INSURING COMMERCIAL RISKS

Continuing Education for California Insurance Professionals

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CHAPTER 1 – TERRORISM AND THE INSURANCE INDUSTRY

Introduction

As the public grows increasingly concerned with terrorism risk, insurance professionals require an understanding of the insurance industry’s desire and ability to provide coverage for acts of terrorism in order to confidently explain policies and procedures to customers. The federal government’s enormous influence in allocating terrorism risk between the public and the insurance industry affects the present status of terrorism coverage and will continue to determine the nature of premiums, policies and reinsurance. Appreciation of the government’s role in these affairs can only increase the insurance professional’s capacity to effectively advise the public.

This introduction sets forth a short summary of the specific topics that we will discuss in the following materials regarding terrorism insurance. Our coverage of these topics opens with a brief discussion of the state of the insurance industry prior to September 11, 2001 and notes how insurers and their customers generally subscribed to the national belief that, in all but a few cases, terrorism was an insignificant risk in the United States; a peril that could have affected American travelers overseas but not much to worry about on the home front.

This faith in national security contrasted with the better-safe-than-sorry measures instituted by Great Britain, a land undoubtedly similar to the United States in its industrial, democratic way of life but one that, as a result of its presence in Northern Ireland, knew about the horrors of terrorism long before America ever did. In an extended summary of Britain’s reaction to terrorism, the reader will learn of damages to property, the loss of lives and the insurance crisis that ultimately convinced this foreign government to support a mutual company of insurers, Pool Re, which can provide reinsurance to British insurance providers if a catastrophic attack occurs. We describe how the pool has functioned over approximately the last decade, what benefits insurers have received from the terrorism insurance plan and what the mutual company expects from each of its members. This section provides a basic summary of how a society that in many ways resembles America’s own implemented a national program to address its terrorism concerns.

The sections on the British insurance industry also contain the arguments for and against government support of Pool Re. Issues such as the government’s responsibility for terrorism-related damages and the government’s ability to withstand major financial losses have nearly mirrored those faced by American lawmakers, insurers and policy holders. We mention, too, the aspects of the program that have made consumers grumble. Some of these sources of dissatisfaction, such as those pertaining to coverage requirements and premium rates, do not directly correspond to the American approach to terrorism insurance, but they should not serve as mere curiosity items to the U.S. insurer. Instead, like all the strengths, weaknesses and criticisms of each terrorism insurance plan presented in the pages that follow, they should invite insurers to consider the options involved with offering the coverage and how each option could either improve or hinder the industry’s approach to terrorism risk and its relationships with policyholders. We also evaluate the effectiveness of Pool Re during relative peacetime and after a terrorist attack, and consider cultural and legal differences between the United States and Britain in order to determine the feasibility of an American terrorism insurance program modeled after the overseas system.

Sections related to September 11, 2001 revisit that painful, violent day and insurers’ response to the multi-billion-dollar losses caused by Osama bin Laden’s al-Qaeda terrorist network. We will discuss the resulting uncertainty within the industry, how terms like “act of
war” could have allowed policy providers to disregard the massive destruction and how insurers ultimately decided to handle abundant, costly claims.

We will examine how the airline industry, one of the most economically endangered groups of businesses after September 11, experienced insurance problems following the attacks. An audience of insurance professionals will be reintroduced to how the government weighed its sense of responsibility for national security and the necessity of air travel against worries about setting precedents for bailouts to financially unstable industries and how politics and compromises led to the passage of the Air Transportation Safety and System Stabilization Act. Details about this act not only remind us of the economic difficulties caused by September 11 but also include insurance-specific information that parallels other parts of the course material. This early portion of the text discloses a dilemma that, at least for Americans, is unique to the 21st century: In order to operate under terms of laws and other agreements, many businesses and property owners need to purchase terrorism insurance, and yet, the unpredictability and potential losses associated with terrorism risks make the coverage either unaffordable or unavailable.

Explanations of the provisions in the airline bailout package stress the relationship between insurance and lawsuits. Although the package assisted airlines in their pursuit of adequately priced and obtainable policies, much of the legislation helped to shield the airlines and other potential sources of liability for the September 11 attacks from having to pay judicial awards that exceeded the limits of their insurance policies. A section on the Victim Compensation Fund, a major element of the airline package, tells how the government encouraged people affected by the terrorist attacks to seek federal rewards instead of jury-mandated reparations. Insurance professionals will familiarize themselves with the program and note how it put billions of dollars into the hands of victims and their families while still leaving many claimants with a sense of disappointment.

We go on to address the broader effects that terrorism had on insurers in the months after September 11. Special mention is made of two small companies that became insolvent following the attacks, as well as one industry leader that lost billions of dollars because of all the damages. Through these examples, one can determine that the costs of the attacks were much more than final nails in the coffins of financially shaky organizations. In fact, they were shared by insurers in as wide a manner as the industry had ever seen. Via consideration of these catastrophic losses for big and small companies alike, people can understand why the insurance industry decided to alter its treatment of terrorism insurance and petitioned state regulators, successfully in most cases, for the exclusion of such coverage in property and casualty policies.

We discuss the panic that the exclusions caused within various sects of the business community and mention how some insurers who could not receive exemptions worked around that roadblock by charging extremely high prices for terrorism coverage. The concerns of the real estate, lending and construction industries, as well as those of consumers, all receive their due and are presented as fears that have not entirely faded away in the years since September 11. The passage of time between the attacks and this writing has made hindsight possible but only to a limited degree. Some studies, statistics and examples cited within these pages have perhaps invalidated a few theories that some people developed when terrorism insurance first became difficult to find in the United States. Contrary to the more pessimistic predictions from a few years ago, real estate transactions did not completely cease in places such as New York City and Boston, and mortgage lenders did not completely deny loans to applicants in parts of the nation where terrorism risk was considered high. Nor did businesses’ terrorism insurance problems force an exodus of companies from metropolises to supposedly safer areas of the country. But other studies,
statistics and examples have proven that business professionals had valid reasons for worrying about the availability and affordability of terrorism coverage, that some Americans were negatively affected by the lack of insurance and that at least some of those negative effects have the potential to resurface if the U.S. government, the insurance industry or both of those parties ever again decline to absorb some terrorism risks.

The text recognizes the uniqueness of workers’ compensation in relation to other lines of insurance, noting the existence of state laws that require most employers to purchase the coverage and the refusal of state regulators to approve terrorism exclusions that apply to this line of insurance. We mention how insurers viewed certain types of employees prior to September 11 and how al-Qaeda’s actions forced underwriters to reevaluate long-held beliefs about some workers’ exposure to on-the-job risks.

For purposes of context and review, we provide brief summaries of some basic insurance concepts and procedures. Because reinsurance companies instigated the alleged terrorism insurance crises in both Great Britain and the United States, the insurance professional will be reminded of the role that these organizations play in the maintenance of a healthy underwriting industry. Because some observers of the terrorism insurance issue attributed the low levels of availability and affordability for the coverage to the inevitable process of a business cycle, some sections explain the sometimes gradual, sometimes swift shifts in the market. The text defines each stage in the underwriting cycle and moves through time, exploring the state of the market before September 11 and afterward while describing how the market arrived at those points.

In order to emphasize the uniqueness and the challenges involved with pricing terrorism insurance coverage and with estimating a client’s risk for that peril, portions of this course investigate various forms of popular risk assessment. By considering three kinds of damages (those caused by fire, weather and terrorism), the student can comprehend how some of the underwriting principles, tools and procedures that relate to fire and weather adequately assist an insurer who wishes to calculate terrorism risk and how some do not.

The comparisons and contrasts between the assessment of weather-related risks and risks related to terrorism can be made through this course’s sections on catastrophe models which, following a series of costly hurricanes in the 1990s, have often replaced insurers’ reliance upon traditional actuarial analysis with an emphasis upon software simulations and the input of experts from outside of the insurance world. The text explains how modelers have aided the insurance community, particularly in assessing damages and risks related to hurricanes in Florida, and comments on the reliability and accuracy of the modelers’ products.

Since the events of September 11, developers of catastrophe models have adapted their creations in order to calculate terrorism risks and potential damages. Two models, those developed by Risk Management Solutions and AIR Worldwide, respectively, are explained in detail to provide an idea of how different modelers have chosen to evaluate terrorism and how insurers have utilized the models when deciding how to price and offer coverage.

Just as they should know about the options available to them through terrorism models, insurance professionals must understand the strengths and weaknesses of these assessment tools. Even if an insurer has faith in the reliability and accuracy of catastrophe models used for weather-related disasters, that supreme confidence does not necessarily translate to faith in current terrorism risk assessment. For various reasons, predicting the severity and frequency of terrorist attacks is viewed by some insurers as nearly impossible. Unlike Mother Nature, the terrorist is a thinking wild card who can adapt to the changes in the world around him and who, with the aid of inventive intelligence, can learn to sidestep the
barriers that the rest of humankind puts in his way. If terrorists pay attention to American homeland security measures and to the way citizens and the government perceive terrorism risks, they can modify their attack modes accordingly by targeting locations where security is low and by utilizing seemingly unconventional weaponry.

In its most simplified form, the predictability aspect of terrorism risk assessment is a guessing game involving nontraditional warfare. With that metaphor in mind, one can argue that perhaps the negative side effect of the United States not experiencing massive terrorism prior to September 11 is that the nation’s insurers have had too little experience with the risk to guess right on a relatively consistent basis. Whereas insurers in Great Britain can examine the land’s terrorism history (albeit one that was limited at Pool Re’s conception to attacks by the Irish Republican Army) to teach themselves a few things about their enemies’ methods of operation, the United States has September 11 to analyze and little else. America is further handicapped in its ability to assess terrorism risks by the cultural differences between its own society and that of its foes. Although the motives and morality of a terrorist in Northern Ireland are by no means easy for a victim to comprehend, they are perhaps much simpler for most of the Western world to understand than those of a militant Islamic fundamentalist who believes in such culturally specific ideas as martyrdom and holy wars.

Though all Americans can benefit from greater education about these cultural differences and the motives of various terrorist groups, these materials were not developed to serve that purpose. In fact, many of the references to al-Qaeda and terrorists in general have been included not to definitively inform, but to disclose the massive amounts of knowledge and perception that the average American, the insurance professional and even the terrorism expert have not yet obtained. Since September 11, the United States has learned a great deal about terrorist organizations, but it is anyone’s guess as to whether or not the country has learned enough in that time to effectively insure Americans against terrorism risks.

Much of the following material emphasizes the issue of shared responsibility for terrorism losses and explores how this concept complicates the many debates over who should pay for insurance coverage. Besides the party who purchases a terrorism policy, the most obvious source of responsibility for terrorism losses is the American government, whose number-one obligation is to protect the nation’s citizens. If intelligence failures nurture a terrorist attack, as they certainly did on September 11, insurers and policyholders pay a financial price. Even when the government is presumably doing its job by investigating threats and immersing itself in knowledge of terrorist organizations, insurers and their clients are still at a potential disadvantage due to a lack of shared information between intelligence experts and underwriters. If insurers do not have an adequate understanding of current threats to national security, they cannot effectively judge their level of risk and cannot offer terrorism coverage to consumers at an absolutely fair price.

Few people have disputed the idea that government bears responsibility for protecting the country against terrorism, but we will note that the absence of debate on that issue has in no way produced a clear consensus opinion on how much Washington should involve itself in the insurance industry. Granted, the government had gotten into the business on previous occasions. (Social Security and federal crop insurance are two such examples.) But the success of those endeavors has been debated for years, and there are many reasons (related to bureaucracy, fiscal risks and dissenting views regarding the state of the insurance industry and the availability of affordable coverage) for the government not to involve itself in the terrorism insurance issue. Of course, there have been plenty of people who have reasoned that government is a part of the solutions to some insurance problems but who have not agreed on how big that part should be.
This is not an advocacy course that aims to convert people from one side of the terrorism insurance debate to the other. Nor is it an endorsement of one person or group’s proposed solution to the alleged terrorism insurance problems in this country. Although the material contains analyses of some of these proposals, pointing out some of the plans’ inadequacies and arguable lapses in logic along with some of their positive attributes, great care has been taken to present various arguments and proposals in a fair manner. In a best-case scenario, insurance professionals will absorb the presented information, consider the presented viewpoints and develop their own opinions about terrorism coverage. Rather than trying to persuade readers to think a certain way, this text invites people to explore the topic and to think for themselves.

In order to facilitate that sort of thinking, this course likely provides more background and details about the multiple proposals for terrorism insurance than any other product available to insurers. Through extensive summaries and a breakdown of legal language, we become informed about the several terrorism insurance bills and plans that were proposed by Congress, the White House, consumer advocates and the insurance industry itself. The abundance of proposals proves that the government has had many options to choose from in regard to how to handle terrorism coverage in the United States. Some, like British-influenced pool arrangements and total loan programs, now seem relatively radical when compared to the Terrorism Risk Insurance Act of 2002 (TRIA), which became the law of the land following more than a year of debate over terrorism insurance. Others now seem comparatively more conservative in their approach, as if their proponents merely wished to modify an earlier proposal. By looking through the proposed plans and at how Washington ultimately decided to address the issue, the reader can track how the state of terrorism insurance got to where it is today, ponder how the world and the industry could have been altered by the implementation of a rejected plan and determine whether or not TRIA was indeed the best deal available for the government, the insurance community and policy holders at the time of its passage.

In contrast to the airline package, terrorism insurance legislation remained in lawmaking limbo for so long. The course points out the specific debates within the broader ones, how people who supported government aid to insurers still wrestled over the details regarding the duration of assistance, the cost of a helping hand and the way to delegate responsibility for a potentially enormous tab. Perhaps most prevalent in the political discussions was the debate over punitive damages, a fight that jeopardized the creation of a terrorism insurance program and, depending on which side of the fence one resided on, seemed either like a valid issue related to coverage or like nothing more than a poorly masked attempt to further a political agenda.

This is a study of insurance and not one of politics. But the text includes information about the lawmaking process anyway in order to stress that political considerations can impact the insurance industry as well as nearly every other facet of society. An insurer, or anyone else for that matter, who wants the government to confront a problem must not only have an idea on how to fix things. That person must also engage in vocal lobbying so that the idea gets noticed by people who possess the power to make it a reality. Beyond insurance-specific concerns, the long road that this country has taken toward government-backed terrorism coverage is a reminder that every issue Congress considers comes accompanied by a multitude of ideas from various sources. As a result of the number of ideas and because of resolute lobbying, the best ideas are often stalled on their way toward reality or, in the worst of cases, deemed unrealistic by lawmakers for often unpredictable and sometimes questionable reasons.
This text provides detailed, yet understandable information about how lawmakers compromised with one another and passed the 2002 version of TRIA. In the section entitled, “TRIA Made Easy,” insurance professionals will learn about their obligations to clients in light of the law and about how the government administers its terrorism insurance program. After reading the section, they will know what sorts of losses the government covers through TRIA and what percentage of those covered losses are still the insurers’ responsibility. The course contains material about the claim process for TRIA-eligible terrorism losses and summarizes the forms that insurers must submit to the government in order to receive reimbursements. Readers are provided with their own copy of TRIA, should they wish to examine the legislation in a more extensive manner.

The course material goes on to explain insurers’ reactions to the law. The Act’s original treatment of captive insurers, domestic terrorism and coverage of attacks that utilize nuclear, biological, chemical or radiological weapons (to name only three examples) tended to either surprise insurers or confuse them. The text confronts these issues by, once again, putting legal language into unthreatening English and by citing the government’s interim guidelines and final determinations, which the Treasury Department published after passage of the Act in order to respond to insurers’ common queries.

We have cited various studies and real-life examples that TRIA’s supporters have used to demonstrate the need for government-backed terrorism insurance and the Act’s contributions to the improved availability and affordability of coverage. Also mentioned are studies and examples that have contradicted TRIA’s supposed effectiveness. Although the Act’s true efficiency cannot necessarily be determined unless the United States experiences another terrorist attack on its soil, these studies helped lawmakers form a more educated opinion of TRIA by its initial expiration date of December 31, 2005. Based on these findings and more lobbying, Congress considered amendments to the Act, most of them pertaining to insurers’ liability for claims and the lines of coverage affected by the law. Some groups and politicians, however, suggested more widespread changes to the Act or a complete overhaul of the program. As is the case with the pre-TRIA proposals, the text summarizes the various plans that floated around Washington at the time so that insurers can contemplate what sort of arrangement would have best served the needs of their industry, their customers and the government.

The first TRIA extension, which went into effect in 2006 and expired at the end of 2007, receives the same treatment in the text as the 2002 law. Easy-to-read summaries contain the relevant changes to the Act, and a copy of the extension has been made available for reference purposes.

At the time this course material was first offered to the public, statements made by the White House and interviews conducted with insurance professionals seemed to suggest that another extension of TRIA was unlikely. So it made sense for the text to conclude with a tone of uncertainty and for students to consider various alternate solutions to the terrorism insurance crisis, including catastrophe bonds and hypothetical pool arrangements for workers’ compensation coverage. The somewhat surprising passage of another TRIA extension through 2014 eliminated some of the urgency involved with finding a permanent solution for terrorism insurance. Still, much of the text’s original material has been preserved here in order to give readers a sense of history and to show that a TRIA extension was by far not the only option on the table in 2007.

Finally, students will learn how the seven-year extension fell into place and how the 2007 amendments affect insurers and the federal government. With the 2007 changes comprising the third major piece of TRIA legislation in just five years, it is clear that terrorism insurance is
an issue that has evolved at a rapid pace and continues to challenge politicians, risk managers and insurance producers. It is, of course, impossible to predict what will happen to TRIA between today and 2014 and how a continued war on terror will influence the insurance community. However, through this course material, insurance professionals can develop an understanding of how terrorism insurance got to where it is today and use that understanding to deal with future challenges.
Looking Back at Terrorism at Home and Abroad

Before the Attacks

Prior to September 11, 2001, few Americans outside of the airline industry concerned themselves with securing terrorism insurance. If average citizens worried about the issue at all, they usually confined their thoughts to the effects of terrorism on overseas vacations. A pricey trip to London, for example, could have become even more costly for the traveler if the Irish Republican Army (IRA) set off bombs in the city, forced the cancellation of commercial flights and indefinitely stranded the tourist a long way from home.

The cautious American could have guarded against such hypothetical disasters by purchasing a policy like the one Access America introduced in 1986, according to the Boston Globe, which covered losses sustained as a result of foreign terrorism at a cost of $3 to $7 for each travel day. In retrospect, however, even that rare example of a pre-September 11 terrorism insurance policy hints at the era's treatment of terror as a largely implausible threat to U.S. citizens. The terrorism aspect of the policy snared some modest media attention for its parent company, but, in reality, the coverage represented only one element of a multi-faceted plan that also insured against emergency hospitalization (terrorism-related or otherwise), lost luggage and other potential hassles for globetrotters.

It was not as if insurance companies were ignoring terrorism coverage for their clients and leaving policyholders vulnerable in the aftermath of a potential attack. In fact, terrorism coverage technically existed for commercial property owners before September 11. The coverage, though, was rarely spelled out in the policies. Instead, terrorism fell into the category of “other perils” in most insurance plans, lumped in with additional risks that could have adversely affected the business community but were not common enough in national culture to merit special mention in contracts.

This non-specific approach to terrorism insurance continued even as the United States found itself in violent situations during the last quarter of the twentieth century. When suspected Libyan bombings in West Berlin prompted U.S. retaliation in 1986, Libyan leader Muammar al-Qaddafi vowed revenge. Although Qaddafi's threats provoked an increase in the cost of terrorism insurance for the airline industry, insurers did not alter their treatment of coverage for commercial properties on American soil. When four men set off a car bomb underneath the World Trade Center seven years later, killing six people and injuring 100, neither insurers nor lawmakers put forth a resolute effort in the name of change. In 1995, domestic terrorists bombed a federal building in Oklahoma City, killing more than 100 people and injuring more than 400. At that time, some insurers wondered out loud about their business’s approach to terrorism, but the industry never progressed beyond the talking stage to a point of new policies for such risks.

Those worries about terrorism on the home front had faded, for the most part, by early September 2001, with insurers experiencing a modestly decent period in their business cycle following years of soft markets but generally adequate profits. According to the U.S. Treasury’s June 30, 2005 report on terrorism risk insurance, property and casualty insurers had earned either increased or steady levels of surplus between 1994 and 2000.

The terrorist attacks on the World Trade Center and the Pentagon changed all that and more by offering indisputable proof of America’s vulnerability to acts of mass destruction. At their most human level, the events of September 11 arguably altered Americans’ perception of their place in an often dangerous world community. The country proved strong enough to withstand horrific threats on its livelihood, but a logical observer could no longer argue that the United States was somehow protected from outside enemies by an invisible shield of
military might and international influence. America learned the hard way that the risks involved with terrorism required greater vigilance and preparation, from government officials and lay citizens alike, than had previously been expected. The time had come for the country to consider horrors that were once unthinkable.

**Great Britain Encounters Terrorism**

Other countries encountered the harsh realities of terrorism long before the United States ever did. Great Britain, America’s most unflinching modern ally, developed an understanding of politically motivated violence through its experiences with the IRA, a militant group formed in 1969 to expel the English from Northern Ireland. As a result, the British government began paying for damages in Northern Ireland. Large-scale bombings in London in the early ‘90s, however, eventually led those in power to support a broader program that addressed terrorism risk throughout Britain.

On April 10, 1992, the IRA set off three-quarters of a ton of explosives in London’s version of Wall Street, known as “the City,” with estimates of damages from the attack ranging from $507.5 million to $599 million. Named after a nearby street, the St. Mary’s Axe bombings caused additional financial pain for a British insurance industry that was still recovering from costly hurricanes that struck the United Kingdom during the late ‘80s.

**Reinsurance and British Terrorism Coverage**

Insurance companies back up their finances by taking out insurance policies of their own. Termed “reinsurance,” these policies transfer portions of financial risks to other parties, thus protecting insurers if they cannot honor financial promises to clients. If the dollar amount of a client’s legitimate claim exceeds an insurer’s resources, reinsurance can theoretically provide the difference, ideally satisfying the customer and keeping the insurer in business. Because one large attack can financially wipe out even a long-time, respectable insurance organization, most insurers will not offer terrorism coverage if they cannot secure reinsurance for themselves.

Reinsurers, though, recognize that insurers’ dependency on them increases in the event of a terrorist attack. The reinsurance companies do not want to risk harming their own financial health any more than the primary insurers do. Normally, a reinsurance company (or an insurance company, too, for that matter) would adjust its prices in order to offset potential losses from a risk. Terrorism was too much of a wild card, however, for British reinsurers in 1992. Companies could predict little, if anything, about the nature of an attack and, therefore, were unable to accurately adjust the prices for their services. Reinsurers assumed (based on the history of the IRA) that a future act of terrorism would involve a bomb of some sort, but they could not predict the amount of explosives that terrorists would use, let alone the location of an attack. These unknown factors seeded panic in reinsurers, many of whom announced that they would no longer provide backstop insurance for terrorism to insurers. Without a potential safety net to catch them in the event of terrorism, representives of the British insurance industry warned in November 1992 that policy providers would confine terrorism coverage to relatively small claims. As will be addressed later in this text in greater detail regarding the U.S. terrorism insurance crisis, the absence of affordable coverage presents numerous troubles for business owners, real estate professionals, lenders and the transportation industries. Simply put, people want their high-level investments protected against unexpected violence.

With many policies due to expire in January 1993, the British insurance industry urged the government to act swiftly, either to provide some form of reinsurance protection so insurance companies could continue to offer terrorism coverage, or to provide terrorism insurance benefits directly to the public. To many insurers, this seemed like a reasonable demand.
After all, it was the government’s policies in Northern Ireland that so angered the IRA in the first place. Certainly, some Britons argued, the government should bear major responsibility for reimbursing citizens whose commercial properties are damaged via terrorism.

Some politicians, though, believed that the insurance companies needed to be more creative in their planning and settle the reinsurance crisis on their own. The British government finally answered the cries for assistance eight months after the St. Mary’s Axe bombings, announcing that it was open to the idea of acting as an insurer of last resort for terrorism coverage.

Before government officials could work out the program’s details, the IRA struck again. The Bishopsgate bombing occurred nearly a year to the date of the St. Mary’s Axe attacks and within the same area of London. The blasts from three tons of explosives killed one person and resulted in an estimated £1 billion in damages. In response to the violence, London introduced intricate security measures, known collectively as “the ring of steel,” in the City district. The City decided to close most of its streets to cars and began videotaping the few automobiles with access to the area and subjecting them to random searches by police. The government, meanwhile, was pushed once again to speed up the progress of retroactive terrorism insurance legislation.

**Pool Re**

Following political debate over how to keep bureaucratic involvement and spending at functional minimums, the British parliament enacted the Reinsurance (Acts of Terrorism) Bill on May 7, 1993, paving the way for government to act as a limited financial backer of the Pool Reinsurance Corporation Ltd., commonly known as “Pool Re.” The pool consists of several commercial insurers that share a portion of their profits from premiums in order to cover terrorism claims. Members agree to help stabilize the legitimacy of the organization by not offering terrorism insurance that competes with the pool. The government picks up the tab for any claims that exceed set amounts of the individual members and the collective pool.

In order to receive money from Pool Re, an insurer needs to have suffered monetary losses as a result of a certified act of terrorism. Pool Re legislation defines terrorism as “acts of persons acting on behalf of, or in connection with, any organization which carries out activities directed towards the overthrowing or influencing, by force or violence, of Her Majesty’s government in the United Kingdom or any other government....”

That language allows for the inclusion of foreign-administered embassies on British soil. Britain’s Secretary of State for Trade and Industry considers how a particular event fits into the definition. Should either the government or Pool Re disagree with the Secretary’s interpretation, a tribunal made up of representatives of both sides of the dispute can overrule the initial finding.

Pool Re policyholders insure their businesses and properties against damage to their building, destruction of their building’s contents and loss of book debts (i.e., uncashed checks). They also have the option of insuring themselves against any financial losses resulting from business interruption. In its initial form, the pool only covered damages caused by fire or explosions, but, at the behest of critics who claimed that terrorists could expand their deadly arsenals to include nuclear, biological and chemical weapons, the mutual company now offers policies that cover all terrorism risks, other than those linked to war and those aimed specifically at computers (hackers, viruses, etc.).

The amount of insured losses covered by Pool Re has changed over the years. Whereas the pool traditionally covered individual insurers’ claims that exceeded £100,000, September 11 made the mutual company reconsider that policy. In a July 23, 2002 summary paper, the
reinsurance organization announced a shift toward industry-wide “retention amounts” (or 
deductibles) that change each year, beginning in 2003. Each Pool Re member now has its 
own retention amount for a single attack and a doubled retention amount for multiple attacks 
that occur in the same year. Pool Re bases retention amounts on individual insurers’ 
premium contributions to the mutual company. The more reinsurance premiums an insurer 
pays to the pool, the higher the retention amount. For 2006, Pool Re set industry-wide 
retention amounts at £100 million per attack and £200 million for multiple attacks during that 
year. The company’s chief executive, Steve Atkins, explained insurers’ responsibility for 
claims in 2006 through this hypothetical example:

“Consider a member who contributes 1 percent of Pool Re’s premium. Their per-event 
retention for 2006 will be £1 million (1 percent of £100 million), and their annual aggregate 
retention for 2006 will be £2 million.”

