the sofa into the living room, the BAP should respond with coverage. But if one of the employees knocks the vase down with her elbow after placing the couch in its intended resting place, the BAP is the wrong place to look for protection.

Liability for accidents that occur after property has been delivered is supposed to be covered by commercial general liability (CGL) insurance, not commercial auto insurance. In fact, many experts advise businesses to buy their BAP and CGL policies from the same carrier. Following this advice might eliminate some confusion when accidents involving pickups or deliveries take place.

Although the BAP will cover businesses when they damage other property while transporting goods, damage to the transported goods will be excluded. For an example, think of furniture delivery again. If a delivery person brings in an end table and accidentally knocks one side against a wall, damage to the table won't be covered. In this scenario, the table was still in the delivery person's care, custody or control. Property in the business's care, custody or control should be covered by some form of inland marine insurance or other commercial property insurance.

Business Use and the Personal Auto Policy

As a general rule, vehicles owned by individuals are meant to be insured through personal auto insurance. Vehicles owned by business entities are meant to be insured through commercial auto insurance.

For the sake of convenience and costs, small-business owners occasionally prefer to use their personal auto policy to cover company-owned vehicles. This strategy might be allowed under limited circumstances by some carriers and might result in lower premiums. However, it can create many complications at claim time and can expose employers and employees to major coverage gaps. Some of the drawbacks of insuring a company-owned vehicle through a personal auto policy (if allowed by the insurer) are listed below:

- Liability limits for personal auto policies tend to be much lower than limits under a BAP. This can create a problem if an accident victim sues the business and the at-fault driver.
- Personal auto insurance typically excludes accidents involving vehicles that are regularly available to the insured but aren't specifically listed on the declarations page. This can create problems if a company vehicle is insured by a boss's personal policy but is used regularly by employees.

- Personal auto policies often won't respond to claims involving vehicles that carry people for a fee. This can create problems for cab companies and limousine services.
- Personal auto policies sometimes don't cover people or businesses at all when a large truck is used for commercial purposes. This can create problems for movers, trucking companies and other businesses that transport large items via public roads.
- Although personally owned cars and vans can be insured through a personal auto policy and used for business purposes, the insured might need to disclose the business use to the insurance company. If drivers regularly use a personally owned vehicle for business and don't alert their insurer, they might have problems getting their claims paid.

Conclusion

Businesses have enough to worry about without having to fret over auto accidents. Commercial auto insurance can help protect them so that they can keep their attention on ways to offer new products and good service. Still, commercial auto insurance tends to be a more complicated subject than personal auto insurance. To sell the appropriate policy, you need to have a strong understanding of coverage forms and the risks they address.



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