In its early years, the pool would have ordered members to contribute an additional 10 
percent of premiums if it ran a deficit. If those premiums still could not have paid for all 
insured losses, the British government would have stepped in as a reinsurer. Since 2003, 
this policy has changed, and members no longer need to contribute additional funds to the 
pool if terrorism claims deplete its accounts. In the event of improper funding, the pool can 
borrow money from the government and repay loans as the company rebuilds a surplus.

The cost of Pool Re coverage and the premiums paid by insurers to the mutual company 
tend to depend upon the location of the insured properties. The pool originally divided Britain 
into two zones, with major cities in one and all other sections of the United Kingdom in 
another. Insurers then considered the potential terrorism risk associated with the property as 
well as the number of properties owned by the policyholder in each zone when pricing 
policies for consumers. That system ended in June 1994, and the pool started basing 
insurers’ premiums on a four-zone plan. Zone A consisted of all properties in Central London 
and demanded the highest premium from policyholders due to the area’s increased risk 
potential. The rest of London, as well as business districts in other cities and towns, made up 
Zone B. Zone C spanned the remainder of England, with the exception of Cornwall and 
Devon. The rest of Great Britain was considered Zone D and boasted the lowest premiums 
for Pool Re coverage. (The pool, though, does not insure property in Northern Ireland, where 
businesses affected by terrorism receive direct government payments, the Isle of Man or the 
Channel Islands.) On Christmas Day 1998, Pool Re simplified its premium system again by 
consolidating its four pricing zones back into two. For zones A and B, the pool charged 
premiums that were .015 percent of a property’s value. Premiums for properties in zones C 
and D amounted to .003 percent of a structure’s value. Insurers pass along their reinsurance 
costs to consumers and are free to price policies based on market demands.

**Criticism of Pool Re**

Like every state-endorsed program before it, Pool Re has had its detractors. Some 
questioned the financial feasibility of the system from the very beginning, doubting that the 
pool or the British government could withstand the costs of a major attack. As long as 
consumers’ premiums remained high, critics argued, the public would opt not to purchase 
policies from Pool Re. Low participation would translate into low capital for the pool and 
increase insurers’ dependency upon the government. The government attempted to soothe 
the public’s apprehension and claimed that as long as terrorism remained infrequent, Great 
Britain would not lose any money in the long-term scope of the pool. But what would have 
happened if terrorism had increased dramatically before the pool grew its finances? 
Assuming that Pool Re could have even paid back the government’s money in the first place, 
the state still could have found itself waiting years for a full return. If that worst-case scenario 
materialized, would not the government have needed to slash funding for other programs in
order to offset its loans to Pool Re? In the minds of some British citizens, the creation of a
government-backed pool of terrorism insurers presented risks that were too big to take.

Some members of the business community have complained about the price of Pool Re
coverage. Rates for the terrorism policies have been unstable, with high prices dropping
during periods of relative calm and then rising when terrorists hit another target. Pool Re
announced policy discounts of 20 percent in 1996, but bombings in East London later that
year forced a return to the prices of old. When the pool began offering all-risk policies in
2003, mandatory premiums paid by insurers to the mutual company doubled.

Other foes of Pool Re voice their displeasure not over the principles of the program but over
more specific issues related to its fine print or lack thereof. Perhaps the biggest complaint
among Pool Re policyholders and those property owners who decline to purchase the
coverage concerns the fact that if people want to insure one building, they must purchase
coverage for all other properties in their portfolio. This is the case even for a policyholder who
owns just one piece of property in central London, where terrorism risk is highest, and 10
pieces of property in a relatively safe part of the English countryside. The inability of the
client to designate only certain properties for terrorism coverage is, of course, detested most
by entities with extensive real estate portfolios that deem it necessary to secure coverage for
some buildings but do not want to be penalized for also owning properties in lower-risk
areas.

**Has Pool Re Worked?**

Although Pool Re’s rule prohibiting members from offering other forms of terrorism insurance
once struck fear into defenders of a free market for goods and services, a few insurers have
declined invitations to join the mutual company and have tried to compete with it. They
accepted what reinsurance rates they could secure and sold their own brand of coverage.

Based on some of the policyholder concerns mentioned previously in this text, some one-
time Pool Re clients have switched insurance providers and opted for independent coverage.
In 1998, for instance, reports indicated that Syndicate 33, of Hiscox Syndicated Ltd., offered
coverage of up to £100 million to property owners at a rate that was 20 percent lower than
similar coverage available through Pool Re. Under Syndicate 33’s policies, clients could pick
and choose which properties to insure.

During its first 13 years of existence, however, Pool Re has avoided the catastrophes
foreseen by its critics. The pool had amassed enough funds by July 2005 to cover the £1.1
billion in damages from four blasts that rocked the London subway system. The April 10,
1998 signing of the Stormont Agreement ushered in improved relations between the British
government and the IRA and possibly played a role in a reduction of premiums. (In 1998
premiums for terrorism coverage dipped 20% in cities and 40% elsewhere.)

But not everyone was ready to pat the government on the back for supposedly aiding in the
reduction of premiums. At the time, no one could predict how long the Irish question would
be handled peacefully, and a reduction in rates based solely on the status of a traditionally
hostile relationship perhaps seemed both premature and risky. Besides, credit for lower Pool
Re premiums could have also gone to the small handful of companies that dared to compete
with the organization. Maybe industrial cycles and the inevitable effects of supply and
demand produced the lower premiums. But whatever the reason for the reductions, the
steady rates since that year (disregarding the 2003 increases for enhanced coverage) might
provide proof that terrorism insurance can be a cost-effective source of property protection.

As recently as 2002, the mutual company and its staff (then comprised of 13 employees)
operated on a budget of approximately £1 million, a decent amount of cash, no doubt, but
hardly enough for the pool to be likened to the handout-heavy, bureaucratic monster that
many Britons feared it would become. To date, Pool Re has not required government assistance in making payments to its policyholders.

Some observers insist that terrorism coverage should return to its old place in Britain as an add-on to property insurance. Most reinsurers, though, still wrestle with the unpredictable nature of terrorism and have yet to change their minds about restricting coverage for British companies. As this text continues, the reader will note reinsurers’ similar attitude toward American clients.

*The Plausibility of an American Pool Re*

The attacks on the World Trade Center and the Pentagon, of course, did not necessarily compare with the acts of terrorism experienced in Britain up to that time. The IRA was fond of setting off bombs. Osama bin Laden’s al-Qaeda network preferred, in this case, crashing airplanes into buildings. Members of the IRA were not interested in suicide missions. Members of al-Qaeda terrorized at all costs, viewing their deaths as honorable examples of martyrdom that would serve them well in an afterlife. Given these differences and the sheer enormity of the September 11 attacks, no one can say with certainty how well Britain would have responded if bin Laden and his followers had decided to target London that day instead of New York City and Washington.

Still, after initial days filled with condolences and concern for the American people, British citizens could step back from all the squabbling over Pool Re’s flaws and be proud that their system for terrorism insurance at least formed a base for a financial contingency plan in the event of a similar attack. A plan like Pool Re would not have helped Americans cope with the enormous human losses that resulted from the planes hitting the buildings. But once the shock subsided, the program’s existence could have served as a source of reassurance for property owners by telling them who would pay to rebuild their community and how that would be accomplished.

Yet, even though Great Britain seemed to be several steps ahead of the United States on the road toward supreme terrorism coverage in 2001, differences in the two countries’ insurance industries and traditional views on government suggest that a carbon copy of Pool Re could not have immediately thrived in America. U.S. insurers are regulated by the states. Therefore, a group of insurers in California could decide to form a mini-Pool Re, but the creation of a national fund for terrorism insurance companies would require a series of rewritten laws.

And even if that barrier to a national system did not exist, one must consider the United States’ sometimes sour response to any potential government program. As detailed earlier in this text, the British government has not yet had to bail out Pool Re and has positioned itself as only a final source of assistance for insurers. But many Americans worry, rightly or wrongly, that an increased role for government in business could, at best, drain the country’s budget or, at worst, cause the nation to fall down a slippery slope toward socialism. These concerns are somewhat less pronounced in Britain, a land deeply rooted in welfare programs. Pool Re provided the United States with an example of a similar country addressing a need for widespread terrorism coverage. But any potential plan for terrorism insurance in America would need to address the nation’s independent necessities and cater to its brand of politics.
Insurance and the Effects of September 11

The Attacks and the Initial Response

The September 11 attacks on the United States killed approximately 3,000 people, injured several thousands more and resulted in damages that were initially estimated to be anywhere from $25 billion to $70 billion. Despite the fact that national security reigned over the minds of most Americans during the days that followed, the nation’s business community forced itself to ponder who would shoulder the financial burden of the costliest disaster in U.S. history up to that point. Although the shocking, catastrophic nature of the situation showed exactly why a person or business should purchase insurance, even clients with extensive coverage had a reason to nervously hold their breath in anticipation of an industry-wide response.

Traditionally, insurance companies can exempt themselves from honoring certain policies following acts of war. A massive conflict on domestic soil, after all, could potentially bankrupt the issuer. Most life insurance providers omitted these exemptions from their policies after the Vietnam War, but many property and casualty insurers can still enforce the exclusions. The violent, politically-motivated attacks of September 11 certainly seemed like an instigator of battle. In speech after speech, President George W. Bush and members of his administration used the phrase “act of war” to describe al-Qaeda’s hijacking and subsequent crashing of four U.S. planes. Legal definitions of “acts of war,” though, usually contained references to nations. Regardless of the United States’ eventual invasion of Afghanistan in response to the Taliban regime’s support of al-Qaeda, the September 11 attacks were technically carried out by an independent, internationally organized terrorist group and not by a specific government.

These factors presented the insurance industry with a few choices. It could have ignored the act of war exemptions and made huge payments to policyholders, or it could have invoked the exemptions and risked either being overruled by the government, cursed by the public or perhaps both. The only good news for insurers was that they had incorrectly counted on experiencing heavy seasons of earthquakes and hurricanes in the several months preceding the attacks. Mother Nature spared the United States somewhat from natural disasters during that time, spoiling insurers’ expectations but leaving them with enough money to handle some other form of trouble. Within days of the terrorist acts, the industry announced its intention to honor all policies legitimately affected by al-Qaeda’s assaults.

September 11 and the Airline Industry

Even if terrorists had not hijacked four planes on September 11, the year 2001 would have still been a rough one for the aviation industry. A slumping U.S. economy before the attacks translated to fewer passengers than usual, and airlines resigned themselves to a projected annual loss of over $1 billion. After the four hijackings and crashes, the government suspended all commercial air travel for three days, preventing airlines from making money off of the few Americans who still had the need or the guts to fly. Many people, though, did not want to be anywhere near an airplane filled with suddenly suspicious-looking strangers anytime soon. So, even when travel resumed, planes flew at small fractions of their intended capacities. As if plunging ticket sales were not enough, airlines also faced increased costs for fuel and the implementation of new, expensive security procedures. A full-blown financial crisis culminated in thousands of airline workers losing their jobs.

The airlines involved in the September 11 attacks (United and American) potentially faced numerous lawsuits from injured victims, property owners and families of the deceased. Insurance for each of the four planes that crashed covered roughly $150 million in damage to
the craft and $1.5 billion in damages on the ground, including loss of life by passengers or bystanders, injuries or property damages. With only a combined $6 billion of coverage between them, the two airlines could not have conceivably compensated all affected parties for their losses. Insurance companies, meanwhile, assessed the vast destruction and feared that more attacks, along with their financial consequences, could be on the way. As a result, providers cancelled war-risk insurance for airlines, thus leaving clients monetarily vulnerable in the event of a similar disaster. Although flight insurers came back with revised policies for war-risk coverage, the airlines deemed the new plans unacceptable. At first, insurers capped their liability for damage on the ground to $50 million per craft. In time, they offered increased coverage of up to $1 billion or so, but prices for the policies seemed far from affordable for the struggling carriers, who lacked the budget to self-insure.

**Airline Insurance in the Old Days**

Until that time, war-risk insurance (much like the terrorism coverage in property and casualty policies) was included in most airline insurance plans. Occasionally, international unrest prompted providers to dramatically raise their rates for planes with certain destinations, and airlines responded by either cutting their services or applying for government assistance. Pan American Airlines, for example, faced steep insurance rates for trips to Tel Aviv and Saudi Arabia during the first Gulf War and reduced flights to those places. The company then applied for coverage from the Federal Aviation Administration (FAA), which offered war-risk insurance for airlines that could not secure affordable rates through the traditional market. This form of assistance only applied to international flights.

**Airlines to Washington: “We Need Help!”**

Almost immediately after September 11, representatives from American and United began lobbying Congress and the White House for aid, hoping to save their individual companies and the industry as a whole from bankruptcy. Some supporters of national assistance for the airlines stressed that the economy depended upon air travel in order to thrive. Any reduction or suspension of services, they argued, would only put further strain on business at home and abroad. Others suggested that the government had participated in the creation of the problem and, therefore, needed to play a part in the solution. It was the government, after all, that required airlines to specifically carry insurance for damage on the ground, and it was the government that was responsible for protecting citizens from terrorists. Along those same lines of reasoning, it was the government that mandated some of the failed security measures on planes and at airports, and it was the government that chose not to evacuate the Pentagon after the attacks on the World Trade Center. Based on those connections between Washington and responsibility for public safety, the airlines hoped they would receive help with all the lawsuits even if politicians could not help with coverage problems.

Many Americans argued just as passionately against a bailout for the airline industry. Yes, September 11 was unfortunate, unexpected and expensive. But the airlines were obviously in bad shape before the attacks, the other side said, and the government should not be responsible for the bad business practices of private companies. In addition, if the airlines received aid, would that require the government to spend its money in order to save the innumerable other industries that were hit hard by the dangerous combination of war and recession? The victims of the attacks also factored into the opposing argument, with some people denouncing any potential plan that assisted business at the expense of grief-stricken families.

**The Air Transportation Safety and System Stabilization Act**

The U.S. government moved with lightning speed, enacting an extensive plan for airline assistance in less than two weeks. The Air Transportation Safety and System Stabilization Act
Act provided the industry with $5 billion in direct government payments and $10 billion in loan guarantees. In terms of insurance, the FAA offered temporary war-risk coverage for domestic flights in the amount of $100 million for each airline. The act placed responsibility for excessive claims on the shoulders of the government. Airlines initially paid $7.50 per flight for the insurance, but rates changed in June 2002. Under the altered plan, airlines paid higher prices to insure longer, fuller flights. Intended, at first, to only span 180 days, the government coverage was extended several times. Those extensions angered some commercial providers, who insisted that they had adequate insurance plans available for airlines and should not have needed to compete with the government for business.

In response to the airlines’ liability concerns, the government shielded the industry from lawsuits pertaining to property and punitive damages from September 11. Liability for lives lost in the attacks was adjusted so as not to exceed the pre-existing insurance coverage of the United and American planes. In return for the assistance, the airlines agreed to refrain from imposing service cutbacks in non-metropolitan areas of the country. (The act authorized an additional $120 million for such service.) If an airline received government assistance, its employees with yearly salaries of $300,000 or more could not receive raises for two years.

Although the airline assistance package became law in speedy fashion, Democratic Party politicians expressed frustration over the legislation, saying it did nothing to help the thousands of workers who lost their jobs after September 11. Some Republicans, too, admitted that the immediate need for aid prevented an absolutely thorough critique of the act. Unfortunately for Congress, thousands of voters spotted the plan’s supposed inadequacies and were not shy about voicing their complaints.

**The Victim Compensation Fund**

The bombing of the World Trade Center in 1993 killed six people and instigated court battles that lasted for several years. The September 11 attacks, with all the human and fiscal losses attached to them, seemed destined to usher in previously unforeseen levels of litigation that could overwhelm the judiciary and bankrupt any liable parties. Among the potential accused, there were the airlines, of course, who owned and operated the hijacked planes and whose collective insurance policies capped out at $6 billion. There were the private security officers on the ground who allowed the terrorists to board the planes with items that were used as weapons. The Port Authority of New York and New Jersey also found itself in the line of legal fire, with some families claiming that the 1993 bombing should have forced building administrators at the World Trade Center to develop an effective evacuation plan as well as more extensive security measures. Families of victims who died in the center’s south tower claimed that their lost loved ones had been instructed to remain in or return to their offices after the attack on the north tower and then perished when the second plane hit their building.

Due, in part, to their fears surrounding potential litigation, lawmakers authorized the creation of the Victim Compensation Fund (VCF) as part of the airline assistance package. The government allowed those citizens affected by the attacks to receive potential reparations in one of two ways. People could pursue a lawsuit, which would be heard by a single federal court in New York, or they could apply for compensation through the national fund. A person could not receive awards for punitive damages in either case.

The government recruited teams of lawyers who provided free legal counsel to anyone who filed for the federal assistance, but everything from the day-to-day operation of the compensation program to its formula for disbursing funds was left up to a chief administrator. Attorney General John Ashcroft surprised political observers by appointing Kenneth Feinberg, an experienced business mediator with former ties to Senator Edward Kennedy, to
the position. If the press reports about him can be believed, Feinberg was one of the few self-proclaimed straight talkers in government and law who actually deserved the billing. As the specifics of the VCF became known to a displeased public, Feinberg did not exempt himself from his own brutal honesty.

Some lawyers counseled their clients to utilize the VCF. The airlines’ flirtations with bankruptcy, as well as the government-imposed limited liability, turned any lawsuit against the industry into a risky endeavor with uncertain cash rewards and long waits for results. Furthermore, in order to prove the liability of an airline or any other party, a plaintiff would probably have needed access to terrorism-related documents, most of which remain classified for security purposes. By contrast, the VCF required no proof of liability from claimants, gave out an initially reported, tax-free average of $1.6 million to each victim and resolved settlements within 120 days.

In calculating victims’ compensation, Feinberg faced the same sort of criticism that people often reserve for providers of life insurance. How, relatives asked, could anyone put a price on life? The VCF’s offerings of $250,000 for pain and suffering seemed ridiculously small to victims’ families. Some people argued that the original figure of $50,000 for each dependent was an insulting appraisal of a parent’s impact on a child’s life. Low-income families were upset that their projected lifetime earnings translated into relatively low compensation.

In a conscious effort to level the playing field for the rich and the poor, Feinberg capped potential lifetime earnings at $231,000 per year and angered the families of upper-class victims. The fund also deducted money for certain assets such as life insurance and pension plans. Those reductions either were not initially understood by the public or were not clarified enough by Feinberg when he instructed each claimant to expect roughly $1.6 million from the program.

But, of course, any amount of money would have seemed trivial to most families who lost loved ones in the attacks. For business purposes, people’s lives are priced every day by third parties based on such factors as projected earnings and personal assets. And few people, be they rich or poor, probably want to know how much they are truly worth in terms of dollars.

In response to public complaints, Feinberg made several alterations to the VCF before its filing deadline at the end of 2003 that raised the average compensation for victims by roughly $200,000. Reparations for spouses and dependents doubled, and, although insurance and pensions still offset a victim’s VCF awards, money obtained through Social Security, 401k plans and charities was explicitly excluded from Feinberg’s assessments. The government also opened the door for undocumented foreign workers to receive money from the fund without having to worry about immigration-related prosecution.

The VCF was slow in successfully wooing victims and their families, but, according to the New York Times, by December 31, 2003, Feinberg’s office had received claims for 97 percent of September 11’s known victims. As the task of distributing the compensation wound down, Feinberg said the program was not as fair to victims as he had first envisioned but that the high number of claims (and the $7 billion given to families) allowed him to deem it a success.

Even with its eventual modifications, the VCF seemed improper in principle to some Americans. People injured in the 1995 bombing at the Alfred P. Murrah Federal Building in Oklahoma City and the families of those killed by that blast had received no compensation from the government. So, the creation of a federal fund for September 11 victims felt like a slap in the face from lawmakers to those people who suffered previous tragedies. Conversely, some observers of the compensation situation worried that offerings of
government money to victims set a dangerously expensive precedent that would fiscally harm the country in the event of a future attack. That same group also considered the Oklahoma City victims and wondered if government would now feel obligated to make payments to them, too. The White House, though, settled the issue, declaring that it would not extend the VCF beyond the realm of September 11.

Once the VCF closed its books, Rand Corp. was able to comprehensively study the financial cost of the terrorist attacks. According to its report, various sources provided victims with a combined $38.1 billion in compensation, with insurance companies contributing roughly half of that amount. For obvious reasons, the insurance industry was intent on never having to cover the effects of such extreme acts of terrorism again.

**Insurers Feel Fiscal Pain**

Of all the disasters ever experienced in the United States up to this time, the events of September 11 affected the broadest range of insurers. The financial repercussions of the attacks bruised even the era’s most fiscally strong providers, while exposing the mismanagement and instability of weaker companies.

At the time, General Re Corporation was the fourth largest reinsurer in the world. Under the guidance of American investor Warren Buffett, General Re’s parent company, Berkshire Hathaway, had increased its net worth for 37 consecutive years. September 11 cost Berkshire Hathaway roughly $2.28 billion, with most of that total resulting from the insurance end of the conglomerate. Assessing his company’s preparedness in regard to terrorism, Buffett claimed General Re could perhaps withstand another attack similar to those on the World Trade Center and the Pentagon but that anything larger or more sophisticated in its weaponry could seriously disable his business. Buffett frighteningly envisioned a future in which terrorists would move beyond the use of airplanes and bombs in favor of nuclear, chemical and biological weapons and destroy enormous amounts of properties and human lives.

With those concerns on his mind, Buffett said General Re could not cover losses from chemical or biological warfare and that nuclear coverage would be an expensive rarity for his reinsurance customers. The company also began paying greater attention to the potential risk of highly concentrated properties, limiting the number of structures it insured within the same geographic area on a stricter basis. Buffett addressed his industry's old-school approach to terrorism, pointed a finger at himself and said it was a huge mistake on the part of insurers to include the coverage free-of-charge within other policies. But General Re still stood firmly on its two legs after September 11 and could look forward to a profit-making phase brought on by price increases and people's general cravings for insurance following a catastrophic event. Other companies were not so lucky.

By September 2002, two insurance companies had reached a dreaded state of insolvency and ceased writing new policies as direct results of al-Qaeda’s suicide missions. The demise of Copenhagen Re was a relatively straightforward case of policy risks coming to life and proving too costly for the provider to handle. Many of the reinsurer’s best and brightest employees had left the organization years earlier, and its premiums and reserves seemed uncomfortably low compared to industry norms during the pre-September 11 soft business cycle.

North Carolina-based Fortress Re’s tale, however, as reported by Mark Maremont in a series of articles for the Wall Street Journal, detailed a multi-faceted mess of questionable accounting and ethics. Employed as a U.S. agent for Sompo Japan Insurance Corp., Fortress became a visible force in aviation reinsurance. The company sold policies that covered anywhere between the first $50 million to $400 million of damages from a crash.
Those risky plans made Sompo liable if nearly any of its insured planes went down. In order to reduce its risk, Sompo instructed Fortress to purchase reinsurance that would reduce the parent organization's liability. Fortress received one-third of any profits, minus the cost of the reinsurance.

Following the four hijackings on September 11, all of which occurred on planes that were insured at least in part by Sompo, Fortress finally surrendered its well-guarded books to its overseas bosses. In fact, Fortress had not purchased traditional reinsurance that allowed Sompo to share risks with other parties. Instead, the agent had opted for cheap finite reinsurance. Sompo received immediate financial assistance from its reinsurers when paying claims, but the Japanese company was required to pay that money back with interest over a number of years. By purchasing less-expensive finite insurance instead of traditional reinsurance and by allegedly failing to alert its superiors to the financial commitments involved with the policies, Fortress Re, according to an eventual lawsuit, falsified its profits and thus received higher commissions from Sompo than it deserved. In the end, the combination of Fortress's alleged deceit and the September 11 attacks caused Taisei Fire, one part of the Sompo empire, to become the second Japanese casualty insurance company to file for bankruptcy protection since World War II, and Sompo reported a loss of $1.4 billion as a result of September 11.

A Coverage Crisis Begins

These examples of major losses help explain why the insurance industry, in late September 2001, announced to the U.S. House Financial Services Committee that it planned to exclude terrorism coverage from standard property and casualty policies beginning in January of the next year. Reinsurers did not want to share in the risks, and insurers did not want to keep the risks for themselves.

Many state regulators sat on the exclusion issue and waited for the federal government to address the problem. When that did not happen by December 31, 2001, when 70 percent of U.S. policies were due to expire, the terrorism coverage exclusions went into effect in 45 states. New York, California, Georgia, Florida and Texas were the only states that denied insurers' requests to exclude terrorism coverage.

The exclusions did not wipe out all terrorism coverage, but they gave insurers flexibility. Some small insurers still offered free coverage, but those instances were relegated to low-risk policyholders. A shoe store in Beaufort, South Carolina, for example, might have been eligible for terrorism insurance at no additional cost, but an office building in the heart of Boston almost certainly had to pay for it.

Metropolitan clients watched the prices of their premiums soar thanks to insurers’ new attitude toward terrorism. Chicago’s chief financial officer Walter Knorr reported that the city spent $125,000 in 2001 for $750 million in coverage for its airports. After September 11, the same insurer charged $7 million for $150 million in coverage.

Most of the new terrorism policies covered up to $100 million in damages. They often insured businesses against acts of terror committed with planes but (like Warren Buffett’s General Re plans) not those involving nuclear, chemical or biological weapons. People who either needed additional coverage or did not want to pay the high premiums offered by one insurer needed to purchase the insurance as an add-on to an additional policy from another provider. In July 2002, Americans could buy stand-alone terrorism insurance from only four companies. These various pricing and availability factors resulted in many businesses buying either not enough terrorism insurance or none at all.
Businesses Ponder Life Without Coverage

Had the events of September 11 not occurred, exclusions of terrorism in insurance policies might not have produced much major concern among various sectors of the business world. But, with al-Qaeda's attacks fresh in everyone’s minds and with the U.S. government issuing color-coded alerts through its Department of Homeland Security and urging citizens to be aware of any suspicious behavior, many people, whether they were buyers and sellers of real estate, mortgage lenders or investors, became extremely reluctant to make major financial commitments to projects that were not fully insurable.

As the December 31, 2001 date for renewals of policies approached, the business community faced an undesirable future without affordable terrorism coverage. Most lenders required all-risk insurance for loans above $50 million, and if a property owner lacked insurance against terrorism, lenders could claim that the borrower was in violation of the terms of mortgage agreements and could call for repayment of existing loans. Without the insurance, businesses worried that new loans would be denied and that developers would be forced to stop building trophy properties that might seem like obvious targets for terrorists. Widespread downturns in the real estate industry would inevitably affect the national economy. According to a late 2001 report by the Mortgage Bankers Association, the real estate trade produced 12 percent of the year’s gross domestic product and employed 8.5 million people. Those figures included not only brokers and salespersons in real estate but also workers in the construction industry, who would lose jobs if there was nothing to build.

Some in the real estate and mortgage fields predicted that a company’s inability to obtain terrorism insurance on a particular piece of property would force that business to relocate. Although that possibility might have helped less densely populated areas of the country by bringing jobs and economic growth to different communities, people generally agreed that high concentrations of businesses in major cities aided efficiency and competition.

Documented Effects of Exclusions and Decreased Availability

In some cases, the fears surrounding the unavailability of terrorism insurance were proven valid by real problems that surfaced in 2002. In other cases, what actually occurred in the business world did not support the worries of the uninsured and the underinsured. Under the circumstances, many insureds got creative with their coverage and did their best to adjust to a rapidly hardening market.

An assortment of property owners dealt with high prices by insuring their entire real estate portfolio at a low level, figuring that they could financially survive an attack if each of their buildings was at least partially covered. Although some companies opted to spread out and open smaller offices instead of containing every aspect of their business within a single skyscraper, lack of coverage did not force a massive exodus by industries away from metropolises like New York City and Chicago to areas of the country where terrorism risk seemed lower. Some banks did not pull back loans from uninsured clients but instead asked for higher returns on their investments. Other lenders exempted small businesses from all-risk requirements unless a business was situated near a high-risk property. Assorted lenders financed initially uninsured projects but insisted that property owners seek out affordable terrorism coverage.

Other lenders decided to do the legwork themselves, securing policies for their clients and expecting repayment for the plans. These sorts of agreements allowed various real estate deals to receive an initial green light from lenders but ultimately fostered serious disputes that tested the strength of business relationships. In the first major battle over terrorism insurance, General Motors’ GMAC Commercial Mortgage Building Group bought $100 million in terrorism coverage for $750,000 to insure its mortgage loan secured by the Mall of
America, the country’s largest shopping center. Simon Property Group Inc., which owned the center, claimed that the lender’s choice of insurance cost too much and insisted on not paying for it. In the end, Simon independently purchased equal coverage for the mall, as well as the rest of its portfolio, at a lower price.

Property developer Douglas Durst spent $500,000 on a $100 million terrorism policy for New York’s Conde Nast building, but that was not enough to satisfy Cigna Investors, which demanded full coverage for the site’s $430 million mortgage. A New York state judge ruled Durst needed to purchase additional insurance, but the state’s Supreme Court disagreed.

According to Jackie Spinner of the Washington Post, utility companies across the country also struggled to find terrorism insurance. Associated Electric & Gas Insurance Services offered policies that covered $50 million in damages, but the provider limited its liability to a collective $100 million for the industry.

Individual examples of insurance-related nightmares for businesses were limited, perhaps, by the reluctance of companies to disclose their problems to the press. After all, a potential investor or customer would be scared off by a business that has been denied coverage for terrorism and thereby had its property labeled as an unsafe site. The relatively small amount of specific, reported horror stories related to terrorism insurance probably made some people wonder if real estate agents and lenders were blowing the issue out of proportion, but on a broader scope, some numbers supported claims of a crisis. GMAC announced in June 2002 that it had rejected $1 billion in loan requests because clients did not possess adequate terrorism coverage. A 2002 survey conducted by the Real Estate Round Table found that deals of $15.5 billion in 17 states had been postponed or revoked due to the missing insurance.

**Terrorism and Workers’ Compensation**

Businesses that managed to avoid problems related to real estate still had to address terrorism coverage through their workers’ compensation plans. With some exceptions for certain industries and small businesses, employers in almost every state must monetarily compensate employees who are physically or mentally harmed while performing job-related activities. The September 11 terrorist attacks resulted in $3 billion to $5 billion in workers’ compensation claims. These collective claims involved deaths and physical injuries, as well as many cases of serious stress disorders. Although 45 state regulators allowed insurers to exclude terrorism coverage from property and casualty policies, most did not allow providers to extend that exclusion to workers’ compensation. Reinsurers, on the other hand, had the power to exclude coverage and left the insurance companies with an undesirable choice between raising prices for clients and not doing business with certain customers at all.

Terrorism insurance for workers’ compensation was not as difficult to find as similar coverage for real estate. In an act of last resort, employers could obtain coverage through their states. But businesses hoping to get good deals for workers’ compensation could not avoid high prices in either the traditional or nontraditional markets. Increased medical costs and the passage of privacy laws had already made workers’ compensation a costly and unpredictable line of coverage for insurers of high-risk employees. And in the aftermath of September 11, many employers whom underwriters once deemed safe suddenly found themselves paying more for the insurance just like every other high-risk customer.

Before the terrorist attacks, workers’ compensation was cheap for financial companies. After all, most white-collar employees with desk jobs at downtown high-rises do not especially handle heavy machinery or need to stare down many gunmen. From a physical standpoint, that kind of office work is far less demanding and far less dangerous than jobs on construction crews, in factories or with the police force. But those logically solid comparisons
of risk sink under the weight of terrorism. Workers at a financial company, regardless of job duties, are at risk post-September 11 because their offices are often located in central parts of cities inside iconic architectural structures. Workers at the World Trade Center, for example, were retrospectively obvious high-risk employees because they labored in buildings that terrorists recognized. Plus, their jobs played a role in the maintenance of the national economy, which terrorists hoped to disrupt.

Fearing similar strikes, insurers who offered workers’ compensation coverage began collecting more extensive information about their current and potential clients. They started to care less about the nature of a company’s business and more about that company’s office space and number of employees. Organizations that occupied several floors in skyscrapers and employed hundreds of workers at the same location sometimes struggled to obtain terrorism coverage. In some cases, businesses requested insurance from 30 providers and received only one offer in response. Some companies reported that comprehensive health plans, wellness programs and data about their employees’ medical histories allowed them to purchase reasonable workers’ compensation coverage. Others, though, found that implementing those kinds of programs and keeping those kinds of records merely froze the prices they paid for insurance instead of lowering them.
Insurance Basics and Background

A Brief Underwriting Review

The financial consequences of an attack and the unavailability of reinsurance are the bottom-line reasons for the alleged terrorism insurance crisis; but insurers have literally made their livings by adjusting to history’s presented risks and absorbing them for a price. As a result, any newcomer to the topic may wonder why terrorism continues to be such a difficult nut for the industry to crack. In order to more fully address that issue, we must possess a general understanding of how an insurer measures risks. After gaining that knowledge, we can then note how terrorism either fits into traditional modes of risk assessment or, on a situational basis, renders these methods useless.

When insurers consider how to offer and price policies, they ask the same basic question faced by anyone making a decision: Are the benefits of this particular action likely to outweigh the risks? More specifically, if insurance companies are debating whether or not to offer policies for damages caused by fire, they must judge the possibility of one (or several) of their clients’ buildings going up in flames and requiring the insurers to provide compensation. Underwriters consider this probable figure for compensation and factor in other costs related to the policy, including those for overhead, reinsurance and a cushion of surplus money in case the laws of probability fail to cooperate. Underwriters then compare the projected total cost of offering coverage to the projected profits. So, of course, if a particular brand of coverage boasts high risks and potentially low profits for the insurer, customers will either pay high premiums for such policies or will not be offered them at all.

Catastrophe Models

Insurance experts as a whole have dealt with fire risks long enough to formulate general estimates of losses in relation to that particular peril. They know from experience that a certain number of fires will occur each year and that no single blaze is likely to endanger the industry. Insurers run into problems, however, when faced with catastrophes. From an insurance standpoint, a catastrophe is typically defined as an incident that causes insured damages of $25 million or more. Unlike the average fire, catastrophes do not occur every day, and they pack a financial punch that could knock an insurer out of business. These factors led risk assessment professionals to develop multi-faceted estimation tools, known as catastrophe models, which help insurers predict the likelihood of a catastrophe and its resulting damages.

Catastrophe models had been around since the 1980s, but it took years for insurers to gain enough confidence in the tools to use them in estimating losses. In the summer of 1992, Hurricane Andrew hit Florida and caused $26 billion-worth of damages. This catastrophe, the most financially disruptive one in American history prior to September 11, left 11 insurers insolvent and forced underwriters to admit that modeling was perhaps more reliable than traditional methods of risk assessment that employ complex actuarial charts. Catastrophe models do not ignore past insurance data, but they deemphasize that data in favor of computer simulation and more widespread expert analysis. In the case of a hurricane, for example, an insurer utilizes information from meteorologists and software from a modeling organization in order to simulate a storm (a Category 3 hurricane that occurred 100 years ago, for instance) and assesses how a similar catastrophe might affect insured lives and properties today in a particular area of the United States. Because hurricanes, like other catastrophes, occur infrequently and are less predictable compared to other perils covered by insurance, modelers simulate several storms in an attempt to provide fair, average-based estimates to underwriters.
Scientific data and simulation can provide an estimate of catastrophic damages, but individual insurers want to know how a sudden disaster may specifically affect them. In order to produce as accurate an estimate of potential losses as possible, underwriters provide modelers with various pieces of information. If insurers want to gauge potential losses from a particular event, they will often do the following:

- Note how many of their policies are held in a particular zip code.
- Examine that area’s history of catastrophes.
- Study data concerning the structure of the buildings they insure in the area, reporting whether a piece of property is weather-resistant or not.
- Use documented losses from any similar disasters as guides.
- Consider the specifics of their policies, paying attention to deductibles and to what sorts of damages are actually covered through the plans.

Although catastrophe models can warn insurers about potential future losses, they serve financial purposes in the present, too. Insurers often point toward estimates derived from models when trying to convince state regulators to permit increased premiums. Because catastrophe models can sometimes estimate losses from events as far into the future as 100 years, insurers have used this form of risk assessment to predict long-term financial outcomes. (The models have even given birth to catastrophe bonds, which will be defined later in this text.)

But confidence in the models varies from one insurer to the next. Different modelers often come up with different estimates of potential losses, prompting insurers to never trust the findings of just one modeling service. Even when the various modeling firms are in general agreement regarding catastrophic losses, they can still be collectively streaky in terms of their predictions. Model estimates for a 1994 earthquake in Northridge, California were nearly 10 times less than the actual damage. Models related to Hurricanes George, Earl and Bonnie generally got the numbers right, but low estimates for Hurricane Katrina caused some insurers to once again question the reliability of the catastrophic models. Others within the industry stress that incomplete data from insurers contributed to the poor estimations. With all of this information in mind, it is perhaps best for an insurer to keep catastrophe models within their proper perspective and to view them as what they truly are: helpful tools but not infallible prognosticators.

**Terrorism Models**

The insurers who did not exclude terrorism coverage from property and casualty policies following September 11 generally relied on modified versions of catastrophe models to assess risks associated with another attack. Underwriters still provided data related to their claim history and policies, and computer programs still simulated events in order to provide estimates of accumulative insured losses for multiple lines of coverage. Experts remained major forces in modeling, but, for obvious reasons, defense workers and terrorism authorities took the place of the seismologists, geologists and meteorologists who modelers used to predict the impact of earthquakes and hurricanes. Based on these new models and their accompanying software, insurers can estimate potential losses from a particular terrorist plot at a selected location. Given a mode of attack, a model can show the insurer which properties are most at risk. The feature can also be inverted and used to rank the types of attacks that would most likely damage a particular property.

Risk Management Solutions (RMS), a risk assessment organization originally formed to measure potential earthquake losses, employed various public safety and terrorism experts
to assist in the creation of its terrorism model. The RMS software can estimate the effects of 32 different kinds of attacks on over 3,000 targeted locations in the United States and abroad. Each RMS simulation treats an attack as an act of “macroterrorism,” a large-scale event that either kills at least 500 people or causes minimum damages of $1 billion. By using dispersion models, the RMS program predicts the reach of chemical, biological, radiological and nuclear weapons, as well as that of traditional bombs. A model for an attack of smallpox is based in part on government contingency plans for outbreaks of infectious diseases. Surveys completed by insurers contribute to RMS’ estimates for business interruption.

Among RMS’ competitors, AIR Worldwide utilizes a similar model that can estimate various multiple-line losses at over 300,000 targeted locations and is the only risk assessment company that uses the same model for chemical, biological, radiological and nuclear attacks as the U.S. Department of Defense. According to an April 19, 2004 report by the Consumer Federation of America (CFA), the Insurance Services Office utilized the AIR model to identify high-risk locations in the United States. At the time, San Francisco, Chicago, Washington D.C., New York City and their surrounding areas were thought to have a high risk of terrorism. Areas near or encompassing Boston, Seattle, Los Angeles, Houston and Philadelphia, the report said, were at “moderate” risk. The rest of the country was termed “low” risk. Jack Seaquist, senior manager at AIR Worldwide Corporation, said in February 2006 that, since the ISO investigation cited by the CFA, his company had produced updated versions of its model, which more finely examine nuclear, biological and chemical attacks. According to Seaquist, ISO’s most recent filing of geography-based terrorism loss costs still categorized Chicago, San Francisco, Washington and New York as the nation’s high-risk cities, but places that ISO once grouped into simple categories of moderate or low levels of terrorism risk have been categorized less broadly. AIR now offers more specific loss reports that focus on several more cities across the country.

**The Trouble with Terrorism Risk Assessment**

As noted previously, however, some insurers do not even trust the reliability of natural catastrophe models. With billions of dollars at stake in the event of a terrorist attack, it would make sense for many people to lack faith in programs designed to project terrorism losses. A hurricane can certainly cost an insurer as much as a bombing, but the terrorist is even less predictable than Mother Nature.

“In order for something to be insurable, you have to have a handle on severity, to some extent, and frequency,” said Julie Rochman, senior vice president of public affairs for the American Insurance Association. “It’s pretty impossible to tell the frequency. The only people who control that are the terrorists.”

Arguably one of the most important psychological tools one warring party can use against another is an understanding of the enemy’s values, viewpoints and emotions. If we cannot feel what our opponents feel, logic suggests, we cannot understand them enough to predict their next move. Making an effort to understand one’s enemy is, of course, difficult enough when bad blood begins to flow among people from similar backgrounds. That understanding is even more elusive when an enemy’s culture differs significantly from one’s own. It is hard to win a game if an opponent plays by different rules.

Clearly, some rules of traditional warfare do not apply in a battle between westerners and members of al-Qaeda. Unflinching martyrdom, a hybrid concept of war and religion so integral to the group’s violent acts, can perhaps never be fully understood on emotional terms by members of modern, secular societies. When first constructing its model to quantify terrorism risk, AIR examined the history of the IRA, but the modelers eventually determined that the goals and value systems of the West’s most notorious terrorist organization
contrasted too greatly with those of al-Qaeda. Because most westerners will always struggle to comprehend the thought process of a terrorist who believes he is fighting a holy war, they might never know what that terrorist will and will not do in the name of his cause.

If, however, terrorism experts are correct in their assertion that al-Qaeda will engage in any activity and take any risk in order to rid the earth of alleged infidels, that understanding (though immensely important to a war on terror) only increases the difficulty involved in fighting terrorists and predicting the nature of attacks. The next terrorist attack could involve planes, cars, trucks, trains, boats, buses, missiles, guns, anthrax, smallpox, a combination of these possibilities or none of them. Because members of groups such as al-Qaeda have nothing to lose, unlike conventional adversaries, their modes of attack are limited only by the constraints of their creativity and finances. Assuming that resources of money and ideas exist, people who truly wish to harm others, with no regard for their own livelihoods, will discover a way to accomplish that goal. If terrorists wish to instill fear into the souls of survivors, they will likely choose an attack mode that deviates from conventional wisdom, or at least from the 30-odd scenarios simulated in most models.

Yet, even if experts and modelers were able to list all potential weapons of a terrorist, the general location of an attack could remain in doubt. Literature from al-Qaeda reveals the organization’s focus on architectural structures that symbolize the Western economy, but the intelligent members of the group will note the security enhancements at these targets and might shift their attention to other places. Israel, for example, boasts perhaps the best airline security system in the world. That might discourage terrorists from formulating an elaborate plan to hijack several Israeli planes, but smaller acts of deadly violence persist in less secure settings of that country. An attack on a federal building or an airport might never occur again in the United States because of heightened alertness at those sites, but a well-organized terrorist group could coordinate several smaller attacks at low-risk locations and still cause major cumulative damage.

Terrorists could also strike a seemingly low-risk target in order to obtain a psychological victory over their enemies. A form of mathematics known as game theory analyzes war strategies and adaptations of rational and intelligent creatures. Among its various teachings, game theory suggests that it is possible for an opponent to gain an advantage over another by making a random decision. In relation to terrorism, al-Qaeda could choose to target building X, be it a high-risk property or not, and therefore make risk assessment an even tougher endeavor. Some experts, such as RMS model developer Dr. Gordon Woo, argue that a random act of terrorism would not harm insurers as much as a more obviously targeted attack. This makes sense on a short-term basis. The random nature of the act would geographically diversify the risk and would perhaps result in fewer casualties and less property damage than, say, an attack on a prominent New York skyscraper. In the long term, though, this random act could present increased negative consequences. If, for example, al-Qaeda randomly strikes a low-risk location, security forces might increase their presence at similar low-risk areas and take some of their limited resources away from traditionally high-risk places. At the climactic moment in that nightmare, the terrorist might once again target the prominent New York City skyscraper and face reduced security barriers.

Some observers have commented that a further problem with terrorism coverage, from the perspectives of both the insurer and the policy holder, exists because several outside parties form a chain of protection against terrorism but any weak link can cause tremendous vulnerability to an attack. In the case of September 11, victims at the World Trade Center depended upon the government to identify terrorists and halt destructive plots. They also depended upon airport security workers and flight crews to prevent terrorists from boarding and hijacking the planes. These factors complicate the process of estimating one’s exposure
to risk, particularly because they incorporate so much potential for human error by people who are not even involved in an insurance transaction. A customer does not want to pay high premiums just because a few airport security workers fail to do their jobs competently, but an insurer may need to charge high premiums for that exact reason.

Arguably the toughest link to evaluate in this security chain is the government. On one hand, al-Qaeda’s successful execution of the September 11 attacks was enough to make citizens question the proficiency of terrorism experts at the federal level, let alone those that now provide guidance for modelers. Furthermore, the patient preparation that characterizes al-Qaeda’s plots and the fact that few links existed between the various September 11 hijackers suggest that intelligence organizations need mounds of time and sources in order to gauge the group’s plans. On the other hand, government bodies such as the Central Intelligence Agency and the Federal Bureau of Investigation view secrecy as an integral element of their success. Expert civilians and the general public will never learn the details of every potential terrorist threat and will never know the full scope of intelligence gathering that government agencies engage in. Without that information, insurers can only achieve a limited level of accurate risk assessment.

But for argument’s sake, imagine that the government decides to publicly pat itself on the back and announces that it has successfully deterred terrorists from attacking the United States on 200 occasions since September 11. What exactly would that announcement mean in terms of risk? Would the government’s success in all of those situations mean that risk is low because we have capable civil servants who shield us from harm? Or would it mean that the country is at high risk because the government has needed to investigate all of those threats? Given that information, should insurers increase premiums for terrorism coverage or let them slip?

Woo, whose model puts great emphasis upon game theory, said RMS does what it can to formulate loss estimates for insurers despite these many human factors.

“The dynamical interaction between terrorists and the forces of counter-terrorism is imbedded within the RMS model,” he said. “Whereas the underlying principles are robust, the model parameters are subject to adjustment according to political events.”

Woo’s model, though, along with every other tool used to estimate severity and frequency of terrorist attacks involves complicated methods that are seemingly based as much upon human behavior, such as an enigmatic factor at times, as they are on indisputable data. At least where risk assessment is concerned, all of the human riddles that are involved with terrorism can make a Category 3 hurricane seem like a light drizzle.

The Underwriting Cycle

Despite all the uncertainties related to the frequency and severity of terrorist attacks, some insurance insiders refused to panic after September 11 and viewed the problems of the real estate business and their own industry as mere products of an underwriting cycle that would change for the better in due time. In general, the underwriting cycle explores the business practices of insurers and relates those practices to the financial health of the industry.

It is perhaps easiest to comprehend the cycle if we begin at its often brief middle point, the uncharacteristically calm time when, overall, insurers and customers are content with the prices of premiums and the availability of coverage. That stage in the cycle ends as soon as competitors decide to lower their prices and expand coverage, hoping to attract more customers and to ultimately increase market shares. As more and more insurers respond by lowering their rates and issuing more policies (consequently increasing their companies’ exposure to risks), the market becomes “soft.”
During soft periods in the cycle, insurers will typically dig into their financial reserves and surplus revenue in order to pay claims and will look for ways to lower internal costs. Once enough insurers decide that they can no longer afford to operate under soft conditions, competition decreases, prices and deductibles rise and insurance becomes more limited in terms of availability and scope. The industry uses this time, known as the cycle’s “hard” period, to replenish its reserves. When insurance companies regain their financial footing, they inevitably return to competing with industry rivals, lowering premiums and expanding coverage. Meanwhile, new parties recognize the demand for insurance among the public, join the industry and create even greater competition. The market’s cycle, from soft to hard and from hard to soft, continues.

Traditionally, one run through the underwriting cycle occurs every six to eight years or so. The years prior to September 11 nurtured a debate over whether or not the typical underwriting cycle had ceased to exist. Most insurers believe that the industry experienced a hard market in the mid-1980s after some companies priced themselves out of business, but no consensus existed regarding hard markets in the following years. Some sources claim insurers experienced more than a decade’s worth of soft market conditions, while others insist that catastrophic events, such as Hurricane Andrew, provoked periods of hardness during the 1990s.

The debate is, perhaps, understandable due to insurers’ historical expectations of the market. If Hurricane Andrew did indeed cause a hard turn in the cycle, its effect on insurance prices lasted for only a brief period of time. Before the terrorist attacks, underwriters observed that the soft periods of the cycle seemed to be lasting longer than ever before, while the hard periods seemed to conclude in a relative flash.

Multiple factors can contribute to an extension of a soft market. A good economy promotes investing and often blinds insurers to potential underwriting problems. A bull market during much of the 1990s, for example, provided insurance companies with surplus revenue that kept prices low even when catastrophes occurred and when policies were less than profitable. A nearly absolute desire on the part of insurers to hang onto customers also promotes softness. If a company risks losing a longtime client to a competitor who offers cheaper policies, that company will often counter with a lower rate. By hanging onto the client via lower prices and essentially eating the difference in cost, the insurer ultimately furthers a crisis phase in the cycle, typified by pricing wars and declining financial reserves. According to various insurance experts, companies might be best served by deemphasizing prices and the importance of market share. Instead, insurance professionals can perhaps best prepare for an insurance crisis by refining the models they use for underwriting and by daring to say “no” to some high-risk clients who demand low rates, even if those customers threaten to take their business elsewhere.

In some ways, the crisis phase in a soft market plays out like a staring contest between the individual insurance company and the rest of the industry. In order to survive relatively unscathed from an extended soft period, insurers must possess realistic understandings of their risks and resources. Sometimes, companies can wait for the rest of the industry to blink first, decrease coverage and charge higher premiums. As the insolvencies from years past proved, however, a financially responsible company might need to be the one to blink. If no one blinks, nothing changes. By September 2001, the staring contest was only beginning to end.
The Insurance Cycle Before and After September 11

As economic growth slowed at the turn of century, insurers saw modest signs of a hardening market. But for many in the industry, a refreshing pool of reserves was forming at a frustrating rate of one drip at a time. More than one expert said in pre-September 11 interviews that “pain” was the only thing that would force a true turn in the insurance cycle. In a somewhat prophetic article for National Underwriter in February 2000, Sean F. Mooney reported that an obvious shift in the underwriting cycle would not occur unless a catastrophe materialized with an attached price tag of $25 billion to $30 billion or unless one sect of the market collapsed. The September 11 attacks produced both of those scenarios, with insured losses reaching $40 billion and with reinsurers and most insurers refusing to issue terrorism coverage. If insurers did not trust the signs of hardening in the market pre-September 11, they finally had reasons to believe them.

For some insurers who had waited several years for a prolonged hard market, prices did not rise as steadily as hoped. By 2004, rates were still going up, but the percentage of the increases paled in comparison to the additional charges that insurers imposed on consumers in the first rate hikes after the attacks. To an extent, this made sense. Premium increases of 20-plus percent in consecutive years would not have endeared the industry to an already disillusioned public. Also, added cultural interest in alternate forms of risk management, from burglar alarms to wellness plans, seemed to cap the amount of money insurers could charge for certain forms of coverage and still expect an adequately sized collection of buyers. By 2005, some observers had pronounced the underwriting cycle soft yet again.
Building Momentum for Federal Aid

The Argument Against Government Involvement in Terrorism Insurance

Although the insurance industry’s cyclical nature represented arguably the most pronounced reason for the national government to stay away from the crisis over terrorism coverage, it was not the only one. Some opponents of government assistance claimed that an economic recession, not a lack of terrorism insurance, was most responsible for the struggles of the real estate industry. People did not build or buy properties, the argument went, because incomes were down and little demand existed for new goods and services at these sites. Plus, when surveyed about why they declined to purchase terrorism insurance for their properties and businesses, most people did not respond with concerns about pricing or availability. Their number-one justification for not getting the coverage was that they did not view themselves as being at risk.

There was also a more principled argument against federal involvement. If the country went to war (as it did first in Afghanistan and later in Iraq), the nation might need to allocate unknown amounts of money for defense purposes. That would be tough to do if property owners became entitled to reimbursements following another September 11. And what would be the government’s responsibility in the event of a nuclear attack, for example, which could claim millions of lives and make the cost of the World Trade Center’s destruction seem like an intern’s stipend?

Most insurers, though, and many people outside of the industry have said, right after September 11 and in the years that have followed, that government should not be exempt from playing a role in the stabilization of a market for terrorism insurance.

“Government is a part of the solution because the government has all the information about threats, specific and general,” said Julie Rochman of the American Insurance Association. “Attacks are not attacks on the Marriott, or a stadium or a hospital. They’re attacks on the United States of America.”

A Sampling of Government Aid

The U.S. government had stepped in on many occasions prior to September 11 to provide various forms of insurance-related assistance during extreme times of need. Perhaps the most obvious examples of this are the benefits provided by the U.S. Social Security Administration, the cornerstone of President Franklin D. Roosevelt’s wide-ranging New Deal programs designed to help Americans cope with the Great Depression. Among other benefits, Social Security provides retirement income and unemployment insurance for qualifying individuals.

In general terms, Social Security and the government’s role in the issuance of terrorism insurance have provoked similar worries from detractors. Roosevelt’s programs ushered in the modern American welfare system and scared foes of big government. Even when the nation began distributing pension-type payments, the concerns over how to pay for future generations were prevalent, and that was before most Americans could expect to live past the age of 65. Then as now, politicians and economists wondered if the taxes imposed on payroll checks would create enough revenue to support the program without the need for benefit cuts. Yet, despite numerous warnings spanning several decades that Social Security is on its last legs, the most comprehensive form of public insurance in the United States endures.

Though less of a hot topic (at least within urban circles), federal crop insurance against catastrophes also has its roots in Roosevelt’s New Deal. The initial program covered few farmers and even fewer crops. But regardless of its limited reach, the plan let victims of the
Dust Bowl knew that elected officials in the nation’s capital were not completely deaf to pained cries over poor harvests. In various reform bills passed during the last quarter-century, the government has noted the financial problems related to federal crop insurance and has addressed them through frequent changes in policy meant to increase consumer participation.

Until the mid-'90s, the United States Department of Agriculture (USDA) traditionally tackled crop issues through two subdivisions. The Federal Crop Insurance Corp. handled the insurance side of business, while the Agricultural Stabilization and Conservation Service (now incorporated into other government programs) dealt with disaster relief. Throughout most of its history, crop relief has not been contingent upon a farmer's insured status. In other words, if floods wiped out Farmer Bill’s crops, the government might give Bill a chunk of cash even if he lacked federal insurance. For many farmers, the choice between paying high, government-set premiums for catastrophe insurance or paying nothing and still having a good shot at reimbursement has been a no-brainer.

In terms of crop insurance, the government operates under the logic that if it offers some nearly free coverage to farmers, policy holders will be more likely to buy additional insurance and will therefore reduce the amount of money needed for disaster relief. But the deal has required a lot of sweetening to meet the taste of farmers. According to the USDA Risk Management Agency, the fully subsidized catastrophe coverage (not including a $100 administrative fee) only compensates farmers for 55 percent of their crop's value and only kicks in when a catastrophe damages more than 50 percent of the crop. In response to complaints about pricing, the government passed various pieces of legislation over the past decade that increased subsidies for additional coverage.

Beyond nurturing a powerful desire to bring more farmers into the insurance game, major floods in the Midwest during 1993 also caused government officials to reexamine their liability for crop damages. In 1980, the crop insurance program expanded to include involvement from private insurers, who received fees for marketing and offering policies without sharing in any of the risks. The Federal Crop Insurance Reform Act of 1994 transferred some risks to the underwriting industry and offered them premium revenue, administrative reimbursement and government-backed reinsurance in return. Some insurers liked the deal but claimed the government did not live up to its part of the bargain. The act allowed the federal system to still issue its own policies to farmers but only in counties where commercial agents did not offer the coverage. Disputes raged when the government, in the eyes of private insurers, overstepped its boundaries and sold policies in places where private crop insurers had supposedly already set up shop.

As for the current success rate of the national crop insurance system (a potential indicator of how effectively the government might administer another federal coverage plan, such as one for terrorism protection), many farmers have withstood the sharp prodding from the federal government to purchase crop policies and have utilized improved irrigation techniques as well as other forms of risk management. Yet, as recently as June 2005, insurance policies were estimated to have covered approximately 80 percent of planted acres in the United States.

**Lobbyists Convince Washington to Help**

The White House and Congress presumably used their knowledge of previous federal presence in the insurance community to form personal opinions about government’s role in the terrorism coverage crisis. They perhaps considered the idea that terrorism coverage could work as a deterrent to enemies, an indication to potential attackers that a future strike would not cause as much economic chaos as September 11. Maybe politicians paid attention
to such interest groups as the Coalition to Insure Against Terrorism, an alliance of real estate associations, transportation organizations and other business groups that emphasized the employment problems that could arise in a country without terrorism policies. Indeed, it was reportedly the jobs issue that won President Bush over, paving the way for him to say to business leaders, in the midst of the legislative process that followed, “I’ve heard some talk on Capitol Hill… that the facts don’t justify the federal government stepping in as a stopgap. They’re not looking at the right set of facts, as far as I’m concerned.”
The Road to TRIA (Terrorism Risk Insurance Act of 2002)

**Insurers Make a First Move**

Although leaders in the government and the insurance industry eventually developed a consensus opinion that the United States needed some form of terrorism insurance legislation, their agreement concerning the major issue sparked little progress and much contentious debate over the details of proposed plans.

Insurers beat politicians to the punch by putting out their own proposal before anyone else could decide on specifics. The industry’s plan, similar to the terrorism insurance arrangement in Great Britain, called for the creation of a pool arrangement that would have honored a percentage of terrorism-related claims. According to Weiss Ratings Inc., which analyzed several of the initial legislative proposals, the government would have been liable for all claims during the program’s first year as well as any additional claims filed before the pool’s funds reached $10 billion. After obtaining that amount of reserves, the pool would have paid for 80 percent of claims, while the government would have handled the remaining 20 percent. After six years, legislators could have ended the pool arrangement or reauthorized the plan.

In addition to the pool figures, the industry proposed that risk play a factor in the pricing of premiums. Insurers said this form of pricing promoted fairness. From their perspective, a convenience store owner in small-town North Dakota should not have to pay as much for coverage as the owner of a Wall Street office building. The industry also argued that the prospect of high premiums could entice high-risk property owners to take greater safety precautions at their sites. In the minds of insurers, better private security measures would decrease the probability of a highly destructive attack.

**Insurers Reveal the Trouble with Federal Coverage**

The industry’s plan and its quick dismissal by the White House and Congress exemplified the recurrent problems associated with seemingly every proposal for government-backed terrorism coverage. For one thing, not everyone believed that risk should have dictated a policy holder’s premium for terrorism insurance. Although American big business certainly was a target in the September 11 attacks, one can probably say with confidence that the members of al-Qaeda were not specifically furious at a particular company stationed in the World Trade Center. Instead, terrorists were furious at the entirety of the United States, a capitalist democracy with cultural values, political policies and international friends that differ from those favored by Islamic, fundamentalist extremists. Although terrorists might never hatch a plot to attack the convenience store owner in North Dakota, that does not mean that terrorists do not want him dead. Because the World Trade Center and the Pentagon served merely as symbolic targets in a broader context of cultural warfare, one could argue that everyone who al-Qaeda hopes to harm (meaning every American, regardless of geography) should share in the cost of terrorism insurance.

A counterargument persists that high premiums for terrorism coverage are simply part of the price property owners pay for space in major metropolitan areas. But that line of thinking nearly implies that people who have been in business for years in the same building and cannot relocate should have seriously considered the threat of terrorism before they chose to move into a supposedly high-risk property. Clearly, the government should have known more about the risks involved with certain U.S. properties prior to September 11. But one wonders how much property owners should have reasonably known at that time regarding their levels of terrorism risk. On Sept. 10, 2001, most people might recall, hardly any layperson could
locate Afghanistan on a map, let alone note the country was ruled by an anti-American, terrorist-supporting regime known as the Taliban.

Even after the attacks on the Pentagon and the World Trade Center, many insurers claimed not enough data existed to accurately quantify terrorism risk. If that was true post-September 11 for insurers with models and defense experts at their disposals, how could anyone have expected property owners to measure terrorism risks pre-September 11 on their own? Beyond the earlier bombings at the World Trade Center and in Oklahoma City, there was no history to set off alarms in the minds of property owners and warn them that their building was at high-risk for a terrorist attack. There were no ominous memories of past destruction, like the ones that undoubtedly run through the brains of property owners in Tornado Alley or like the ones that will, for the foreseeable future, haunt everyone in post-Katrina Louisiana.

There is also only so much that policy holders can do to secure their properties against terrorists. Although some engineering techniques can protect buildings from disastrous weather, builders will probably not be able to shield a structure from multiple planes that ram through its sides. And as far off into the future as technology seems to be in terms of developing plane-proof buildings, the world may see that kind of protection long before it ever encounters full-proof defenses for commercial properties against massive nuclear strikes.

Regardless of these points and counterpoints, the insurance industry’s plan for a terrorism insurance pool fell on deaf political ears mainly because of the big role it gave to the federal government. Six years seemed like an overly long commitment, particularly for a pool that would not have been responsible for at least a year’s-worth of potential claims and that demanded an increased level, if not an overload, of bureaucracy. No terrorism insurance measure could pass through Congress unless fiscal conservatives could somehow be convinced that the plan was strictly temporary, not a handout to insurers and contingent upon the status of the war on terror. Legislators from both sides of the political aisle agreed that eventually, as the war effort became more successful, the government’s responsibilities to any plan should be transferred to private insurers.

For some people, the idea of a merely temporary terrorism insurance program seems flawed based on the perceivably broad goals of the war on terror. On one hand, no one knows, as at the time of this writing, if or when the United States and its allies will root out Osama bin Laden or secure relative peace in Iraq. On the other hand, even if those two goals are accomplished, perhaps not even the White House can say whether or not the war on terror will have actually reached a conclusion. Therefore, the word “temporary” may never fit snugly into international conversation regarding America’s quest to protect itself from terrorists. If good conquers evil, and all terrorism ceases to exist, then terrorism insurance will no longer be an issue. But until that day comes, or if it never does, government officials might struggle to determine when a temporary insurance plan should reach its end. In order for government involvement to conclude, legislators and underwriters must be convinced that the insurance industry can survive even when it takes on terrorism risks. And the government must be confident that terrorists will not view an end to federal coverage as a sign of relaxed American attitudes toward homeland security. Washington may want to keep game theory in mind when considering a discontinuation of federal coverage and recognize that lulls in terrorist activity could only represent the calm before a storm of more violence.

If private insurers are to ever amicably accept the burden of terrorism risk, one of two things must occur. In the more pessimistic of the two scenarios, insurers must recognize the potential for market-share dominance that would present itself if they lowered prices and increased availability. This is a dreary hypothetical situation because it expects insurers’ greed to overpower their senses of realism and fiscal responsibility. In a more moral
alternative, the insurance community and Washington might need to make an equitable swap, with insurers becoming more accountable for claims in exchange for either relevant government intelligence or help in the development of a supreme risk-assessment model.

**A View from the White House**

Deeming the insurance industry’s proposal too bureaucratic and drawn-out, the Bush administration introduced its own terrorism insurance plan in November 2001, which would have increased liability of insurers every year but would have required no deductible during its first 12 months of existence. Under the White House proposal, the government would have paid for 80 percent of total claims up to $20 billion and 90 percent of total claims that exceeded that dollar amount. In the program’s second year, insurers would have paid for the first $10 billion in claims, half of the next $10 billion and 10 percent of anything over. During the next year, the industry would have been responsible for the first $20 billion, half of the next $20 billion and 90 percent of excess claims. The plan included an industry-wide cap of $23 billion for the second year and $36 billion for the third year. The government would have capped its own liability at $100 billion for each of the three years. The caps on all parties, featured similarly in other terrorism insurance proposals, might have caused people to wonder who would pay for insured losses above $100 billion, but the White House and Congress generally agreed that they would figure out how to respond to such extreme damages only after an attack of that magnitude occurred.

On the whole, insurers were relatively pleased with the President’s plan. The 20 percent level of responsibility for the first $20 billion in the initial year was higher than most people in the underwriting community would have liked, but many insurers felt encouraged at the sight of some progress and hoped out loud that the 20 percent figure was a flexible amount, suggested by the administration, that would drop amid more intensive negotiations.

Bush’s proposal also called for the prohibition of punitive damages in lawsuits related to future terrorist attacks. Plaintiffs typically sue for punitive damages when they feel that a defendant’s actions were not only wrong but also committed outside of the lines of human decency, causing hardships like pain and suffering that do not lend themselves to an easily determinable figure of compensation. Beyond their effects on a particular court case, punitive damages can serve as precautionary notice to society that certain forms of wrongdoing could cost a guilty party a tremendous amount of money even if actual, calculable damages are relatively small. In the legal world, punitive damages have become increasingly controversial as, rightly or wrongly, sympathetic juries have awarded larger and larger damages to winning plaintiffs. In order to shield themselves from punitive losses that they might need to pay on behalf of their clients, insurance companies have substantially raised liability premiums for medical professionals and other groups of clients who possess a high risk of being sued for enormous amounts of money. In support of these consumers and their insurers, President Bush had previously advocated caps on punitive damages in medical malpractice suits and had favored similar limits on litigants in lawsuits related to September 11. To Bush and many citizens who believed that punitive damages had gotten out of control, trial lawyers with dollar signs in their eyes deserved much of the blame for high liability premiums and colossal punitive rewards through their instigation of overblown or frivolous lawsuits. Because terrorist attacks would certainly breed significant legal claims, the Bush administration did not want an already major problem for many insurers and insureds to mushroom into something much more troublesome that could also potentially place the U.S. government on a list of liable parties. But many lawmakers and lay citizens believed just as fiercely that limits on punitive damages would prevent the advancement of justice in situations where victims truly suffered horrific pain that could not be repaired through compensation for medical bills, to name one general example. The limits also could retard the transmission of a precedent-setting moral
message, one that said to the guilty party, “You behaved repulsively, and now, you must suffer the consequences.”

The Bush administration’s firm attitudes toward punitive damages brought on the most political fight of the legislative period for terrorism insurance. A seemingly never-ending war of words between the administration and its Democratic foes pitted one party with alleged special interests against another. Whether related to terrorism coverage, airline bailouts or the cost of medical insurance, the debate over punitive damages involved the same basic accusations. Republicans charged Democrats with pandering to an electoral base of trial lawyers who were allegedly ruining American businesses and tying up the courts with frivolous lawsuits and excessive demands for compensation. Democrats accused Republicans of siding with big-time party contributors from the corporate world instead of with the average citizen who was seriously harmed because of another person’s gross negligence. The fight over punitive damages intensified later in the legislative process once the Senate and its Democratic majority began considering various terrorism bills.

Several conservatives, too, disliked the Bush plan, claiming it veered too much into handout territory. Some Washington observers speculated that many members of Congress still felt the side effects of figurative hangovers from their experiences with the $15 billion airline bailout package that followed September 11. That collection of legislation passed quickly against the better judgment of some lawmakers in a national-emergency environment at a moment when no politician wanted to seem unpatriotic or stingy. By the time of the terrorism insurance debate, members of Congress had regained their political resolve. After a brief crisis period of holding hands, opponents in the big boxing ring of Capitol Hill had returned to their respective right and left corners and had put their gloves back on.

**Construction of a House Plan**

Despite the Bush plan’s attempt at resolving some of the bureaucratic issues presented by the industry proposal, members of the House Financial Services Committee thought they could do a better job of saving taxpayers’ dollars than the White House. H. R. 3210, introduced by Representative Michael Oxley, R-Ohio, and known as the Terrorism Risk Protection Act, was passed by the Republican-controlled House with a 227-193 vote on November 29, 2001 and called for the creation of a federal loan program to assist insurers burdened with terrorism claims. Like all proposed U.S. legislation, the bill would have required passage by the Senate and (in most cases) signed approval from the President in order to become law. Under the House bill, government assistance would have kicked in if the industry, as a whole, had sustained insured losses of $1 billion. In that situation, the government would have covered 90 percent of losses, minus a $5 million deductible from each insurer for 2003 and a $10 million deductible for additional years. An individual insurance company could have received aid if it experienced $100 million in losses with that figure exceeding 10 percent of the company’s surplus and net premiums. In that case, the individual insurance company would have been entitled to 90 percent of coverage for losses minus 10 percent of its net premiums.

The government would have charged assessment fees to all commercial insurers in order to recoup the first $20 billion of assistance, which would have been obtained by the insurers through policyholder surcharges. Assessment fees for each insurer would have been relative to that company’s percentage of net industry premiums. In other words, companies that insured many clients against terrorism losses and collected a larger percentage of industry premiums would have generally paid higher premiums to the government. Those assessments could not have exceeded 3 percent of an insurer’s net premiums each year. If industry-wide assistance passed $20 billion, the Treasury could have charged commercial property and casualty insurers an additional 3 percent assessment fee. When assessing fees
to insurers and surcharges to customers, the Secretary of the Treasury would have considered the level of risk associated with insurers in particular geographic areas as well as the potential effects on businesses and taxpayers. The length of time during which surcharges would have been collected would have depended upon how much the government loaned to the industry. If insurers needed to raise premium rates in order to cover assessment fees, the act would have voided relevant state laws regarding prices.

The Secretary would have overseen the low-interest loan program and notified insurers of any assessment charges with 60 days of notice. Insurers who could not have paid their portion of the government loans or who gave false information regarding premiums or claims to the Treasury Department would have faced a penalty greater than or equal to $1 million depending upon the amount of assistance at issue. The government could have also raised interest rates on the outstanding loans or denied future assistance to insurers who did not live up to the terms in the law. The Treasury Department would have had the power, however, to defer repayments for insurers who ran the risk of becoming insolvent following an attack.

The bill left open the possibility of coverage for self-insured entities but stressed that those self-insured parties would have received no assistance unless a decision regarding their status had been reached before an act of terrorism. So, if the bill had become law on, say, November 20, 2001 without self-insured provisions attached to it, and terrorists struck later that day, the government would have provided no compensation for its self-insured citizens.

Initially, the legislation called for the introduction of reserve funds for insurers, but Congress ultimately dropped this measure in favor of a House Ways and Means preference for a mandatory study of the issue due four months after the plan’s enactment. The study would have examined how reserves could help insurers, how much money should go into the reserves and who would oversee the creation and proper maintenance of those funds.

The Terrorism Risk Protection Act, like the terrorism insurance bills that followed it, would have set up a system for legal claims that arose from an attack. Cases would have been heard in district courts designated by the Judicial Panel on Multidistrict Litigation, and the House also voted in favor of limiting an attorney’s right to financial settlements or judgments to 20 percent of damages awarded on a claim. Lawyers found in violation of this part of the act could have received a fine of up to $2,000 as well as a potential jail sentence of up to one year. In the event of a financial settlement or a judgment in favor of a plaintiff, the resulting money would have been subjected to deductions based on how much reimbursement the plaintiff had already received through other government means, such as a revived Victim Compensation Fund.

In keeping with the Bush administration’s stance, the House bill stipulated that these courts would generally not have awarded punitive damages in terrorism-related lawsuits; but people who took part in terrorist activities would have still had to pay such rewards. If the government managed to freeze the financial resources of a terrorist organization, that money could have been used for punitive reimbursement. By including a right of subrogation in the act, the House plan would have allowed Washington to step into the shoes of any injured party and sue a person or organization in order to recover money lost by the government or American businesses because of an act of terrorism.

One of the subtle yet important differences among each of the proposed terrorism insurance bills is the way they defined terrorism. The most basic distinctions among the definitions involved the person committing the act, the place where the attack occurred and the amount of resulting insured losses. Some proposals defined terrorism broadly and would have allowed insurers to receive government reinsurance for more violent acts than other plans
would have allowed. Other proposals contained comparatively strict definitions of terrorism, meaning that insurers would have been less likely to obtain reimbursement from the government for certain attacks. The government’s ultimate choice of a definition for an act of terrorism would affect customers, too, because insurance companies could structure policies to exclude some types of attacks and still comply with federal and state laws.

The House’s plan would have given the Secretary the final word in determining whether or not an attack was an act of terrorism. It featured one of the broader definitions of a covered event. The National Association of Insurance Commissioners (NAIC) would have been advised to use the legislation as a basis for a further definition that would have applied to all states:

An act meets the requirements … if the act--

(i) is unlawful;

(ii) causes harm to a person, property, or entity, in the United States, or in the case of a domestic United States air carrier or a United States flag vessel (or a vessel based principally in the United States on which United States income tax is paid and whose insurance coverage is subject to regulation in the United States), in or outside the United States;

(iii) is committed by a person or group of persons or associations who are recognized, either before or after such act, by the Department of State or the Secretary as an international terrorist group or have conspired with such a group or the group's agents or surrogates;

(iv) has as its purpose to overthrow or destabilize the government of any country, or to influence the policy or affect the conduct of the government of the United States or any segment of the economy of United States, by coercion; and

(v) is not considered an act of war, except that this clause shall not apply with respect to any coverage for workers compensation.

Lawmakers designed the Terrorism Risk Protection Act to end at the beginning of 2003 but allowed for a possible two-year extension of the plan.

On to the Senate?

Needless to say, insurers disliked the proposal passed by the House of Representatives. Whereas the Bush plan required the industry to pay a percentage of claims following a deductible in its second and third years, the House resolution’s low-interest loan program would have forced insurers to contribute every red cent in the long run, either from their own pockets or from those of their policyholders.

Despite the passing of the House resolution, the bill still needed Senate authorization in order to become law. Many Democrats in Congress’ upper house still held firm to their refusal to allow the prohibition of punitive damages. Some also agreed with insurers that the government should share liability for terrorism instead of simply processing loans from the Treasury Department. Given greater responsibility for claims, insurers would need to raise premiums for consumers. If affordability became a major issue for the public, Americans would not purchase terrorism coverage, and the whole purpose of a government-endorsed plan—to make the insurance available to the masses at a reasonable price—would have been a lost cause. But Senate Majority Leader Tom Daschle, D-S.D., reportedly expected his colleagues to compromise and to get a single proposal out into the open within a few weeks of the House vote. Instead, Daschle ended up waiting nearly a year for terrorism insurance legislation to pass through both houses of Congress.
The National Terrorism Reinsurance Fund Act

The Senate presented alternate solutions. Perhaps the most radical plan for terrorism coverage produced by the Senate came from South Carolina Democrat Ernest “Fritz” Hollings. The senator’s proposal of the National Terrorism Reinsurance Fund Act, introduced November 29, 2001, came closer than any other Congressional terrorism insurance plan to resembling Great Britain’s Pool Re. And although consumers would have faced surcharges in order to offset insurers’ contributions to the fund as well as loans secured by the pool-like program, the bill took the firmest stance of all proposals in the area of price regulation.

Hollings’ plan called on insurers to make quarterly payments to a national system overseen by the Secretary of Commerce. Those funds would have been used to pay for reinsurance to cover terrorism claims that surpassed 10 percent of an insurer’s surplus and net premiums. In its proposed first year, the fund would have covered 90 percent of those losses. During additional years, coverage would have varied based on the percentage of premiums contributed by an individual insurer. The fund would have required insurers to include terrorism coverage in most lines of property and casualty insurance. (Multiple peril lines for homeowners and farmers, mortgage and financial guaranty coverage and private-passenger automobile insurance were exceptions.) Federal reinsurance could have applied to non-required lines if an insurer offered terrorism coverage through them. In addition, insurers would not have been allowed to either revoke existing coverage or refuse to cover certain policyholders for reasons related solely to terrorism risk.

Although the fund itself would have had a cap of $50 billion for each year of existence, the Treasury Department would have handled 90 percent of damages between $50 billion and $100 billion in 2002 and 80 percent of those damages in 2003. Had the fund ever reached its $50 billion cap, the Commerce Secretary would have gone before Congress and suggested courses of action to stabilize finances. If premiums had produced unneeded surplus for the fund, the Secretary could have invested that money and used the resources that accumulated over time to cover future losses.

In order to finance the fund, the government would have required participating insurers to contribute up to 3 percent of their direct written premiums each year. Participants with poor credit ratings (defined in the bill as “lower than the second from highest credit rating awarded by nationally recognized credit rating agencies”) would have been charged an additional yearly premium of 0.5 percent. Insurers would have recouped these assessment fees by adding surcharges to customers’ policies.

The Treasury Department would have given the fund a seed loan of $2 billion, which would have been repaid through assessment fees. The fund could have obtained additional loans from the Treasury Department in order to pay for terrorism claims as long as outstanding debts did not exceed $50 billion. The Secretary of the Treasury would have chosen interest rates for the loans. If the fund had not been able to repay the money to the government on its own, insurers would have faced another assessment fee, less than or equal to 3 percent of their direct written premiums, and consumers would have encountered larger surcharges.

Through their terrorism insurance proposals, lawmakers hoped to promote the availability of affordable coverage. While the various coverage amounts in the plans (some as high as 90 percent) certainly could have enticed insurers to offer terrorism policies again, they did not directly address price concerns on behalf of consumers. Proponents of the bills seemed to operate under the logic that greater supply would promote competition and therefore keep prices for the insurance at reasonable levels, but almost none of the bills’ sponsors went so far as to include specific language pertaining to price regulation in their plans. Under Hollings’ plan, insurers would not have been allowed to raise premiums each year any more
than the combined percentage that they were paying to the fund in regular assessment fees and fees meant to cover its loans. If, for example, a company was paying 3 percent of its net premiums to the fund for reinsurance plus 2 additional percent to cover the fund’s loans, that insurer could not have increased customers’ premiums by more than 5 percent. If, however, the threat of terrorism made a larger increase unavoidable, insurers could have petitioned state regulators by filing a report with them at least a month before the increase was due to take effect and by explaining the reasons for the additional charges. Each year, a committee made up of insurers, government officials, consumers and independent actuaries would have studied terrorism insurance rates and aided Congress if and when the House and Senate considered enforcing stricter price regulations.

If insurers billed claims to the fund, the Secretary would have made an initial determination regarding the loss and its relationship to a terrorist attack. Upon learning of that first decision, the government or the insurance industry could have requested a hearing on the issue. The hearing would have prompted a final decision from the Secretary subject to judicial review. The bill did not include any provisions limiting punitive damages.

Hollings’ proposal defined terrorism in a somewhat tighter manner than the House bill, particularly in its exclusion of acts committed by other governments:

(A) IN GENERAL- The terms “terrorism” and “act of terrorism” mean any act, certified by the Secretary in concurrence with the Secretary of State and the Attorney General, as a violent act or act dangerous to human life, property or infrastructure, within the United States, its territories and possessions, that is committed by an individual or individuals acting on behalf of foreign agents or foreign interests (other than a foreign government) as part of an effort to coerce or intimidate the civilian population of the United States or to influence the policy or affect the conduct of the United States government.

(B) ACTS OF WAR- No act shall be certified as an act of terrorism if the act is committed in the course of a war declared by the Congress of the United States or by a foreign government.

The National Terrorism Reinsurance Fund Act would have expired on the first day of 2005, but the Treasury Department would have been allowed to collect assessment fees until the fund had paid off all of its loans. If, in the discretion of the Secretary of Commerce, the fund became unnecessary prior to that date, it could have been dissolved. If the fund had concluded with money at its disposal, members of the industry would have received a portion of the excess cash, based on their individual premium contributions, for use in a reserve account. Insurers could have accessed reserves in the event of a terrorist attack or weather catastrophe that produced $2 billion in damages. Any money left over from the fund, after the reserve distribution, would have returned to the Treasury.

The Terrorism Insurance Act

On the same day that Hollings introduced his bill, Republican Senator John McCain of Arizona unveiled his own proposal, known as the Terrorism Insurance Act. His plan would have required the government to pay 80 percent of terrorism losses if an insurer’s liability reached $10 million or if damages exceeded 5 percent of net premiums. The government would have capped its liability at $100 billion, and insurers would have reimbursed the country through assessment fees for the first $50 billion of assistance. Insurers would have covered these fees by including a surcharge of up to six percent in every property and casualty premium. When levying assessment fees, the Secretary of Commerce would have had to consider the economic consequences that resulting surcharges would produce for various sizes of businesses in various parts of the country.
The McCain bill mirrored the House plan in its views on self-insured entities and prohibited punitive damages against anyone other than terrorists and people who knowingly assisted them in their plots. McCain’s legislation did not address acts of war, but like Hollings, the senator excluded foreign governments from his definition of terrorists:

- An act meets the requirements of this subparagraph if the act--
  
  (i) is unlawful;
  
  (ii) causes harm to a person, property, or entity, in the United States;
  
  (iii) is committed by a group of persons or associations who--
    
    (I) are not a government of a foreign country or the de facto government of a foreign country; and
    
    (II) are recognized by the Department of State or the Secretary as a terrorist group or have conspired with such a group or the group's agents or surrogates; and
    
    (III) has as its purpose to overthrow or destabilize the government of any country or to influence the policy or affect the conduct of the government of the United States by coercion.

The Terrorism Insurance Act would have covered those events defined as acts of terrorism during 2002 and 2003 with apparently no extensions.

The Terrorism Risk Insurance Act of 2001

Like President Bush, Senator Phil Gramm was a Republican with roots in Texas, and, of all the House and Senate terrorism proposals, his plan seemed closest to the White House’s preferred program. Under Gramm’s Terrorism Risk Insurance Act of 2001, which four other senators cosponsored and which Gramm introduced one day after the presentations of the Hollings and McCain bills, the Treasury Department would have covered 90 percent of insured losses above $10 billion in 2002 and 2003. If the government had chosen to extend the act to include 2004, insurers would have picked up the first $20 billion in terrorism losses for that year before they received assistance. Liability for the industry and government would have been capped at $100 billion. The legislation would not have required insurers to pay any reinsurance premiums to Washington for its help but would have required them to offer terrorism coverage as part of all property and casualty policies. The Treasury Secretary could have imposed civil penalties on insurers who did not abide by the terms of the act, but the legislation lacked specifics in this regard.

Gramm’s bill would have reserved punitive damages only for terrorists and their conspirators. In other words, government officials and building owners would not have been liable for punitive damages. The bill also would have consolidated all lawsuits resulting from an attack into one court, which the Judicial Panel on Multidistrict Litigation would have selected within 90 days of the incident. The legislation would have given the Secretary final approval of any financial settlements and stated that any additional financial compensation that plaintiffs received from the government (via a revived Victim Compensation Fund, for example) would have been deducted from judicial monetary rewards. These lawsuit stipulations, including the near-ban on punitive damages, would have expired contingent upon the expiration of the insurance program. The bill would have put foreign governments in the category of terrorists, and, at least in matters directly related to insurance, its own definition of terrorism would have replaced any state determinations:
The term “act of terrorism” means any act that is certified by the Secretary, in concurrence with the Secretary of State, and the Attorney General of the United States--

(i) to be a violent act or an act that is dangerous to--
   (I) human life;
   (II) property; or
   (III) infrastructure;

(ii) to have resulted in damage within the United States, or outside of the United States in the case of an air carrier described in paragraph (3)(A)(ii); and

(iii) to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

(B) LIMITATION- No act or event shall be certified by the Secretary as an act of terrorism if--

(i) the act or event is committed in the course of a war declared by the Congress; or

(ii) losses resulting from the act or event, in the aggregate, do not exceed $5,000,000.

The possible extension of the act through 2004 would have depended upon the state of the insurance market. If prices had still been too high or coverage too difficult to price, an extension could have occurred as long as the Secretary managed to demonstrate how the legislation could correct such problems and how it could nurture an improving market that would claim greater responsibility for future claims. Although the act had an initial expiration date of December 31, 2003, the Secretary could have continued to reimburse insurers for terrorism claims and to receive assessment fees after the program’s conclusion provided that the triggering attack happened during the legislation’s lifetime.

**Cutting a Deal: The Terrorism Risk Insurance Act of 2002**

In June 2002, the Senate voted to disallow an amendment to the Terrorism Risk Insurance Act of 2002 (TRIA) that would have prohibited punitive damages in lawsuits related to terrorism. The bill, as introduced by Christopher Dodd, D-Conn., would have required insurance companies to pay a deductible on their terrorism coverage equal to their market shares (from the two years before an attack) multiplied by $10 billion for the program’s first year and multiplied by $15 billion following that year. Once insurers met their deductibles, the government would have paid for 80 percent of aggregate damages up to $10 billion. Costs beyond $10 billion would have received 90 percent coverage from Washington. The Treasury Secretary would have been responsible for establishing a “netting” period, a beginning and cutoff point for insurers and their policyholders to file valid claims with the government. Participation in the plan would have been mandatory for property and casualty insurers, and the law would have required participants to offer terrorism coverage in all policies other than those in federal crop, private mortgage and financial guaranty lines.

The legislation would have distributed funds to reinsurers as long as they had signed contracts with their clients prior to passage of the act. The distribution of federal funds would have been relative to the amount of risk shared by reinsurers and primary insurers. If, for example, legal agreements obligated a reinsurer to handle 20 percent of an insurer’s terrorism risks, then 20 percent of an insurer’s compensation package would have gone to that reinsurer. This provision for shared compensation would have ended when the reinsurance policy reached a renewal period or had been in effect for one year.
Like the McCain bill, Dodd’s TRIA left a door open for self-insured entities to receive government assistance as long as the Secretary chose to extend the coverage to them before an attack. The act’s definition of terrorism seemed to exclude attacks on overseas U.S. operations, such as bombins at embassies:

Act of terrorism—

(A) CERTIFICATION — The term “act of terrorism” means any act that is certified by the Secretary, in concurrence with the Secretary of State, and the Attorney General of the United States—

(i) to be a violent act or an act that is dangerous to--

(I) human life;
(II) property; or
(III) infrastructure;

(ii) to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel described in paragraph (3)(A)(ii); and

(iii) to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

(B) LIMITATION — No act or event shall be certified by the Secretary as an act of terrorism if--

(i) the act or event is committed in the course of a war declared by the Congress; or

(ii) losses resulting from the act or event, in the aggregate, do not exceed $5,000,000.

Like the Gramm proposal, the plan could not have been extended unless the Secretary reported poor market conditions for terrorism insurance and convinced Congress and the White House that an extension could lessen, if not solve, that problem. Dodd’s June 2002 version of TRIA did not completely prohibit punitive damages in terrorism cases, but the act stipulated that the program’s money could not be used to cover those sorts of rewards. With that compromise in place, the Senate approved the act in its June 18, 2002 session with an 84-14 vote.

But, because the Senate passed a different bill than the one approved by the House during the previous year, both legislative bodies needed to modify their positions and create a mutually acceptable plan in order for a final law to materialize. Again, President Bush and some House Republicans seemed unwilling to approve any piece of legislation that lacked extensive limits on punitive judgments. The long-term dispute among politicians finally concluded thanks to a compromise that had been suggested by Senator Charles Schumer, a New York Democrat whose home state perhaps had the most urgent need for terrorism coverage. The final Dodd proposal allowed people to sue for punitive damages but disallowed the use of government money to pay for punitive settlements or judgments. This revised form of TRIA took pages out of the playbooks of the Victim Compensation Fund, the passed House resolution and the Gramm bill, putting all lawsuits that stem from an attack under the jurisdiction of one ( or more, if needed) federal district court. With that arrangement in place, trial lawyers would have no control over where litigation occurs and therefore would not be able to search for communities that might be more sympathetic to their clients and more likely to favor large punitive judgments. The give and take between the House, Senate...
and White House over punitive damages finally got the Terrorism Risk Insurance Act of 2002 through both houses of Congress, and President Bush signed the legislation into law on November 26 of that year.

**The Persistence of Dissent**

Amid all the legislative debate, the Consumer Federation of America (CFA), a non-profit association made up of over 300 groups with consumer-conscious agendas, lobbied legislators and pushed for alternate forms of relief that would not incorporate huge amounts of taxpayers’ money. In existence since the late ’60s, the CFA has also recently pushed Congress and government agencies to support peer-to-peer networks for digital music distribution, supported mandatory “country of origin” labels on meat products, spoken out against mergers in the communications industry and promoted greater regulation of broadband internet services, cable companies and the utilities industry.

From the CFA’s perspective, insurers were making profits and could realistically take on more financial responsibilities than any of the terrorism insurance proposals gave to them. Instead of paying billions of dollars to an entire industry, CFA members said, government should limit the scope of its terrorism insurance policies by directly helping those citizens who struggled to obtain affordable coverage. In order to reduce prices of premiums, the non-profit organization suggested an extension of the Liability Risk Retention Act, legislation that eased the creation of self-insurance and captive arrangements (in which a business establishes its own insurance company to cover risks) while encouraging private insurers to lower premiums.

During final negotiations between the House and Senate, the CFA sent a letter to Representative Oxley and Senator Paul Sarbanes, D-Md., urging the two lawmakers to keep insurance customers and taxpayers in mind when determining the fate of government-backed terrorism insurance in America. If the government was going to pass a bloated and unnecessary bill, the consumer group said, legislators should at least not make TRIA more bloated and unnecessary by granting coverage to life insurers, who had gotten to the game late and wanted terrorism protection similar to the kind offered to property and casualty providers.

Also, the group wanted government to address the potential price differences for coverage before and after TRIA’s enactment. Preferably, a consumer would receive a rebate that would correspond with the presumed reduction in prices after the Act became law. At the very least, the CFA wanted clauses added to TRIA that fostered a pain-free opportunity for customers to revise their old policies under the new premium rates. Although Congress did turn down life insurers’ requests for inclusion in TRIA, the CFA’s other complaints and concerns, the ones alleging unnecessary handouts from the government and unfair pricing by insurers, remained relatively constant throughout TRIA’s first run and its subsequent renewal process.
TRIA Made Easy

*The Thinking of Congress*

In Sec. 101 of the final Terrorism Risk Insurance Act of 2002, Congress stated what many insurers, lenders, property owners and real estate executives had been saying since September 11: Insurance plays a vital role in the maintenance of the U.S. economy. Whether during war or peacetime, the spreading of financial risk through policies eases the reluctance of Americans to buy, sell, invest or trade items of value in both national and international markets. When crises occur and shake the world’s faith in peace and prosperity, as the attacks on September 11 certainly did, a firm institution of insurance numbs some of the resulting chaos and expedites recovery, ideally allowing victims to comprehend which of their losses might be recoverable and which might not.

The Act noted the difficulties that insurers encountered after the terrorist attacks, how risk assessment through traditional data analysis became unreliable in regard to terrorism coverage and how unpredictability forced the industry to either discontinue the coverage or offer it to consumers at often high and unsteady prices. Congress mentioned, in general terms, the headaches that low availability and high prices caused for the construction industry, real estate agents, property owners and renters. Most importantly, the writers of the law recognized the special circumstances involved with a “national crisis” like September 11 and declared the government should share insurance risks with the private sector and provide substantial yet temporary assistance for insurers and consumers in order to give the underwriting market the time and the means to adapt and recover.

**Coverage by the Numbers**

TRIA originally provided 90-percent federal backstop terrorism coverage to insurers (through 2006), subject to an annually rising deductible that was based on an insurer’s direct earned premiums from property and casualty policies of the preceding year. For the span of November 26, 2002 through December 31, 2002 (termed the “Transition Period”), the government set the deductible at 1 percent of direct earned premiums. That percentage escalated to 7 percent in 2003, to 10 percent in 2004 and to 15 percent in 2005, all in an attempt by Congress to ease the industry into greater responsibility for insured terrorism claims.

As an example, let us imagine that, in 2005, an individual insurer’s losses from terrorism totaled $100 million and that the insurer’s direct earned premiums in 2004 equaled $50 million. In this case, the insurer would have had a deductible of $7.5 million (15 percent of $50 million) and would have been responsible for an additional $9.25 million (10 percent of $92.5 million) of claims that would have otherwise been covered through TRIA. In the end, the insurer would have to bear $16.75 million of claims from the attacks, and the government would have reimbursed the insurer for $83.25 million of claims.

Neither the insurance community nor the government must absorb aggregate losses above $100 billion in a year. If losses from terrorism exceed the cap, the Secretary of the Treasury will report to Congress, who will decide what to do next. If the insured party receives any other form of federal compensation for terrorism losses thanks to another law or to a federal program similar to the September 11 Victim Compensation Fund, the government will deduct that money from TRIA rewards.

**Repayments**

In what is perhaps a compromise between the House’s resolution (which called for reimbursement of all government assistance) and Dodd’s Senate bill (which stipulated no such refund), TRIA requires insurers to repay the Treasury for a portion of its aid in certain
situations. The Act relates repayment of government funds to a figure called the “insurance marketplace aggregate retention amount.” This amount is the lesser of the insurance industry’s terrorism-related losses in a year and a number specified in the Act for that 12-month span. If the sum of deductibles and the 10 percent of terrorism losses not covered by TRIA is less than the insurance marketplace aggregate retention amount, the industry refunds the difference between those numbers to the government. If the sum of the industry’s deductibles and losses from the remaining 10 percent equals or exceeds the insurance marketplace aggregate retention amount, no repayment is necessary under general conditions. The 2002 version of TRIA designated the following insurance marketplace aggregate retention amounts for corresponding years:

- $10 billion for the Transition Period and 2003 combined.
- $12.5 billion for 2004.

Let us pretend that, in 2005, insured losses from terrorism totaled $100 billion and that the insurance industry’s direct earned premiums in 2004 totaled $50 billion. In this scenario, insurers would have collectively had a deductible of $7.5 billion (15 percent of $50 billion). After meeting its deductible, the industry would have been left with $92.5 billion in insured losses ($100 billion minus $7.5 billion). Insurers then would have been responsible for $9.25 billion of the losses (10 percent of $92.5 billion) with TRIA covering the rest. Because the sum of the deductible ($7.5 billion) and the 10 percent of losses not covered by TRIA ($9.25 billion) would have been $16.75 billion and therefore greater than the 2005 insurance marketplace aggregate retention amount (the lesser of $15 billion and $100 billion), insurers would not have needed to repay the government for its assistance in the form of mandatory recoupment.

Now let us assume that the same terrorist attack occurred in 2005 but that the insurance industry’s direct earned premiums in 2004 totaled $25 billion. In this case, insurers would have had a collective deductible of $3.75 billion (15 percent of $25 billion). That would have left the industry with $96.25 billion in insured losses ($100 billion minus $3.75 billion). Insurers would have been responsible for $9.625 billion-worth of that (10 percent of $96.25 billion), while the government would have covered the rest. In this case, because the sum of the deductible ($3.75 billion) and the 10 percent of losses not covered by TRIA ($9.625 billion) would have been $13.375 billion and therefore less than the 2005 insurance marketplace aggregate retention amount (the lesser of $15 billion and $100 billion), insurers would have needed to repay the government for part of its assistance. The government would have demanded payment equal to the difference between $15 billion and $13.375 billion, which would have come to $1.625 billion. Although this example and the one preceding it demonstrate instances when mandatory recoupment would and would not have been an issue based on differing industry-wide direct earned premiums, it should be noted that different amounts of insured losses from an attack could also have been utilized in order to explain TRIA’s formula for mandatory recoupment.

The Secretary of the Treasury also has the power to demand “discretionary recoupment” even if amounts paid by insurers exceed or equal the insurance marketplace aggregate retention amount. TRIA requires insurers to repay the government in these mandatory and discretionary instances through “terrorism loss risk-spreading premiums.” These premiums, quantified by the Secretary and attached as surcharges to all property and casualty policies in effect after the risk-spreading premium’s introduction, cannot amount to more than 3 percent of what a consumer already pays for property and casualty insurance. Even if they
have not issued a terrorism policy or been affected by an attack, all property and casualty insurers must pay these risk-spreading premiums to the Treasury.

The terrorism loss risk-spreading premiums can, however, differ from one policy or insurer to the next, based on several factors. When determining the amounts and durations of terrorism loss risk-spreading premiums, the Secretary needs to consider the following:

- The potential effects of the premiums on rents in urban areas.
- The cost of insurance in urban areas, particularly for small businesses.
- The level of terrorism risk associated with rural areas.
- The probable severity of attacks in rural areas.
- Other forms of reimbursement (such as crop insurance) available to Americans in rural areas.
- The level of terrorism risk associated with each line of coverage.

By giving the Secretary the power to choose the size of terrorism loss risk-spending premiums, lawmakers seem to have answered the legislative questions regarding who should pay for government-backed coverage and how much those parties should contribute to the program.

**The Duties of the Insurer**

TRIA requires mandatory participation from all U.S. property and casualty insurers. When first enacted, the legislation ordered participants to offer terrorism coverage in all commercial property and casualty policies, until 2005, that “[did] not differ from the terms, amounts, and other coverage limitations applicable to losses arising from events other than acts of terrorism.” The Secretary had until September 2004 to extend this part of TRIA through 2005 and did so on June 18, 2004. TRIA does not, however, demand that insurers cover every customer who walks through their doors. Although insurers cannot deny terrorism coverage to a client on, say, a fire policy, insurers can still turn a customer down for overall fire coverage if the providers are too uncomfortable with terrorism risk. Also, if that fire policy contains exclusions or limits, as nearly every insurance policy does, those exclusions and limits still apply even if a terrorist produces the flames.

In the December 11, 2002 interim guidelines for the Act, the Treasury Department stated that insurers needed to offer terrorism coverage as part of policies in the following commercial lines, which the NAIC listed in its Exhibit of Premiums and Losses:

- Fire.
- Allied lines.
- Farm owners multi-peril.
- Commercial multi-peril (liability and non-liability portions).
- Ocean marine.
- Inland marine.
- Workers’ compensation.
- Products liability.
- Other liability.
• Commercial auto no-fault (personal injury protection).
• Other commercial auto liability.
• Commercial auto physical damage.
• Aircraft (all perils).
• Surety.
• Burglary and theft.
• Boiler and machinery.

Along with additional types of policies that are mentioned in later sections of this text related to TRIA's extension, insurers do not need to include terrorism coverage in the following lines, which are not covered by TRIA:

• Crop.
• Flood.
• Livestock.
• Private mortgage.
• Financial guaranty.
• Medical malpractice.
• Health.
• Life.

TRIA generally does not limit insurers’ ability to set their own rates for terrorism coverage. However, the passage of the Act forced members of the industry to quickly decide on premiums. Insurers had to alert owners of preexisting policies to the program’s benefits and accompanying premiums within 90 days of TRIA’s enactment. In the case of a policy issued during the first 90 days of TRIA, insurers needed to provide this information when making an offer to clients. Currently, an insurer must include the details of terrorism coverage within the policy itself. According to the December 11, 2002 interim guidelines, insurers may deliver this information through a broker, agent or other third party, but they still are held accountable if a client does not receive it.

Once clients know about the program’s coverage and price, they can either accept or decline the terrorism part of a policy. If clients decline the coverage, the insurer may reinstate a terrorism exclusion that was in effect prior to TRIA or impose a new one. In order to decline the insurance, clients may sign a form that states their agreement to the exclusion. If clients do not pay the accompanying premium for terrorism coverage within 30 days of learning about the program’s details, an insurer may interpret their inaction as a statement of decline as long as the customers knew about the deadline.

If clients agree to the terrorism provisions in a policy, they or someone on their behalf must file all related claims with the insurer who wrote the policy. An insurer must process terrorism claims relevant to the policy provisions and must submit the claims to the Secretary of Treasury along with certified proof of the insured’s reimbursement from the insurer. Each year, insurance companies must also submit premium data for the previous 12 months to the Treasury Department in order for the government to assign them appropriate deductibles.
The Secretary has the power to establish the process for the actual flow of cash between the insurer and the Treasury.

**Penalties**
TRIA permits the Secretary to charge civil monetary fines to insurers who do not comply with the law. These penalties amount to the greater of $1 million and any disputed moneys. The Secretary can charge insurers such penalties, after a hearing, in response to the following negligent acts or other violations of the legislation:

- Failure to pay premiums in the amount or manner specified by either the Act or the Secretary of the Treasury.
- Deliberate submission of false premium data to the Treasury Department.
- Filing of false terrorism claims for government assistance.
- Distortion of insured losses.

**Relationship to Other Laws and Regulations**
When the government enacted TRIA, the legislation effectively wiped away all state laws, regulations and insurance exclusions (which had traditionally governed the industry) that contradicted the Act’s terms. Laws, regulations and exclusions that did not contradict the Act were not affected. Although TRIA does not specify rate restrictions for terrorism coverage, the Act states that a regulator can deny insurers the ability to charge premiums that it deems “excessive, inadequate or unfairly discriminatory.” In other words, insurers may charge the owner of a New York City skyscraper more than they would charge the average client for equal terrorism coverage, but insurance professionals must ground the decision to charge that client more for a policy in reason rather than in greed or unfounded fear.

Two instances of TRIA voiding state laws relate to topics that will be discussed in greater detail later in this text. The first involves states’ definitions of terrorism, which, for the purposes of TRIA, are now preempted by the national definition found within the Act. The other instance concerns litigation from certified terrorist attacks. Although legal proceedings in cases pertaining to death, personal injury or property damage might differ from state to state, those cases related to terrorism shall be handled uniformly as stipulated in the Act. TRIA also allows the Secretary to bypass any state laws that would either hinder or prevent an audit of an insurer by the government. TRIA does not alter the specifics of the post-September 11 airline bailout package, also known as the Air Transportation and System Stabilization Act.

**The Role of Reinsurance**
Despite not extending the benefits of TRIA to include reinsurance companies, the Act does not prohibit participating insurers from entering into reinsurance contracts. An insurer may enter into an agreement with a reinsurer in order to pay either a TRIA deductible or the 10 percent of insured losses that TRIA does not cover. In order to prevent insurers from receiving a windfall, if the sum of the money obtained by an insurer through TRIA and other reinsurance exceeds yearly insured losses, the insurer must reroute the additional funds to the Treasury Department.

**Judicial and Liability Issues**
If one considers all of the hard-fought political battles over punitive damages that preceded the enactment of TRIA, it should come as no surprise that much of the Act concerns judicial procedures and liability issues. As mentioned previously in these materials, Senate Democrats succeeded in their attempt to prevent total prohibition of punitive rewards for
terrorism losses. However, amounts awarded to plaintiffs as punitive damages do not count as insured losses under TRIA, and cannot be obtained through any other government program.

The Act grants the Judicial Panel on Multidistrict Litigation the power to establish one or more federal district courts for the hearing of terrorism-related suits from their beginning to end. The panel must install these courts within 90 days of a certified terrorist attack and must choose a corresponding location for proceedings that promotes efficiency and considers the convenience of the litigating parties. TRIA provides the U.S. government with a right of subrogation, meaning that Washington may choose to sue terrorist parties in order to recover dollars paid out on behalf of insurance companies under TRIA.

In some cases, the government must approve financial settlements of terrorism lawsuits. In suits brought against government workers, building owners and employers, for example, the Secretary of the Treasury can nullify liability rewards above $2 million resulting from death or personal injury and can reject settlements above $10 million for property cases. Through TRIA though, the government has stated that it will put no limits on the liability of anyone who “knowingly participates in, conspires to commit, aids and abets, or commits any act of terrorism.” In a related piece of the legislation, TRIA allows the government to use any frozen terrorist assets as a source of monetary compensation for victims and their families. The President may waive this stipulation in TRIA in order to preserve national security or in order to uphold international agreements.

**Terrorism Defined**

TRIA only covers acts of terrorism that are certified as such by the Secretary of the Treasury, who must consult with the Secretary of State and Attorney General but whose ultimate decision is not subject to any form of review. In order for the Secretary to certify an attack as an act of terrorism under TRIA, that act must cause violent or otherwise dangerous harm to Americans, their property or the nation’s infrastructure. When TRIA was first enacted, government-backed terrorism coverage would have only been available if the person who committed the terrorist act had done so in connection with “a foreign person or foreign interest” and with the intention of provoking action from either American citizens or the government. It is possible for a certified act of terrorism to occur on U.S. soil, on U.S. ships (in the air or at sea) or at U.S. embassies and consulates located in other countries.

TRIA does not compensate insurers for terrorist activities that fail to produce $5 million in insured losses or that Congress classifies as acts of war. TRIA does, however, make an exception to the act of war exclusion for workers’ compensation. So, if, for example, the government connects a U.S.-based attack by Iraqis to the second Gulf War, TRIA might not cover the resulting property damage, but the government would still reimburse insurers for on-the-job injuries or occupational deaths that arise from that attack. Insurers are eligible for government-backed terrorism benefits only if the violence occurs during the span of TRIA’s enactment. Therefore, the Act could not have reimbursed insurers for their losses from September 11.

**Ending the Program**

When first enacted, TRIA required that the Secretary report to Congress by June 30, 2005 about the program’s effectiveness and about the ability of the private terrorism insurance market to cope with either a non-existent or decreased level of government assistance. As the reader will note again later, the government and insurers viewed the findings within the report as a possible signal of how long the Act would remain in effect. Lawmakers originally set the Terrorism Risk Insurance Act of 2002 to expire at midnight January 1, 2006, though the government eventually approved an extension of the program through 2007 and later
approved another extension that is set to last through 2014. After the legislation expires, the government can still collect outstanding premiums and process claims from an attack that occurred prior to TRIA’s conclusion.

**Filing Claims**

In order to receive reimbursement for losses through TRIA, insurers must submit five forms to the Treasury Department. The government must first receive an Initial Notice of Insured Loss form. Insurers complete this document when losses from an attack pass the halfway point of their deductible. Based on this information, the administrators of the federal program will ideally develop a decent estimate of how much the government will pay insurers in a year for terrorism claims.

A Certification of Loss form summarizes the amount of federal compensation an insurer will receive for terrorism losses. Insurers report the amount of money they have already spent to cover terrorism claims for the year as well as the amount they expect to pay for any outstanding claims. The insurer computes additions, subtractions, divisions and multiplications based on several variables, including total losses, deductibles, reinsurance, mandated federal shares, punitive awards and compensation from other federal programs. These mathematical operations also determine whether or not an insurer actually owes the government money based on reinsurance and other arrangements.

An insurer must also submit a document known as Schedule A, which determines an insurer’s deductible for TRIA coverage. In one section of this form, insurers specify direct earned premiums for each line of property and casualty policies that they provide. In a second section, insurers list premiums for commercial property and casualty lines that TRIA will not cover. Insurers must provide the government with reasons why these premiums should not factor into the federal program. In its instructions for filling out Schedule A, the government mentions examples of premiums that could fit into this second section:

- Premiums earned through non-commercial coverage in a hybrid policy.
- Premiums earned through coverage that involves entities existing outside of TRIA’s geographic specifications.
- Premiums earned through commercial property and casualty lines that TRIA does not cover, such as crop insurance or livestock insurance.

Next on Schedule A, insurers list lines and premiums from the form’s first section that they handed off to a state residual market. A fourth step requires insurers to document lines and premiums not listed in the form’s first section that they received from state residual markets. To determine their yearly deductible for TRIA coverage, insurers first calculate the following:

\[
\text{(Total direct earned premiums from property and casualty policies + total direct earned premiums from property and casualty policies from residual markets)} - \text{(Total direct earned premiums from non-TRIA property and casualty policies + total direct earned premiums from property and casualty policies that were passed on to residual markets)}
\]

Insurers then multiply the above calculation by the year’s mandated percentage of direct earned premiums. If certified terrorist attacks had occurred in 2005, for example, insurers would have multiplied their direct earned premiums by 15 percent.

One person designated by an insurer and its affiliates completes Schedule B, also referred to as a Certification of Compliance. Self-explanatory in name, the document serves as legal acknowledgement that the insurer upheld the rules of TRIA during the claim process.
On Schedule C, called the “Loss Bordereau,” insurers itemize each terrorism claim, those within or beyond their deductible, in detail. This form specifies the line, location, and date of each insured loss. It also has spaces for insurers’ information, insureds’ information and payment information. The government must receive Schedule B and Schedule C with each Certification of Loss form. Schedule A must also arrive with these forms unless an insurer turned it in with the Initial Notice of Insured Loss document.

Although insurers can download hard copies of the five claim forms from the Treasury Department's Web site, the government requests that people utilize electronic filing procedures in order to unify and expedite the reimbursement process. To file electronic claims, insurers must register online, provide company contact information and designate authorized personnel to handle the claims. Companies will receive a password which can only be used by the individuals who were authorized through the registration. Affiliated companies must choose one representative among themselves to file all claims on their behalf.

**Text of Terrorism Risk Insurance Act of 2002**

We conclude this section by providing a copy of TRIA, as it was originally enacted, for your review.

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**One Hundred Seventh Congress**  
**of the**  
**United States of America**  
**AT THE SECOND SESSION**

Begun and held at the City of Washington on Wednesday, the twenty-third day of January, two thousand and two

An Act

To ensure the continued financial capacity of insurers to provide coverage for risks from terrorism.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) **SHORT TITLE-** This Act may be cited as the “Terrorism Risk Insurance Act of 2002”.

(b) **TABLE OF CONTENTS-** The table of contents for this Act is as follows:

- Sec. 1. Short title; table of contents.

**TITLE I--TERRORISM INSURANCE PROGRAM**

- Sec. 101. Congressional findings and purpose.
- Sec. 102. Definitions.
- Sec. 103. Terrorism Insurance Program.
- Sec. 104. General authority and administration of claims.
- Sec. 105. Preemption and nullification of pre-existing terrorism exclusions.
- Sec. 106. Preservation provisions.
- Sec. 107. Litigation management.
- Sec. 108. Termination of Program.

**TITLE II--TREATMENT OF TERRORIST ASSETS**

- Sec. 201. Satisfaction of judgments from blocked assets of terrorists, terrorist organizations, and State sponsors of terrorism.
TITLE III--FEDERAL RESERVE BOARD PROVISIONS
Sec. 301. Certain authority of the Board of Governors of the Federal Reserve System.

TITLE I--TERRORISM INSURANCE PROGRAM
SEC. 101. CONGRESSIONAL FINDINGS AND PURPOSE.
(a) FINDINGS- The Congress finds that--
(1) the ability of businesses and individuals to obtain property and casualty insurance at reasonable and predictable prices, in order to spread the risk of both routine and catastrophic loss, is critical to economic growth, urban development, and the construction and maintenance of public and private housing, as well as to the promotion of United States exports and foreign trade in an increasingly interconnected world;
(2) property and casualty insurance firms are important financial institutions, the products of which allow mutualization of risk and the efficient use of financial resources and enhance the ability of the economy to maintain stability, while responding to a variety of economic, political, environmental, and other risks with a minimum of disruption;
(3) the ability of the insurance industry to cover the unprecedented financial risks presented by potential acts of terrorism in the United States can be a major factor in the recovery from terrorist attacks, while maintaining the stability of the economy;
(4) widespread financial market uncertainties have arisen following the terrorist attacks of September 11, 2001, including the absence of information from which financial institutions can make statistically valid estimates of the probability and cost of future terrorist events, and therefore the size, funding, and allocation of the risk of loss caused by such acts of terrorism;
(5) a decision by property and casualty insurers to deal with such uncertainties, either by terminating property and casualty coverage for losses arising from terrorist events, or by radically escalating premium coverage to compensate for risks of loss that are not readily predictable, could seriously hamper ongoing and planned construction, property acquisition, and other business projects, generate a dramatic increase in rents, and otherwise suppress economic activity; and
(6) the United States Government should provide temporary financial compensation to insured parties, contributing to the stabilization of the United States economy in a time of national crisis, while the financial services industry develops the systems, mechanisms, products, and programs necessary to create a viable financial services market for private terrorism risk insurance.

(b) PURPOSE- The purpose of this title is to establish a temporary Federal program that provides for a transparent system of shared public and private compensation for insured losses resulting from acts of terrorism, in order to--
(1) protect consumers by addressing market disruptions and ensure the continued widespread availability and affordability of property and casualty insurance for terrorism risk; and
(2) allow for a transitional period for the private markets to stabilize, resume pricing of such insurance, and build capacity to absorb any future losses, while preserving State insurance regulation and consumer protections.

SEC. 102. DEFINITIONS.
In this title, the following definitions shall apply:

(1) ACT OF TERRORISM-

(A) CERTIFICATION- The term “act of terrorism” means any act that is certified by the Secretary, in concurrence with the Secretary of State, and the Attorney General of the United States--

(i) to be an act of terrorism;
(ii) to be a violent act or an act that is dangerous to--
   (I) human life;
   (II) property; or
   (III) infrastructure;
(iii) to have resulted in damage within the United States, or outside of the United States in the case of--
   (I) an air carrier or vessel described in paragraph (5)(B); or
   (II) the premises of a United States mission; and
(iv) to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

(B) LIMITATION- No act shall be certified by the Secretary as an act of terrorism if--

(i) the act is committed as part of the course of a war declared by the Congress, except that this clause shall not apply with respect to any coverage for workers’ compensation; or
(ii) property and casualty insurance losses resulting from the act, in the aggregate, do not exceed $5,000,000.

(C) DETERMINATIONS FINAL- Any certification of, or determination not to certify, an act as an act of terrorism under this paragraph shall be final, and shall not be subject to judicial review.

(D) NONDELEGATION- The Secretary may not delegate or designate to any other officer, employee, or person, any determination under this paragraph of whether, during the effective period of the Program, an act of terrorism has occurred.

(2) AFFILIATE- The term “affiliate” means, with respect to an insurer, any entity that controls, is controlled by, or is under common control with the insurer.

(3) CONTROL- An entity has “control” over another entity, if--

(A) the entity directly or indirectly or acting through 1 or more other persons owns, controls, or has power to vote 25 percent or more of any class of voting securities of the other entity;
(B) the entity controls in any manner the election of a majority of the directors or trustees of the other entity; or
(C) the Secretary determines, after notice and opportunity for hearing, that the entity directly or indirectly exercises a controlling influence over the management or policies of the other entity.

(4) DIRECT EARNED PREMIUM- The term “direct earned premium” means a direct earned premium for property and casualty insurance issued by any insurer for insurance against losses occurring at the locations described in subparagraphs (A) and (B) of paragraph (5).
(5) INSURED LOSS- The term “insured loss” means any loss resulting from an act of terrorism (including an act of war, in the case of workers’ compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if such loss--
   (A) occurs within the United States; or
   (B) occurs to an air carrier (as defined in section 40102 of title 49, United States Code), to a United States flag vessel (or a vessel based principally in the United States, on which United States income tax is paid and whose insurance coverage is subject to regulation in the United States), regardless of where the loss occurs, or at the premises of any United States mission.

(6) INSURER- The term “insurer” means any entity, including any affiliate thereof--
   (A) that is--
      (i) licensed or admitted to engage in the business of providing primary or excess insurance in any State;
      (ii) not licensed or admitted as described in clause (i), if it is an eligible surplus line carrier listed on the Quarterly Listing of Alien Insurers of the NAIC, or any successor thereto;
      (iii) approved for the purpose of offering property and casualty insurance by a Federal agency in connection with maritime, energy, or aviation activity;
      (iv) a State residual market insurance entity or State workers’ compensation fund; or
      (v) any other entity described in section 103(f), to the extent provided in the rules of the Secretary issued under section 103(f);
   (B) that receives direct earned premiums for any type of commercial property and casualty insurance coverage, other than in the case of entities described in sections 103(d) and 103(f); and
   (C) that meets any other criteria that the Secretary may reasonably prescribe.

(7) INSURER DEDUCTIBLE- The term “insurer deductible” means--
   (A) for the Transition Period, the value of an insurer’s direct earned premiums over the calendar year immediately preceding the date of enactment of this Act, multiplied by 1 percent;
   (B) for Program Year 1, the value of an insurer’s direct earned premiums over the calendar year immediately preceding Program Year 1, multiplied by 7 percent;
   (C) for Program Year 2, the value of an insurer’s direct earned premiums over the calendar year immediately preceding Program Year 2, multiplied by 10 percent;
   (D) for Program Year 3, the value of an insurer’s direct earned premiums over the calendar year immediately preceding Program Year 3, multiplied by 15 percent; and
   (E) notwithstanding subparagraphs (A) through (D), for the Transition Period, Program Year 1, Program Year 2, or Program Year 3, if an insurer has not had a full year of operations during the calendar year immediately preceding such Period or Program Year, such portion of the direct earned premiums of the insurer as the Secretary determines
appropriate, subject to appropriate methodologies established by the Secretary for measuring such direct earned premiums.

(8) NAIC- The term “NAIC” means the National Association of Insurance Commissioners.

(9) PERSON- The term “person” means any individual, business or nonprofit entity (including those organized in the form of a partnership, limited liability company, corporation, or association), trust or estate, or a State or political subdivision of a State or other governmental unit.

(10) PROGRAM- The term “Program” means the Terrorism Insurance Program established by this title.

(11) PROGRAM YEARS-

(A) TRANSITION PERIOD- The term “Transition Period” means the period beginning on the date of enactment of this Act and ending on December 31, 2002.

(B) PROGRAM YEAR 1- The term “Program Year 1” means the period beginning on January 1, 2003 and ending on December 31, 2003.

(C) PROGRAM YEAR 2- The term “Program Year 2” means the period beginning on January 1, 2004 and ending on December 31, 2004.

(D) PROGRAM YEAR 3- The term “Program Year 3” means the period beginning on January 1, 2005 and ending on December 31, 2005.

(12) PROPERTY AND CASUALTY INSURANCE- The term “property and casualty insurance”--

(A) means commercial lines of property and casualty insurance, including excess insurance, workers’ compensation insurance, and surety insurance; and

(B) does not include--

(i) Federal crop insurance issued or reinsured under the Federal Crop Insurance Act (7 U.S.C. 1501 et seq.), or any other type of crop or livestock insurance that is privately issued or reinsured;

(ii) private mortgage insurance (as that term is defined in section 2 of the Homeowners Protection Act of 1998 (12 U.S.C. 4901)) or title insurance;

(iii) financial guaranty insurance issued by monoline financial guaranty insurance corporations;

(iv) insurance for medical malpractice;

(v) health or life insurance, including group life insurance;

(vi) flood insurance provided under the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.); or

(vii) reinsurance or retrocessional reinsurance.

(13) SECRETARY- The term “Secretary” means the Secretary of the Treasury.

(14) STATE- The term “State” means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, each of the United States Virgin Islands, and any territory or possession of the United States.

(15) UNITED STATES- The term “United States” means the several States, and includes the territorial sea and the continental shelf of the United States, as those terms are defined in the Violent Crime Control and Law Enforcement Act of 1994 (18 U.S.C. 2280, 2281).

(16) RULE OF CONSTRUCTION FOR DATES- With respect to any reference to a date in this title, such day shall be construed--
A) to begin at 12:01 a.m. on that date; and
B) to end at midnight on that date.

SEC. 103. TERRORISM INSURANCE PROGRAM.

(a) ESTABLISHMENT OF PROGRAM-

(1) IN GENERAL- There is established in the Department of the Treasury the Terrorism Insurance Program.

(2) AUTHORITY OF THE SECRETARY- Notwithstanding any other provision of State or Federal law, the Secretary shall administer the program, and shall pay the Federal share of compensation for insured losses in accordance with subsection (e).

(3) MANDATORY PARTICIPATION- Each entity that meets the definition of an insurer under this title shall participate in the Program.

(b) CONDITIONS FOR FEDERAL PAYMENTS- No payment may be made by the Secretary under this section with respect to an insured loss that is covered by an insurer, unless--

(1) the person that suffers the insured loss, or a person acting on behalf of that person, files a claim with the insurer;

(2) the insurer provides clear and conspicuous disclosure to the policyholder of the premium charged for insured losses covered by the Program and the Federal share of compensation for insured losses under the Program--

(A) in the case of any policy that is issued before the date of enactment of this Act, not later than 90 days after that date of enactment;

(B) in the case of any policy that is issued within 90 days of the date of enactment of this Act, at the time of offer, purchase, and renewal of the policy; and

(C) in the case of any policy that is issued more than 90 days after the date of enactment of this Act, on a separate line item in the policy, at the time of offer, purchase, and renewal of the policy;

(3) the insurer processes the claim for the insured loss in accordance with appropriate business practices, and any reasonable procedures that the Secretary may prescribe; and

(4) the insurer submits to the Secretary, in accordance with such reasonable procedures as the Secretary may establish--

(A) a claim for payment of the Federal share of compensation for insured losses under the Program;

(B) written certification--

(i) of the underlying claim; and

(ii) of all payments made for insured losses; and

(C) certification of its compliance with the provisions of this subsection.

(c) MANDATORY AVAILABILITY-

(1) INITIAL PROGRAM PERIODS- During the period beginning on the first day of the Transition Period and ending on the last day of Program Year 2, each entity that meets the definition of an insurer under section 102--

(A) shall make available, in all of its property and casualty insurance policies, coverage for insured losses; and

(B) shall make available property and casualty insurance coverage for insured losses that does not differ materially from the terms, amounts, and other coverage limitations applicable to losses arising from events other than acts of terrorism.
(2) PROGRAM YEAR 3- Not later than September 1, 2004, the Secretary shall, based on the factors referred to in section 108(d)(1), determine whether the provisions of subparagraphs (A) and (B) of paragraph (1) should be extended through Program Year 3.

(d) STATE RESIDUAL MARKET INSURANCE ENTITIES-

(1) IN GENERAL- The Secretary shall issue regulations, as soon as practicable after the date of enactment of this Act, that apply the provisions of this title to State residual market insurance entities and State workers' compensation funds.

(2) TREATMENT OF CERTAIN ENTITIES- For purposes of the regulations issued pursuant to paragraph (1)--

(A) a State residual market insurance entity that does not share its profits and losses with private sector insurers shall be treated as a separate insurer; and

(B) a State residual market insurance entity that shares its profits and losses with private sector insurers shall not be treated as a separate insurer, and shall report to each private sector insurance participant its share of the insured losses of the entity, which shall be included in each private sector insurer's insured losses.

(3) TREATMENT OF PARTICIPATION IN CERTAIN ENTITIES- Any insurer that participates in sharing profits and losses of a State residual market insurance entity shall include in its calculations of premiums any premiums distributed to the insurer by the State residual market insurance entity.

(e) INSURED LOSS SHARED COMPENSATION-

(1) FEDERAL SHARE-

(A) IN GENERAL- The Federal share of compensation under the Program to be paid by the Secretary for insured losses of an insurer during the Transition Period and each Program Year shall be equal to 90 percent of that portion of the amount of such insured losses that exceeds the applicable insurer deductible required to be paid during such Transition Period or such Program Year.

(B) PROHIBITION ON DUPLICATIVE COMPENSATION- The Federal share of compensation for insured losses under the Program shall be reduced by the amount of compensation provided by the Federal Government to any person under any other Federal program for those insured losses.

(2) CAP ON ANNUAL LIABILITY-

(A) IN GENERAL- Notwithstanding paragraph (1) or any other provision of Federal or State law, if the aggregate insured losses exceed $100,000,000,000, during the period beginning on the first day of the Transition Period and ending on the last day of Program Year 1, or during Program Year 2 or Program Year 3 (until such time as the Congress may act otherwise with respect to such losses)--

(i) the Secretary shall not make any payment under this title for any portion of the amount of such losses that exceeds $100,000,000,000; and

(ii) no insurer that has met its insurer deductible shall be liable for the payment of any portion of that amount that exceeds $100,000,000,000.
(B) INSURER SHARE- For purposes of subparagraph (A), the Secretary shall determine the pro rata share of insured losses to be paid by each insurer that incurs insured losses under the Program.

(3) NOTICE TO CONGRESS- The Secretary shall notify the Congress if estimated or actual aggregate insured losses exceed $100,000,000,000 during the period beginning on the first day of the Transition Period and ending on the last day of Program Year 1, or during Program Year 2 or Program Year 3, and the Congress shall determine the procedures for and the source of any payments for such excess insured losses.

(4) FINAL NETTING- The Secretary shall have sole discretion to determine the time at which claims relating to any insured loss or act of terrorism shall become final.

(5) DETERMINATIONS FINAL- Any determination of the Secretary under this subsection shall be final, unless expressly provided, and shall not be subject to judicial review.

(6) INSURANCE MARKETPLACE AGGREGATE RETENTION AMOUNT- For purposes of paragraph (7), the insurance marketplace aggregate retention amount shall be--

(A) for the period beginning on the first day of the Transition Period and ending on the last day of Program Year 1, the lesser of--

(i) $10,000,000,000; and
(ii) the aggregate amount, for all insurers, of insured losses during such period;

(B) for Program Year 2, the lesser of--

(i) $12,500,000,000; and
(ii) the aggregate amount, for all insurers, of insured losses during such Program Year; and

(C) for Program Year 3, the lesser of--

(i) $15,000,000,000; and
(ii) the aggregate amount, for all insurers, of insured losses during such Program Year.

(7) RECOUPMENT OF FEDERAL SHARE-  

(A) MANDATORY RECOUPMENT AMOUNT- For purposes of this paragraph, the mandatory recoupment amount for each of the periods referred to in subparagraphs (A), (B), and (C) of paragraph (6) shall be the difference between--

(i) the insurance marketplace aggregate retention amount under paragraph (6) for such period; and
(ii) the aggregate amount, for all insurers, of insured losses during such period that are not compensated by the Federal Government because such losses--

(I) are within the insurer deductible for the insurer subject to the losses; or
(II) are within the portion of losses of the insurer that exceed the insurer deductible, but are not compensated pursuant to paragraph (1).

(B) NO MANDATORY RECOUPMENT IF UNCOMPENSATED LOSSES EXCEED INSURANCE MARKETPLACE RETENTION- Notwithstanding subparagraph (A), if the aggregate amount of uncompensated insured losses referred to in clause (ii) of such subparagraph for any period referred to in subparagraph (A), (B), or
(C) of paragraph (6) is greater than the insurance marketplace aggregate retention amount under paragraph (6) for such period, the mandatory recoupment amount shall be $0.

(C) MANDATORY ESTABLISHMENT OF SURCHARGES TO RECOUP MANDATORY RECOUPMENT AMOUNT- The Secretary shall collect, for repayment of the Federal financial assistance provided in connection with all acts of terrorism (or acts of war, in the case of workers compensation) occurring during any of the periods referred to in subparagraph (A), (B), or (C) of paragraph (6), terrorism loss risk-spreading premiums in an amount equal to any mandatory recoupment amount for such period.

(D) DISCRETIONARY RECOUPMENT OF REMAINDER OF FINANCIAL ASSISTANCE- To the extent that the amount of Federal financial assistance provided exceeds any mandatory recoupment amount, the Secretary may recoup, through terrorism loss risk-spreading premiums, such additional amounts that the Secretary believes can be recouped, based on--

(i) the ultimate costs to taxpayers of no additional recoupment;
(ii) the economic conditions in the commercial marketplace, including the capitalization, profitability, and investment returns of the insurance industry and the current cycle of the insurance markets;
(iii) the affordability of commercial insurance for small- and medium-sized businesses; and
(iv) such other factors as the Secretary considers appropriate.

(8) POLICY SURCHARGE FOR TERRORISM LOSS RISK-SPREADING PREMIUMS-

(A) POLICYHOLDER PREMIUM- Any amount established by the Secretary as a terrorism loss risk-spreading premium shall--

(i) be imposed as a policyholder premium surcharge on property and casualty insurance policies in force after the date of such establishment;
(ii) begin with such period of coverage during the year as the Secretary determines appropriate; and
(iii) be based on a percentage of the premium amount charged for property and casualty insurance coverage under the policy.

(B) COLLECTION- The Secretary shall provide for insurers to collect terrorism loss risk-spreading premiums and remit such amounts collected to the Secretary.

(C) PERCENTAGE LIMITATION- A terrorism loss risk-spreading premium (including any additional amount included in such premium on a discretionary basis pursuant to paragraph (7)(D)) may not exceed, on an annual basis, the amount equal to 3 percent of the premium charged for property and casualty insurance coverage under the policy.

(D) ADJUSTMENT FOR URBAN AND SMALLER COMMERCIAL AND RURAL AREAS AND DIFFERENT LINES OF INSURANCE-

(i) ADJUSTMENTS- In determining the method and manner of imposing terrorism loss risk-spreading premiums, including the amount of such premiums, the Secretary shall take into consideration--
(I) the economic impact on commercial centers of urban areas, including the effect on commercial rents and commercial insurance premiums, particularly rents and premiums charged to small businesses, and the availability of lease space and commercial insurance within urban areas;
(II) the risk factors related to rural areas and smaller commercial centers, including the potential exposure to loss and the likely magnitude of such loss, as well as any resulting cross-subsidization that might result; and
(III) the various exposures to terrorism risk for different lines of insurance.

(ii) RECOUPMENT OF ADJUSTMENTS- Any mandatory recoupment amounts not collected by the Secretary because of adjustments under this subparagraph shall be recouped through additional terrorism loss risk-spreading premiums.

(E) TIMING OF PREMIUMS- The Secretary may adjust the timing of terrorism loss risk-spreading premiums to provide for equivalent application of the provisions of this title to policies that are not based on a calendar year, or to apply such provisions on a daily, monthly, or quarterly basis, as appropriate.

(f) CAPTIVE INSURERS AND OTHER SELF-INSURANCE ARRANGEMENTS- The Secretary may, in consultation with the NAIC or the appropriate State regulatory authority, apply the provisions of this title, as appropriate, to other classes or types of captive insurers and other self-insurance arrangements by municipalities and other entities (such as workers’ compensation self-insurance programs and State workers’ compensation reinsurance pools), but only if such application is determined before the occurrence of an act of terrorism in which such an entity incurs an insured loss and all of the provisions of this title are applied comparably to such entities.

(g) REINSURANCE TO COVER EXPOSURE-
(1) OBTAINING COVERAGE- This title may not be construed to limit or prevent insurers from obtaining reinsurance coverage for insurer deductibles or insured losses retained by insurers pursuant to this section, nor shall the obtaining of such coverage affect the calculation of such deductibles or retentions.

(2) LIMITATION ON FINANCIAL ASSISTANCE- The amount of financial assistance provided pursuant to this section shall not be reduced by reinsurance paid or payable to an insurer from other sources, except that recoveries from such other sources, taken together with financial assistance for the Transition Period or a Program Year provided pursuant to this section, may not exceed the aggregate amount of the insurer’s insured losses for such period. If such recoveries and financial assistance for the Transition Period or a Program Year exceed such aggregate amount of insured losses for that period and there is no agreement between the insurer and any reinsurer to the contrary, an amount in excess of such aggregate insured losses shall be returned to the Secretary.

(h) GROUP LIFE INSURANCE STUDY-
(1) STUDY- The Secretary shall study, on an expedited basis, whether adequate and affordable catastrophe reinsurance for acts of terrorism is available to life insurers in the United States that issue group life insurance,
and the extent to which the threat of terrorism is reducing the availability of group life insurance coverage for consumers in the United States.

(2) CONDITIONAL COVERAGE- To the extent that the Secretary determines that such coverage is not or will not be reasonably available to both such insurers and consumers, the Secretary shall, in consultation with the NAIC--

(A) apply the provisions of this title, as appropriate, to providers of group life insurance; and
(B) provide such restrictions, limitations, or conditions with respect to any financial assistance provided that the Secretary deems appropriate, based on the study under paragraph (1).

(i) STUDY AND REPORT-

(1) STUDY- The Secretary, after consultation with the NAIC, representatives of the insurance industry, and other experts in the insurance field, shall conduct a study of the potential effects of acts of terrorism on the availability of life insurance and other lines of insurance coverage, including personal lines.

(2) REPORT- Not later than 9 months after the date of enactment of this Act, the Secretary shall submit a report to the Congress on the results of the study conducted under paragraph (1).

SEC. 104. GENERAL AUTHORITY AND ADMINISTRATION OF CLAIMS.

(a) GENERAL AUTHORITY- The Secretary shall have the powers and authorities necessary to carry out the Program, including authority--

(1) to investigate and audit all claims under the Program; and
(2) to prescribe regulations and procedures to effectively administer and implement the Program, and to ensure that all insurers and self-insured entities that participate in the Program are treated comparably under the Program.

(b) INTERIM RULES AND PROCEDURES- The Secretary may issue interim final rules or procedures specifying the manner in which--

(1) insurers may file and certify claims under the Program;
(2) the Federal share of compensation for insured losses will be paid under the Program, including payments based on estimates of or actual insured losses;
(3) the Secretary may, at any time, seek repayment from or reimburse any insurer, based on estimates of insured losses under the Program, to effectuate the insured loss sharing provisions in section 103; and
(4) the Secretary will determine any final netting of payments under the Program, including payments owed to the Federal Government from any insurer and any Federal share of compensation for insured losses owed to any insurer, to effectuate the insured loss sharing provisions in section 103.

(c) CONSULTATION- The Secretary shall consult with the NAIC, as the Secretary determines appropriate, concerning the Program.

(d) CONTRACTS FOR SERVICES- The Secretary may employ persons or contract for services as may be necessary to implement the Program.

(e) CIVIL PENALTIES-

(1) IN GENERAL- The Secretary may assess a civil monetary penalty in an amount not exceeding the amount under paragraph (2) against any insurer that the Secretary determines, on the record after opportunity for a hearing--

(A) has failed to charge, collect, or remit terrorism loss risk-spreading premiums under section 103(e) in accordance with the requirements of, or regulations issued under, this title;
(B) has intentionally provided to the Secretary erroneous information regarding premium or loss amounts;
(C) submits to the Secretary fraudulent claims under the Program for insured losses;
(D) has failed to provide the disclosures required under subsection (f); or
(E) has otherwise failed to comply with the provisions of, or the regulations issued under, this title.

(2) AMOUNT - The amount under this paragraph is the greater of $1,000,000 and, in the case of any failure to pay, charge, collect, or remit amounts in accordance with this title or the regulations issued under this title, such amount in dispute.

(3) RECOVERY OF AMOUNT IN DISPUTE - A penalty under this subsection for any failure to pay, charge, collect, or remit amounts in accordance with this title or the regulations under this title shall be in addition to any such amounts recovered by the Secretary.

(f) SUBMISSION OF PREMIUM INFORMATION -
(1) IN GENERAL - The Secretary shall annually compile information on the terrorism risk insurance premium rates of insurers for the preceding year.
(2) ACCESS TO INFORMATION - To the extent that such information is not otherwise available to the Secretary, the Secretary may require each insurer to submit to the NAIC terrorism risk insurance premium rates, as necessary to carry out paragraph (1), and the NAIC shall make such information available to the Secretary.
(3) AVAILABILITY TO CONGRESS - The Secretary shall make information compiled under this subsection available to the Congress, upon request.

(g) FUNDING -
(1) FEDERAL PAYMENTS - There are hereby appropriated, out of funds in the Treasury not otherwise appropriated, such sums as may be necessary to pay the Federal share of compensation for insured losses under the Program.
(2) ADMINISTRATIVE EXPENSES - There are hereby appropriated, out of funds in the Treasury not otherwise appropriated, such sums as may be necessary to pay reasonable costs of administering the Program.

SEC. 105. PREEMPTION AND NULLIFICATION OF PRE-EXISTING TERRORISM EXCLUSIONS.

(a) GENERAL NULLIFICATION - Any terrorism exclusion in a contract for property and casualty insurance that is in force on the date of enactment of this Act shall be void to the extent that it excludes losses that would otherwise be insured losses.
(b) GENERAL PREEMPTION - Any State approval of any terrorism exclusion from a contract for property and casualty insurance that is in force on the date of enactment of this Act, shall be void to the extent that it excludes losses that would otherwise be insured losses.
(c) REINSTATEMENT OF TERRORISM EXCLUSIONS - Notwithstanding subsections (a) and (b) or any provision of State law, an insurer may reinstate a preexisting provision in a contract for property and casualty insurance that is in force on the date of enactment of this Act and that excludes coverage for an act of terrorism only--
(1) if the insurer has received a written statement from the insured that affirmatively authorizes such reinstatement; or
(2) if--
(A) the insured fails to pay any increased premium charged by the insurer for providing such terrorism coverage; and
(B) the insurer provided notice, at least 30 days before any such reinstatement, of--
   (i) the increased premium for such terrorism coverage; and
   (ii) the rights of the insured with respect to such coverage, including any date upon which the exclusion would be reinstated if no payment is received.

SEC. 106. PRESERVATION PROVISIONS.

(a) STATE LAW- Nothing in this title shall affect the jurisdiction or regulatory authority of the insurance commissioner (or any agency or office performing like functions) of any State over any insurer or other person--
   (1) except as specifically provided in this title; and
   (2) except that--
      (A) the definition of the term “act of terrorism” in section 102 shall be the exclusive definition of that term for purposes of compensation for insured losses under this title, and shall preempt any provision of State law that is inconsistent with that definition, to the extent that such provision of law would otherwise apply to any type of insurance covered by this title;
      (B) during the period beginning on the date of enactment of this Act and ending on December 31, 2003, rates and forms for terrorism risk insurance covered by this title and filed with any State shall not be subject to prior approval or a waiting period under any law of a State that would otherwise be applicable, except that nothing in this title affects the ability of any State to invalidate a rate as excessive, inadequate, or unfairly discriminatory, and, with respect to forms, where a State has prior approval authority, it shall apply to allow subsequent review of such forms; and
      (C) during the period beginning on the date of enactment of this Act and for so long as the Program is in effect, as provided in section 108, including authority in subsection 108(b), books and records of any insurer that are relevant to the Program shall be provided, or caused to be provided, to the Secretary, upon request by the Secretary, notwithstanding any provision of the laws of any State prohibiting or limiting such access.

(b) EXISTING REINSURANCE AGREEMENTS- Nothing in this title shall be construed to alter, amend, or expand the terms of coverage under any reinsurance agreement in effect on the date of enactment of this Act. The terms and conditions of such an agreement shall be determined by the language of that agreement.

SEC. 107. LITIGATION MANAGEMENT.

(a) PROCEDURES AND DAMAGES-
   (1) IN GENERAL- If the Secretary makes a determination pursuant to section 102 that an act of terrorism has occurred, there shall exist a Federal cause of action for property damage, personal injury, or death arising out of or resulting from such act of terrorism, which shall be the exclusive cause of action and remedy for claims for property damage, personal injury, or death arising out of or relating to such act of terrorism, except as provided in subsection (b).
(2) PREEMPTION OF STATE ACTIONS- All State causes of action of any kind for property damage, personal injury, or death arising out of or resulting from an act of terrorism that are otherwise available under State law are hereby preempted, except as provided in subsection (b).

(3) SUBSTANTIVE LAW- The substantive law for decision in any such action described in paragraph (1) shall be derived from the law, including choice of law principles, of the State in which such act of terrorism occurred, unless such law is otherwise inconsistent with or preempted by Federal law.

(4) JURISDICTION- For each determination described in paragraph (1), not later than 90 days after the occurrence of an act of terrorism, the Judicial Panel on Multidistrict Litigation shall designate 1 district court or, if necessary, multiple district courts of the United States that shall have original and exclusive jurisdiction over all actions for any claim (including any claim for loss of property, personal injury, or death) relating to or arising out of an act of terrorism subject to this section. The Judicial Panel on Multidistrict Litigation shall select and assign the district court or courts based on the convenience of the parties and the just and efficient conduct of the proceedings. For purposes of personal jurisdiction, the district court or courts designated by the Judicial Panel on Multidistrict Litigation shall be deemed to sit in all judicial districts in the United States.

(5) PUNITIVE DAMAGES- Any amounts awarded in an action under paragraph (1) that are attributable to punitive damages shall not count as insured losses for purposes of this title.

(b) EXCLUSION- Nothing in this section shall in any way limit the liability of any government, an organization, or person who knowingly participates in, conspires to commit, aids and abets, or commits any act of terrorism with respect to which a determination described in subsection (a)(1) was made.

(c) RIGHT OF SUBROGATION- The United States shall have the right of subrogation with respect to any payment or claim paid by the United States under this title.

(d) RELATIONSHIP TO OTHER LAW- Nothing in this section shall be construed to affect--

(1) any party’s contractual right to arbitrate a dispute; or
(2) any provision of the Air Transportation Safety and System Stabilization Act (Public Law 107-42; 49 U.S.C. 40101 note.).

(e) EFFECTIVE PERIOD- This section shall apply only to actions described in subsection (a)(1) that arise out of or result from acts of terrorism that occur or occurred during the effective period of the Program.

SEC. 108. TERMINATION OF PROGRAM.

(a) TERMINATION OF PROGRAM- The Program shall terminate on December 31, 2005.

(b) CONTINUING AUTHORITY TO PAY OR ADJUST COMPENSATION- Following the termination of the Program, the Secretary may take such actions as may be necessary to ensure payment, recoupment, reimbursement, or adjustment of compensation for insured losses arising out of any act of terrorism occurring during the period in which the Program was in effect under this title, in accordance with the provisions of section 103 and regulations promulgated thereunder.

(c) REPEAL; SAVINGS CLAUSE- This title is repealed on the final termination date of the Program under subsection (a), except that such repeal shall not be construed--

(1) to prevent the Secretary from taking, or causing to be taken, such actions under subsection (b) of this section, paragraph (4), (5), (6), (7), or (8) of
section 103(e), or subsection (a)(1), (c), (d), or (e) of section 104, as in effect on the day before the date of such repeal, or applicable regulations promulgated thereunder, during any period in which the authority of the Secretary under subsection (b) of this section is in effect; or (2) to prevent the availability of funding under section 104(g) during any period in which the authority of the Secretary under subsection (b) of this section is in effect.

(d) STUDY AND REPORT ON THE PROGRAM-
(1) STUDY- The Secretary, in consultation with the NAIC, representatives of the insurance industry and of policy holders, other experts in the insurance field, and other experts as needed, shall assess the effectiveness of the Program and the likely capacity of the property and casualty insurance industry to offer insurance for terrorism risk after termination of the Program, and the availability and affordability of such insurance for various policyholders, including railroads, trucking, and public transit.
(2) REPORT- The Secretary shall submit a report to the Congress on the results of the study conducted under paragraph (1) not later than June 30, 2005.

TITLE II--TREATMENT OF TERRORIST ASSETS

SEC. 201. SATISFACTION OF JUDGMENTS FROM BLOCKED ASSETS OF TERRORISTS, TERRORIST ORGANIZATIONS, AND STATE SPONSORS OF TERRORISM.

(a) IN GENERAL- Notwithstanding any other provision of law, and except as provided in subsection (b), in every case in which a person has obtained a judgment against a terrorist party on a claim based upon an act of terrorism, or for which a terrorist party is not immune under section 1605(a)(7) of title 28, United States Code, the blocked assets of that terrorist party (including the blocked assets of any agency or instrumentality of that terrorist party) shall be subject to execution or attachment in aid of execution in order to satisfy such judgment to the extent of any compensatory damages for which such terrorist party has been adjudged liable.

(b) PRESIDENTIAL WAIVER-
(1) IN GENERAL- Subject to paragraph (2), upon determining on an asset-by-asset basis that a waiver is necessary in the national security interest, the President may waive the requirements of subsection (a) in connection with (and prior to the enforcement of) any judicial order directing attachment in aid of execution or execution against any property subject to the Vienna Convention on Diplomatic Relations or the Vienna Convention on Consular Relations.
(2) EXCEPTION- A waiver under this subsection shall not apply to--
(A) property subject to the Vienna Convention on Diplomatic Relations or the Vienna Convention on Consular Relations that has been used by the United States for any nondiplomatic purpose (including use as rental property), or the proceeds of such use; or
(B) the proceeds of any sale or transfer for value to a third party of any asset subject to the Vienna Convention on Diplomatic Relations or the Vienna Convention on Consular Relations.

(c) SPECIAL RULE FOR CASES AGAINST IRAN- Section 2002 of the Victims of Trafficking and Violence Protection Act of 2000 (Public Law 106-386; 114 Stat. 1542), as amended by section 686 of Public Law 107-228, is further amended--
(2) in subsection (b)(2)(B), by inserting after “the date of enactment of this Act” the following: “(less amounts therein as to which the United States has an interest in subrogation pursuant to subsection (c) arising prior to the date of entry of the judgment or judgments to be satisfied in whole or in part hereunder)”;
(3) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and
(4) by inserting after subsection (c) the following new subsection (d):

“(d) DISTRIBUTION OF ACCOUNT BALANCES AND PROCEEDS INADEQUATE TO SATISFY FULL AMOUNT OF COMPENSATORY AWARDS AGAINST IRAN-

“(1) PRIOR JUDGMENTS-

“(A) IN GENERAL- In the event that the Secretary determines that 90 percent of the amounts available to be paid under subsection (b)(2) are inadequate to pay the total amount of compensatory damages awarded in judgments issued as of the date of the enactment of this subsection in cases identified in subsection (a)(2)(A) with respect to Iran, the Secretary shall, not later than 60 days after such date, make payment from such amounts available to be paid under subsection (b)(2) to each party to which such a judgment has been issued in an amount equal to a share, calculated under subparagraph (B), of 90 percent of the amounts available to be paid under subsection (b)(2) that have not been subrogated to the United States under this Act as of the date of enactment of this subsection.

“(B) CALCULATION OF PAYMENTS- The share that is payable to a person under subparagraph (A), including any person issued a final judgment as of the date of enactment of this subsection in a suit filed on a date added by the amendment made by section 686 of Public Law 107-228, shall be equal to the proportion that the amount of unpaid compensatory damages awarded in a final judgment issued to that person bears to the total amount of all unpaid compensatory damages awarded to all persons to whom such judgments have been issued as of the date of enactment of this subsection in cases identified in subsection (a)(2)(A) with respect to Iran.

“(2) SUBSEQUENT JUDGMENT-

“(A) IN GENERAL- The Secretary shall pay to any person awarded a final judgment after the date of enactment of this subsection in a case filed on January 16, 2002, and identified in subsection (a)(2)(A) with respect to Iran, an amount equal to a share, calculated under subparagraph (B), of the balance of the amounts available to be paid under subsection (b)(2) that remain following the disbursement of all payments as provided by paragraph (1). The Secretary shall make such payment not later than 30 days after such judgment is awarded.

“(B) CALCULATION OF PAYMENTS- To the extent that funds are available, the amount paid under subparagraph (A) to such person shall be the amount the person would have been paid under paragraph (1) if the person had been awarded the judgment prior to the date of enactment of this subsection.

“(3) ADDITIONAL PAYMENTS-
“(A) IN GENERAL- Not later than 30 days after the disbursement of all payments under paragraphs (1) and (2), the Secretary shall make an additional payment to each person who received a payment under paragraph (1) or (2) in an amount equal to a share, calculated under subparagraph (B), of the balance of the amounts available to be paid under subsection (b)(2) that remain following the disbursement of all payments as provided by paragraphs (1) and (2).

“(B) CALCULATION OF PAYMENTS- The share payable under subparagraph (A) to each such person shall be equal to the proportion that the amount of compensatory damages awarded that person bears to the total amount of all compensatory damages awarded to all persons who received a payment under paragraph (1) or (2).

“(4) STATUTORY CONSTRUCTION- Nothing in this subsection shall bar, or require delay in, enforcement of any judgment to which this subsection applies under any procedure or against assets otherwise available under this section or under any other provision of law.

“(5) CERTAIN RIGHTS AND CLAIMS NOT RELINQUISHED- Any person receiving less than the full amount of compensatory damages awarded to that party in a judgment to which this subsection applies shall not be required to make the election set forth in subsection (a)(2)(B) or, with respect to subsection (a)(2)(D), the election relating to relinquishment of any right to execute or attach property that is subject to section 1610(f)(1)(A) of title 28, United States Code, except that such person shall be required to relinquish rights set forth--

“(A) in subsection (a)(2)(C); and

“(B) in subsection (a)(2)(D) with respect to enforcement against property that is at issue in claims against the United States before an international tribunal or that is the subject of awards by such tribunal.

“(6) GUIDELINES FOR ESTABLISHING CLAIMS OF A RIGHT TO PAYMENT- The Secretary may promulgate reasonable guidelines through which any person claiming a right to payment under this section may inform the Secretary of the basis for such claim, including by submitting a certified copy of the final judgment under which such right is claimed and by providing commercially reasonable payment instructions. The Secretary shall take all reasonable steps necessary to ensure, to the maximum extent practicable, that such guidelines shall not operate to delay or interfere with payment under this section.”.

(d) DEFINITIONS- In this section, the following definitions shall apply:

(1) ACT OF TERRORISM- The term “act of terrorism” means--

(A) any act or event certified under section 102(1); or

(B) to the extent not covered by subparagraph (A), any terrorist activity (as defined in section 212(a)(3)(B)(iii) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(3)(B)(iii))).

(2) BLOCKED ASSET- The term “blocked asset” means--

(A) any asset seized or frozen by the United States under section 5(b) of the Trading With the Enemy Act (50 U.S.C. App. 5(b)) or under sections 202 and 203 of the International Emergency Economic Powers Act (50 U.S.C. 1701; 1702); and

(B) does not include property that--

(i) is subject to a license issued by the United States Government for final payment, transfer, or disposition by or to a
person subject to the jurisdiction of the United States in connection with a transaction for which the issuance of such license has been specifically required by statute other than the International Emergency Economic Powers Act (50 U.S.C. 1701 et seq.) or the United Nations Participation Act of 1945 (22 U.S.C. 287 et seq.); or
(ii) in the case of property subject to the Vienna Convention on Diplomatic Relations or the Vienna Convention on Consular Relations, or that enjoys equivalent privileges and immunities under the law of the United States, is being used exclusively for diplomatic or consular purposes.

(3) CERTAIN PROPERTY- The term “property subject to the Vienna Convention on Diplomatic Relations or the Vienna Convention on Consular Relations” and the term “asset subject to the Vienna Convention on Diplomatic Relations or the Vienna Convention on Consular Relations” mean any property or asset, respectively, the attachment in aid of execution or execution of which would result in a violation of an obligation of the United States under the Vienna Convention on Diplomatic Relations or the Vienna Convention on Consular Relations, as the case may be.


TITLE III--FEDERAL RESERVE BOARD PROVISIONS

SEC. 301. CERTAIN AUTHORITY OF THE BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM.

Section 11 of the Federal Reserve Act (12 U.S.C. 248) is amended by adding at the end the following new subsection:
“(r)(1) Any action that this Act provides may be taken only upon the affirmative vote of 5 members of the Board may be taken upon the unanimous vote of all members then in office if there are fewer than 5 members in office at the time of the action.
“(2)(A) Any action that the Board is otherwise authorized to take under section 13(3) may be taken upon the unanimous vote of all available members then in office, if--
“(i) at least 2 members are available and all available members participate in the action;
“(ii) the available members unanimously determine that--
“(I) unusual and exigent circumstances exist and the borrower is unable to secure adequate credit accommodations from other sources;
“(II) action on the matter is necessary to prevent, correct, or mitigate serious harm to the economy or the stability of the financial system of the United States;
“(III) despite the use of all means available (including all available telephonic, telegraphic, and other electronic means), the other members of the Board have not been able to be contacted on the matter; and
“(IV) action on the matter is required before the number of Board members otherwise required to vote on the matter can be contacted
through any available means (including all available telephonic, telegraphic, and other electronic means); and

“(iii) any credit extended by a Federal reserve bank pursuant to such action is payable upon demand of the Board.

“(B) The available members of the Board shall document in writing the determinations required by subparagraph (A)(ii), and such written findings shall be included in the record of the action and in the official minutes of the Board, and copies of such record shall be provided as soon as practicable to the members of the Board who were not available to participate in the action and to the Chairman of the Committee on Banking, Housing, and Urban Affairs of the Senate and to the Chairman of the Committee on Financial Services of the House of Representatives.”.

Responses to the Law

Surprise, Relief, Confusion

As tends to happen with the passage of fresh laws, many citizens heard or read about the new program and were unsure as to how it directly affected them. Captive insurers, in particular, could not necessarily tell how they fit into TRIA’s long, complex and yet sometimes frustratingly vague definition of “insurer”:

INSURER- The term “insurer” means any entity, including any affiliate thereof--

(A) that is--

(i) licensed or admitted to engage in the business of providing primary or excess insurance in any State;

(ii) not licensed or admitted as described in clause (i), if it is an eligible surplus line carrier listed on the Quarterly Listing of Alien Insurers of the NAIC, or any successor thereto;

(iii) approved for the purpose of offering property and casualty insurance by a Federal agency in connection with maritime, energy, or aviation activity;

(iv) a State residual market insurance entity or State workers’ compensation fund; or

(v) any other entity described in section 103(f), to the extent provided in the rules of the Secretary issued under section 103(f);

Section 103(f) states the following:

CAPTIVE INSURERS AND OTHER SELF-INSURANCE ARRANGEMENTS-
The Secretary may, in consultation with the NAIC or the appropriate State regulatory authority, apply the provisions of this title, as appropriate, to other classes or types of captive insurers and other self-insurance arrangements by municipalities and other entities (such as workers’ compensation self-insurance programs and State workers’ compensation reinsurance pools), but only if such application is determined before the occurrence of an act of terrorism in which such an entity incurs an insured loss and all of the provisions of this title are applied comparably to such entities.

Some captive insurers interpreted that language to mean that a captive could decide for itself whether or not it wanted coverage under TRIA and could apply for membership to the program by informing the Secretary of Treasury of its preference. Other captives, who collected direct earned premiums from the entities that they insured, assumed that TRIA already applied to them.
Even for those captives who agreed on a legal interpretation of their TRIA status, there was
debate over whether or not being covered through TRIA put these insurers in a good
situation or a bad one. Sure, in modern troubled times, a terrorism backstop could be a
saving grace, particularly for owners or renters of high-risk properties who wanted coverage
but could not get it for a decent price in the regular market. But captives wondered if enough
of their policyholders, usually small in number to begin with, would opt for terrorism coverage
and make it possible for the typical captive to handle its TRIA deductible and the 10 percent
of insured losses that the Act did not cover. Furthermore, as was the case with regular
insurers, a captive who issued terrorism policies would have needed to pay government-
imposed recoupment fees even if none of its participants suffered terrorism-related damages.

In interim guidelines from December 26, 2002, the Treasury Department said captives were,
indeed, mandatory participants in TRIA. Faced with the financial obligations attached to the
program and preferring to fall outside of TRIA’s scope, the Vermont Captive Insurance
Association teamed up with the state’s U.S. senators, Democrat Patrick Leahy and
independent Jim Jeffords, and sent acting Secretary of the Treasury Kenneth W. Dam a
letter, which contrasted the executive branch’s interpretation of captives’ role in TRIA with the
interpretation of some of the lawmakers who voted for the Act. Noting that the Treasury did
not intend to set its guidelines in stone, some captives hoped the department would
eventually change its mind regarding captives, but that had not occurred by the time this
course material was finalized.

A broader range of insurers were dissatisfied with what they felt was an overly limited
definition of a certified terrorist attack:

**ACT OF TERRORISM-**

(A) CERTIFICATION- The term “act of terrorism” means any act that is certified by the
Secretary, in concurrence with the Secretary of State, and the Attorney General of the United
States--

(i) to be an act of terrorism;

(ii) to be a violent act or an act that is dangerous to--

   (I) human life;

   (II) property; or

   (III) infrastructure;

(iii) to have resulted in damage within the United States, or outside of the United
States in the case of--

   (I) an air carrier or vessel described in paragraph (5)(B); or

   (II) the premises of a United States mission; and

(iv) to have been committed by an individual or individuals acting on behalf of any
foreign person or foreign interest, as part of an effort to coerce the civilian
population of the United States or to influence the policy or affect the conduct of
the United States Government by coercion.

TRIA’s original definition of terrorism clearly did not include violent acts committed by
Americans. As a result, the government insurance program would somewhat surprisingly not
have covered losses from the 1995 Oklahoma City bombings, the 1996 attack on Atlanta’s
Olympic Park, or the shootings at Columbine High School in 1999. Despite the horrific nature
of al-Qaeda’s attacks, events similar to these three examples of massive violence perhaps
seemed more likely than foreign strikes to occur in most of the United States. Although U.S. embassies and consulates receive TRIA benefits, the Act’s original definition of terrorism seemed to exclude coverage for the overseas offices of American companies. Anyone who wanted to insure against these gaps in the law needed to purchase a stand-alone policy from one of only a small handful of insurers who offered the coverage to American customers.

Unless insurers include the coverage in their terrorism policies (and most do not), insured losses from nuclear, biological, chemical or radiological (NBCR) attacks do not receive TRIA benefits. Most insurers supported these exclusions. After all, Washington had already deemed potential losses from an accident at a nuclear plant so steep that the government had chosen for decades to insure Americans against the risk of a meltdown through a federal program. It perhaps would have been silly for lawmakers, after years of acknowledging the insolvency issues related to mishaps at power plants, to suddenly expect insurers to take on the risks associated with nuclear missiles and other weapons of mass destruction (WMDs).

Some consumers, however, envisioned a humongous insurance gap. Long before anyone could get the image of the destroyed World Trade Center out of their heads, unidentified terrorists moved on to a different attack plan, sending mail tainted with anthrax to members of the Senate and other Americans. According to one terrorism model, a widespread anthrax attack on New York City could have caused total losses of up to $90 billion, more than double the cost of September 11 and potentially none of it covered under TRIA.

Of course, anthrax is only one of many weapons that terrorists could utilize to hurt their enemies. Almost immediately after September 11, President Bush began cautioning Americans about an “axis of evil” made up of Iraq, Iran and North Korea, warning citizens that any of those countries might develop WMDs and pass those deadly materials on to anti-American terrorist groups. Not only would a nuclear nightmare, for example, cause greater damage than an anthrax scare (based on RMS’ analysis); it would also not count as a certified act of terrorism under TRIA in nearly every instance.

The second Gulf War, which the United States waged in Iraq for the stated purpose of preventing the production or any eventual transfer of WMDs, also exposed a hole in TRIA. Reportedly, the war produced great demand for terrorism coverage in the United States, but anyone who bought a TRIA-sponsored policy could not be sure that violent acts committed on U.S. soil in response to the invasion would have counted under the legislation because of the law’s war exclusions.

Some people have looked beyond what TRIA does and does not cover and have criticized the terrorism insurance program for its alleged inability to live up to its purpose. Long before Congress considered a concrete terrorism insurance bill, the government dismissed the insurance industry’s proposal of a British-influenced pool because that program would have supposedly created too much bureaucracy. But by voting for TRIA, politicians approved a law that called for a number of government studies, that made insurers submit premium data to Washington, that bestowed a ton of power upon the Secretary of the Treasury and (pricing decisions aside) gave hardly any control to private insurers. Although TRIA has numerous supporters among insurers and customers alike, seemingly none of its proponents champion the program as a hands-off endeavor.

The whole idea behind the temporary aspect of TRIA was that the government insurance program would give the industry time to recover from September 11 and to adjust to the threat of terrorism. Lawmakers reasoned that the program would end once the private insurance market got back on its feet and could handle terrorism risks on its own. TRIA’s treatment of captive insurers seemed to conflict with an ultimate goal of commercial stability. Although the Treasury Department ruled that captives are mandatory participants in TRIA,
some companies realized that TRIA coverage obtained through a captive can often involve a lower premium than that of a traditional policy. In those cases, a cost-conscious consumer has an incentive to join or create a captive. And without that consumer’s business, some observers say, the true insurance companies lose a chance to, at long last, absorb terrorism risks.

Soon after TRIA’s enactment, members of the CFA (who had advised against the creation of a federal insurance program for terrorism) got out their calculators, punched in some numbers and frowned. Because of TRIA, the organization claimed, the insurance industry owed its customers a refund of up to 50 percent on terrorism coverage. The collection of consumer groups estimated that government assistance cut the cost of a potential $25 billion terrorist attack by 53 percent for insurers compared to the price before the legislation took effect. According to CFA officials, TRIA also knocked insurers’ liability for losses in a $40 billion attack down by 68 percent. Insurers insisted that the premiums they charged for terrorism coverage were not thinly veiled attempts to rip consumers off. From the industry’s point of view, the CFA’s calculators could never compute a fair price for terrorism policies because they lacked a button that measured frequency. Insurers claimed that uncertainty, not greed, dictated the high premiums, and the government, by ignoring the issue of refunds, generally agreed.

Despite these complaints related to the legislation in its finished form, neither insurers nor their clients crowded the White House lawn or the steps of Congress in fiery, massive protest of TRIA. The government’s program might have been imperfect during its first three years of operation, but many insurers viewed it as at least an adequate tool that kept real estate deals afloat and increased the affordability and availability of workers’ compensation insurance. In fact, when the time came for lawmakers to renew TRIA, some of the same people who had criticized the legislation upon its unveiling decided in retrospect that the government-backed terrorism program was a decent system after all.

**The Effects of TRIA**

A person’s opinion of TRIA’s effectiveness during its first run perhaps depended upon how one analyzed the numbers found in various studies. To some people, TRIA was an unnecessary piece of legislation that, in practice, did little if anything to solve the issues surrounding terrorism coverage. This seemed like a rational position to take if a person concentrated on a few numbers in a few studies. In a report released in March 2003 by the Council of Insurance Agents and Bankers, 60 percent of 212 surveyed brokers said less than 10 percent of their small-business clients had purchased terrorism coverage. That number seemed tiny considering that, compared to big corporations, small businesses were likely to pay lower premiums and could, in some cases, get TRIA coverage for nothing. Another study, done a year later by the same organization, found that only 20 percent of surveyed businesses had purchased the insurance. That study followed one by Prudential Financial Inc. from 2002 in which only 14% of companies said they had full coverage for terrorism and 54 percent said they had none.

Those numbers did not leap off the page in support of a national insurance backstop program. If any high numbers captured the attention of TRIA’s detractors, they were the prices of premiums that some businesses paid for coverage after the Act became law. A representative of insurance industry leader Marsh & McLennan Cos. revealed in 2003 that, for some customers, full terrorism coverage increased consumers’ premiums by 1,000 percent. To some observers, these statistics proved TRIA failed to accomplish its goals of improving the amount of terrorism insurance written by U.S. providers and of keeping prices at reasonable levels.
In his April 14, 2005 testimony before the Senate Committee on Banking, Housing and Urban Affairs, the CFA’s J. Robert Hunter said A.M. Best had estimated a $49 billion surplus for property and casualty insurers between the end of 2000 and 2004. Certainly, the CFA argued, an industry that had allegedly made all that money could take care of itself in most cases of terrorism.

People who supported TRIA probably thought their foes were looking at the wrong numbers and were not thinking analytically. After all, unless small businesses were located in high-risk areas, terrorism insurance was not a major concern for them anyway. Meanwhile, the 1,000 percent increases in premiums detailed by the Marsh executive were reserved for high-risk clients with full coverage. On average, Marsh customers paid an additional 25 percent of their premium for terrorism insurance. Besides, as the Treasury Department stressed in its own June 30, 2005 study of the issue, the main reason people gave for deciding not to purchase terrorism insurance was not the allegedly high premiums. Instead, respondents said they did not consider themselves to be at high risk for an attack.

More optimistic data in a 2003 Marsh report included the revelation that acceptance of terrorism insurance increased each quarter after TRIA’s enactment. At the time of the completed study, coverage was most prevalent in the Northeast, where 30.3 percent of businesses carried it, compared to an 18.6 percent acceptance rate in the West. In a follow-up study by Marsh in 2004, 45 percent of 754 surveyed firms said they had terrorism insurance. By then, acceptance had grown highest in the Midwest, with 53.8 percent of companies having purchased the coverage. The same study estimated that 51.1 percent of Northeastern businesses had the insurance and that acceptance in the West had risen to 33.6 percent.

To support TRIA’s positive effects on pricing, proponents of the legislation could mention the good fortune of New York’s Metropolitan Transportation Authority. Before the Act, the organization’s captive insurer, First Mutual Transportation Assurance Co., could secure no more than $70 million-worth of terrorism coverage. With TRIA as law, the captive managed to net $1 billion in related insurance.

TRIA’s supporters could also cite a September 2005 article by National Banker’s Donald R. Glitz and Kathryn Marquardt, which stated that the premium for a $10 million piece of property outside of a major city had dropped 80 percent since the implementation of TRIA. The 90 percent reduction in the price of mortgage loans in inner cities, also reported in that article, was another potential source of ammunition in the war over the law’s renewal.

Although terrorism risk in small communities seemed low, TRIA’s demand that all property and casualty insurers inform clients of the availability and pricing of terrorism insurance brought the issue to the attention of more Americans. Government officials in Burlington, Wis. (population 9,936 as of 2000) purchased coverage for the city, noting the affordable price. The occasional small-town acceptance of terrorism policies certainly did not make insurers that much richer, but these occasional instances revealed a starting point for a journey that would hopefully lead to greater diversification of terrorism risks for the industry.

To Renew or Not to Renew

As stated earlier in this text, the 2002 version of TRIA only provided for insurers to make their coverage available subject to the law’s requirements through 2004. The law allowed the Treasury Department to decide by September 2004 whether or not terrorism policies needed to contain the same limits and deductibles as non-terrorism policies through 2005 as well. For many insured clients, especially commercial property owners, this was an immensely important deadline because insurers specifically structured policies issued or renewed in June 2004 to expire at the end of 2004, all in order to shield the policy providers from
increased terrorism risk in the absence of TRIA. If the government chose to extend the availability clause, the real estate industry could then breathe a sigh of relief, and insurers could renew those policies for 2005.

If, however, the Secretary chose to sit on the clause and to allow coverage to tighten, the nightmares involving unavailable and prohibitively expensive coverage would have returned. Property owners and lenders would have had to scramble again to find adequate coverage at a decent price in order to keep old deals afloat and to keep new ones from sinking under the weight of nervous investors. When the Treasury Department did indeed extend this part of TRIA, ensuring the availability of terrorism insurance at least until the beginning of 2006, some supporters of the legislation smiled and assumed that this action signified early support from Washington for a continuation of TRIA beyond its December 31, 2005 expiration date.

Once again, groups like the CFA made their voices heard in the media, lobbying against an extension of the federal insurance plan. Through their research, members of the CFA determined terrorism was hard to obtain in only nine U.S. cities. Based on that information, the organization reasoned that if there needed to be some form of TRIA, the government ought to limit the program, perhaps by confining aid to those nine cities. Furthermore, the association argued the hard market that began before September 11 and continued after the attacks had given the insurance community enough of an opportunity to stabilize itself. By 2005, the group said, insurers should have been able to offer affordable terrorism coverage to consumers without needing any help from taxpayers.

Like citizens who had voted for the losing candidate in an election, opponents of TRIA had sucked up their disgust and taken consolation in the possibility that, after a few years, the legislative slate could be wiped clean. To them, an extension went against the law’s allegedly “temporary” agenda, pulled the issue of terrorism off-track and made them wonder when they would ever take control of what, in their minds, was a runaway legislative train controlled by insurance companies.

In testimony to the Subcommittee on Capital Markets, Insurance and Government-Sponsored Enterprises of the House Committee on Financial Services, the CFA’s J. Robert Hunter said the consumer organization was not beneath the concept of compromise. More than anything, the association wanted TRIA and any government-backed terrorism program to end. But the CFA said it could live with an extension of the Act under certain circumstances. For one, the group wanted government to charge premiums to insurers for the coverage. Hunter argued that these premiums should exceed the value of the insurance because excessive pricing by the government would encourage greater participation of reinsurers and improve competition. (In his April 19, 2004 Senate testimony, Hunter proposed that the government figure out how much TRIA coverage cost taxpayers and then charge insurers an additional 25 percent for each additional year of the program.) The CFA also proposed the following revisions to the Act:

- Assurance that the extension would be temporary.
- Prohibition of TRIA coverage unless a terrorist attack causes $500 million in damages.
- An industry deductible of roughly $75 billion that increases by $10 billion each year.
- A decrease in the federal share of TRIA claims from 90 percent to 85 percent and a 5 percent reduction in coverage for each additional year.

Most insurers begged to differ with the CFA and insisted that various social and business ingredients were still stewing together four years after September 11 and still making a government backstop for terrorism coverage necessary. In a study by the Council of
Insurance Agents and Brokers, the same one that reported 20 percent acceptance of terrorism coverage in 2004, 80 percent of the brokers said they supported an extension of TRIA. Alan Greenspan, Chairman of the Board of Governors of the National Reserve, backed up insurers in testimony before the House Financial Services Committee in July 2005, predicting that the market would not be able to effectively handle terrorism insurance without government assistance. Though not attributed to Greenspan, a further economic concern regarding a world without TRIA was that overseas businesses might hesitate to branch out into U.S. territory if Washington could not provide terrorism coverage for their offices. Without TRIA or something to replace it, some economists feared, these cautious companies would opt to move their business to other countries such as England, France or Germany, where government-provided coverage was in place.

Insurers conceded that reinsurance for terrorism losses had become a tad easier to obtain on the open market by the middle of 2005. But reinsurers tended to limit coverage to less than 20 percent of an insurer's liability. With that limitation at least partially in mind, regulators in almost all states were prepared to allow insurers to impose terrorism exclusions on property and casualty policies if legislators had declined to extend TRIA. Regardless of the proposed exclusions, laws in most states would have forced insurers to cover terrorism in workers’ compensation lines as well as terrorism-related fire damages.

Yet, as was the case during the initial lobbying period for a terrorism backstop program, insurers needed to emphasize more than just their own interests when pushing members of Congress to back a TRIA extension. On that note, an industry study released in September 2004, and mentioned in the Chicago Tribune, estimated that TRIA’s disappearance from American law would have resulted in a loss of $53 billion along with 326,000 jobs. During TRIA’s renewal process, Representative Barney Frank, D-Mass., spoke about his support of the revamped legislation and was quoted in the Washington Post on November 17, 2005.

“I do not regard TRIA as a favor to the insurance industry,” he said. “It’s a favor to the insureds.”
The Extension Process

Back to Washington

Although TRIA required the Treasury Department to release a June 30, 2005 report on the government’s terrorism insurance arrangement and the private insurance market’s ability to offer and sell the coverage, the industry hoped to receive a quicker word on the program’s status. Insurers wanted significant notice of whether or not TRIA would last so that they could prepare themselves for either a strenuous period of underwriting or a chaotic stretch of filing policy exclusions with the individual states. Officially, the Treasury Department refused to comply with their requests, saying that any pronouncements about TRIA’s future before the required date for the report would have involved premature decisions derived from premature data. But the Treasury Department seemed to indicate that it had no intention of supporting legislation that would make Washington responsible for costs that insurers could handle on their own.

In its long-awaited comprehensive report to Congress from June 30, 2005, “Assessment: The Terrorism Risk Insurance Act of 2002,” the Treasury Department recommended that lawmakers not renew the legislation as it stood. The report did not dismiss ideas about continuing the insurance program in an altered form. Nor did it suggest that a few years of TRIA would ultimately solve the pricing and availability problems for terrorism insurance in the United States.

Following the government report, Secretary of the Treasury John Snow outlined the executive branch’s conditions for an extension of TRIA in a revised form that would increase the insurer’s role in the program:

- Higher deductibles for insurers.
- Higher percentage of insured losses for insurers.
- Minimum insured losses of $500 million for certified terrorist attacks.
- Removal of commercial auto insurance from the list of TRIA-covered lines.
- Removal of general liability insurance from the list of TRIA-covered lines.
- The exact numbers within the various TRIA extension bills from Congress were not identical from one plan to the next, but they generally supported Snow’s stated requirements.

Though each Congressional proposal for a TRIA extension was unique, many of the proposals were at least somewhat in line with Snow’s way of thinking.

The Terrorism Insurance Backstop Extension Act of 2004

Representative Pete Sessions, R-Texas, sponsored the Terrorism Insurance Backstop Extension Act of 2004. His proposal called for a continuation of TRIA through 2007, with insurers paying higher deductibles in the program’s last year but with the government still paying for 90 percent of insured losses above those amounts. During 2006, this act would have required insurers to pay a deductible equivalent to 15 percent of their direct earned premiums from 2005. The government would have also used the 2005 premium data to determine the deductible for 2007, which would have increased to 20 percent of direct earned premiums. Insurance marketplace aggregate retention amounts (those figures discussed earlier that are used to determine mandatory recoupment premiums paid by insurers to the government for reinsurance) would have risen to $17.5 billion in 2006 and to $20 billion in 2007.
Early versions of the Sessions act stated the government needed to complete a follow-up study on terrorism’s effects on group life insurance and release it by June 1, 2005 so that Congress could decide once and for all whether or not to include the line of coverage in TRIA. The act also would have required another study, due that same day, regarding alternatives for terrorism insurance that did not involve federal assistance. Based on an amended version of the legislation from November 18, 2004, the latter investigation remained as part of the plan. But House lawmakers abandoned the idea of a mere study on terrorism and group life, planning instead to include the coverage among TRIA’s covered lines.

The Terrorism Risk Insurance Program Extension Act of 2004

Congressman Michael Capuano, D-Mass., also hoped to extend the benefits of TRIA to group life insurance through his sponsorship of the Terrorism Risk Insurance Program Extension Act of 2004. Capuano’s bill would have extended the federal terrorism backstop arrangement until the end of 2008. That additional year of coverage, however, would have involved conditions. The government would have only handled terrorism claims in 2008 if insurers had issued the policies before that year. Government coverage for 2008 would not have existed for policyholders with insurance that was not due to expire until 2009.

Capuano’s proposal would have set the insurance market aggregate retention amounts at $15 billion for each year. Insurer deductibles would have remained 15 percent of direct earned premiums throughout the extension period, but in the first two additional years, those deductibles would have been based upon premium data from the preceding year. Deductibles for 2008 would have been based on direct earned premiums from that year.

The Terrorism Risk Insurance Extension Act of 2004

Senator Dodd, who had helped to finally steer his legislative colleagues toward a compromise with House Republicans during the initial negotiations for TRIA, proposed the first of his two extension plans in July 2004. Among Dodd’s suggested changes to TRIA was the tightening of the government’s liability for terrorism claims. Instead of capping government payments at $100 billion for each year, the extension would have limited federal responsibility to $100 billion for the entirety of the program.

Like Capuano, Dodd supported deductibles of 15 percent, coverage of policies that ran throughout 2008 (as long as a policy had gone into effect before that year and did not expire before December 31) and the addition of group life insurance to TRIA’s list of covered lines. Differences between the two men’s plans were in their details and legislative language. Dodd’s Terrorism Risk Insurance Extension Act of 2004 stated that the Secretary of the Treasury could allow group life insurers to have different insurance marketplace aggregate retention amounts than the rest of the industry, depending upon that market’s size. Had Dodd’s bill become law, the Secretary would have had 90 days to implement procedures and regulations specifically designed for group life providers. For other insurers, the Dodd extension would have mandated insurance marketplace aggregate retention amounts that were identical to those in Sessions’ bill ($17.5 billion in 2006 and $20 billion in 2007).

The Terrorism Insurance Backstop Extension Act of 2005

Having failed to get his 2004 terrorism insurance bill passed, Massachusetts congressman Michael Capuano championed another version of a TRIA extension in March 2005 when he introduced the Terrorism Insurance Backstop Extension Act of 2005. In similar fashion to his earlier bill, the act would have covered policies that insurers issued before 2008 and that did not continue through 2009. Many of the numbers in the act were identical to those in previous legislative proposals. The deductibles of 15 percent of the previous year’s direct earned premiums for 2006 and 20 percent for 2007 mirrored the figures supported by
Sessions, though Capuano added a 20 percent deductible (as well as a $20 billion insurance marketplace aggregate retention amount) for 2008 based on that year’s premium data. The insurance marketplace aggregate retention amounts for 2006 and 2007 ($17.5 billion and $20 billion respectively) were identical to the ones found in the Sessions and Dodd bills. The inclusion for life insurance, found in all the previously mentioned extension proposals, was there, too, as were the reports with modified due dates. This time, the Treasury Department would have been required to do a study on alternate approaches to terrorism insurance and submit it by September 1, 2005. A Government Accountability Office report on the efficiency of the program would have been sent to lawmakers by June 20, 2007.

The similarities and differences between these assorted bills are admittedly too subtle to entertain anyone other than yawn-resistant political junkies, but they demonstrate a major contrast between the initial TRIA negotiations and the debates that pertained to the Act’s extension. The arguments over dollars and cents in 2001 and 2002 carried over into the extension discussions. Yet the fights did not seem as capable of jeopardizing the fate of TRIA as they had in the past. Lawmakers had let property and casualty policies expire December 31, 2001 without any form of terrorism insurance laws in place, but Congress seemed on course to meet the December 31, 2005 deadline to extend TRIA. The second time around, there were no specific, enormous roadblocks to progress, no stubborn decrees about the permissibility of punitive damages, for example. Generally speaking, if an extension of TRIA was going to materialize, it was not going to be a radical departure from the original law.

The Terrorism Risk Insurance Revision Act of 2005

The arguably most extensive revision of TRIA to reach either of the legislative houses came in the form of the Terrorism Risk Insurance Revision Act of 2005, sponsored by Republican Representative Richard Baker of Louisiana. Of all of the terrorism insurance bills mentioned in these materials, Baker’s plan for a continued TRIA provided the most intricate stipulations about liability for nuclear, biological, chemical and radiological (NBCR) attacks. The act would have required insurers to offer coverage for these horrific situations, but the language of the legislation could have made that requirement nearly, if not completely, irrelevant:

“(c) Mandatory Availability- Each entity that meets the definition of an insurer under section 102-- …

“(2) shall make available, in any of its covered lines of insurance policies that exclude coverage for losses resulting from NBCR terrorism, coverage for losses resulting from NBCR terrorism that may differ materially from the terms, amounts, and other coverage limitations applicable to losses arising from events other than NBCR terrorism;…”

In that clause, the simple absence of the word “not” between “may” and “differ” could have given insurers innumerable options in an ultimate plan to avoid these specific kinds of terrorism risks. Barring state regulatory intervention, insurance companies could have demanded astronomically high premiums for the coverage from consumers and set low liability caps for themselves. Policy providers could have proposed exclusions that limited all but a miniscule number of scenarios in which NBCR attacks might occur. An insurer might have had the power, for example, to exclude attacks involving anthrax. Or, by contrast, an insurer could have covered anthrax attacks but tried to exclude all other forms of bacteria-related assaults.

The act would have extended TRIA’s benefits to group life insurers while removing commercial auto insurance from the program’s list of mandatory lines. Life insurance, in general terms, was addressed in a brief paragraph that stated insurers could neither prohibit
a traveler’s right to venture abroad nor charge unreasonable prices for travelers’ policies. The act was also one of the few TRIA extension proposals that included an altered definition of terrorism, which, in this case, seemed to incorporate attacks committed by Americans:

“(1) ACT OF TERRORISM-

“(A) CERTIFICATION- The term “act of terrorism” means any act that is certified by the Secretary, in concurrence with the Secretary of State, and the Attorney General of the United States--

“(i) to be an act of terrorism;

“(ii) to be a violent act or an act that is dangerous to--

“(I) human life;

“(II) property; or

“(III) infrastructure;

“(iii) to have resulted in damage within the United States, or outside of the United States in the case of--

“(I) an air carrier or vessel described in paragraph (5)(B); or

“(II) the premises of a United States mission; and

“(iv) to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

“(B) LIMITATION- No act shall be certified by the Secretary as an act of terrorism if the act is committed as part of the course of a war declared by the Congress, except that this clause shall not apply with respect to any coverage for workers’ compensation or group life insurance.”

The Terrorism Risk Revision Act would have abandoned TRIA’s standard 90-percent level of coverage in favor of a scaling system that linked the government’s liability to the amount of insured losses. Washington would have covered the following amounts of losses after insurers met their deductibles:

- 80 percent of industry losses below $10 billion.
- 85 percent of insured losses between $10 billion and $20 billion.
- 90 percent of losses between $20 billion and $40 billion.
- 95 percent of losses over $40 billion.

The act also would have increased insurers’ deductibles, based on the previous year’s direct earned premiums and would have implemented different increases for different lines of coverage including group life. In 2006, insurers would have faced the following deductibles:

- 16 percent for workers’ compensation coverage.
- 21.5 percent for group life coverage.
- 20 percent for property coverage.
- 25 percent for casualty coverage.
- An additional 7.5 percent for coverage of NBCR attacks.
During additional years of the program, deductibles would have increased by the following percentages:

- 2 percent for workers’ compensation coverage.
- 2.5 percent for property and group life coverage.
- 5 percent for casualty coverage.
- An additional 0.75 percent for coverage of NBCR attacks.

Insured losses from NBCR attacks could have counted against multiple deductibles. In other words, if an anthrax attack had harmed mailroom employees, insurers could have applied the resulting damages toward their workers’ compensation deductible and their deductible for NBCR attacks. The legislation would have reduced deductibles by 0.1 percent for each $1 billion of losses each year, but the act would not have allowed deductibles for any line of coverage to drop below 5 percent.

Government coverage would have kicked in through the Terrorism Risk Insurance Revision Act in 2006 if insured losses totaled $50 million. For each additional year, the triggering amount for federal assistance would have increased by $50 million. If terrorist attacks caused $1 billion in damages, the next year’s trigger would have decreased by $10 million. Baker’s proposal limited this stipulation so that the trigger could have never dropped below $50 million.

Like the major terrorism insurance House bill that preceded TRIA, Baker’s plan involved total repayment of government money. In order for insurers to reimburse the Treasury Department, they could have added surcharges of up to 3 percent (on a yearly basis) to their TRIA-covered policies. The act would have allowed insurers to put a portion of their direct earned premiums into capital reserve accounts, which they could have dipped into in order to pay for deductibles, the percentage of losses that TRIA failed to cover or losses that the government refused to handle because no triggering amount had been met. Upon the conclusion of the program (either the end of 2007 or the end of 2008 depending upon the results of a government study), 10 percent of any remaining money in these capital reserve accounts would have gone to the Treasury, and insurers would have held onto the rest.

Baker’s bill also elaborated on TRIA’s acceptable practices for filing terrorism claims. By the end of 2006, insurers would have been required to handle TRIA claims through the NAIC’s System for Electronic Rate and Form Filing, thereby speeding up the reimbursement process for victims and standardizing procedures from one insurer to the next.

**The Benefits for Victims of International Terrorism Act of 2003**

Another Congressional terrorism bill that differed greatly from the rest of the presented proposals did not involve commercial property and casualty coverage. Instead, Senator Richard Lugar, R-Ind., introduced a June 17, 2003 bill, known as the Benefits for Victims of International Terrorism Act of 2003, which dealt with federal involvement in the issues of liability and victim compensation and called on the government to provide money to individuals and their families who are killed, injured or held hostage by international terrorists. Instead of spelling out its own definition of terrorism, Lugar’s plan referred the law’s readers to one found in the Homeland Security Act of 2002. But the proposal did mention a few specifics that distinguished a covered claim from an uncovered claim. Like the original version of TRIA, the plan designated the title of terrorist solely upon an attacker with foreign connections. Had the bill become law, people would have received compensation if terrorists attacked them in response to actions taken by the U.S. government or if terrorists targeted them simply for being Americans.
Although Lugar’s bill lacked specific financial figures for compensation, the Benefits for Victims of International Terrorism Act contained general guidelines for rewards that distanced the legislation from some of the controversies related to the VCF, the compensation fund for victims of September 11. Unlike the VCF, the Lugar plan would not have calculated rewards based on a victim’s individual financial worth. Lugar proposed a simpler method of compensation that, in general, would have given similar victims similar rewards. Beneficiaries of killed Americans would have received a certain amount of money. The government would have granted injured victims a different amount, and hostage victims would have received yet another figure. Lugar’s plan stated that the otherwise unspecified compensation for injured victims or hostages (be they injured or not) should not exceed government rewards for beneficiaries of the dead.

Lugar’s legislation would have encompassed terrorist events from as far back as November 1, 1979, meaning that, with legal wrangling, victims of previous bombings at embassies and of the pre-September 11 World Trade Center attack might have been able to obtain compensation. It also would have given money to victims regardless of fault, meaning, for example, that the government could not have penalized a claimant for working in a knowingly high-risk office building.

These victim-friendly provisions aside, the bill was not one big blank check. Hostage situations involving ransoms or on-duty military personnel would not have resulted in any compensation, and people could not have filed multiple claims for the same event. The family of someone who died at the hands of a terrorist would not have been entitled to more money if the killers had also claimed that person as a hostage. The bill also stated that anyone who had been eligible for the VCF would not have been eligible for payments under the new plan unless people had the horrible misfortune of being hurt in another terrorist strike. As with the judicial restrictions of the VCF, victims’ instigation of civil actions related to an attack would have barred them from receiving government aid.

The act would have given Americans one year to make claims for attacks that occurred between November 1, 1979 and the day it became law. Once the act went in the books, people would have had two years to file claims for further terrorist events. In order to receive any money, beneficiaries would have had to prove that a victim’s death was the result of terrorism and that they were indeed entitled to the deceased’s portion of compensation. Parents who wanted to receive payments on behalf of late children, for example, would have had to prove their status as legal guardians. Likewise, an injured person would have needed to submit proof to the government that their ailments were the products of an attack.

Administrative power for the program would have gone to the Secretary of State, who would have determined the validity of a terrorist attack by conferring with the heads of the Defense, Homeland Security and Treasury departments. The Secretary’s decision, as in all matters related to the program, would have been final and could not have been challenged through judicial review. Lugar’s bill got to the point of senatorial hearings but did not move any further, perhaps due to the limits that it would have imposed on victims who wished to sue governments, terrorist groups and other allegedly liable parties in an attack.
Two More Years of Terrorism Coverage

The Terrorism Risk Insurance Extension Act of 2005

Like Representative Capuano, Senator Dodd did not let the failure of one of his extension bills dissuade him from proposing another one. His Terrorism Risk Insurance Extension Act of 2005 contained the same insurance marketplace aggregate retention amounts ($17.5 billion for 2006 and $20 billion for 2007) as his similarly named 2004 proposal, but many important differences existed between the older bill and the 2005 version that successfully made its way through the Senate on November 18, 2005.

Under this passed Senate bill, insurers would have faced deductibles of 17.5 percent of direct earned premiums from the previous year in 2006 and 20 percent in 2007. Like Baker's proposal, the extension plan set the triggering amount for 2006 TRIA coverage at $50 million and at $100 million for 2007. The Senate voted to extend TRIA coverage to directors and officers liability insurance but opted to eliminate the following lines of coverage from the government program:

- Commercial auto insurance.
- Burglary and theft insurance.
- Surety insurance.
- Professional liability insurance.
- Farm owners multi-peril insurance.

Rather than include group life insurance under TRIA, the Senate chose to address that line of coverage through a study that would have been done by the President’s Working Group on Financial Markets, the NAIC, policy holders and insurance experts. A report, which would have also addressed terrorism coverage for NBCR attacks, would have been due by September 30, 2006.

The Extension as Law

With the December 31 expiration of TRIA perilously close, the Terrorism Risk Insurance Extension Act of 2005 went through some tweaking and movement back and forth from the Senate to the House and back again before being passed along, on December 19, 2005, to President Bush, who signed the Act into law three days later. Much of the law contains procedural changes. Lawmakers deleted many parts of TRIA that applied only to past years and rearranged some paragraphs and subsections. In order to avoid redundancy and to address relevance, this section summarizes only the content-related changes that the government made to the 2002 law.

The extension that Bush approved differs little from the Senate version described in the previous section. The Terrorism Risk Insurance Extension Act of 2005 extended TRIA through 2007 with the government covering 90 percent of insured losses in 2006 and 85 percent in the next year. Deductibles, based on the preceding year’s direct earned premiums, were 17.5 percent for insurers in 2006 and rose to 20 percent of those premiums in 2007. Insured-loss triggers for government assistance were $50 million for 2006 (a 900 percent increase of TRIA’s trigger for 2005) and $100 million for 2007. The $50 million trigger for 2006 did not go into effect until March 31, 2006, meaning that the government would have covered damages of $5 million from a single certified attack through that date. What did change from the Dodd bill were the insurance marketplace aggregate retention amounts, which went into law as $25 billion for 2006 and $27.5 billion for 2007 and made the insurance industry more likely than in the past to be responsible for mandatory recoupment of
government money. (For the sake of comparison, the retention amount for 2005 was $15 billion.)

In addition to the excluded lines of insurance listed in the 2002 law, the 2005 extension excluded the following from government-backed terrorism coverage:

- Commercial auto insurance.
- Farm owners multi-peril insurance.
- Burglary and theft insurance.
- Surety insurance.
- Professional liability insurance.

In its January 5, 2006 interim guidelines for insurers regarding the extension, the government conceded that “professional liability insurance” was a somewhat non-specific term. In order to fend off any public confusion, Washington advised insurers to abide by a definition used in conjunction with the NAIC’s System for Electronic Rate and Form Filing, which, based on NAIC language, meant that TRIA no longer applied to:

- Coverage available to pay for liability arising out of the performance of professional or business duties related to an occupation, with coverage being tailored to the needs of the specific occupation. Examples include abstracters, accountants, insurance adjusters, architects, engineers, insurance agents and brokers, lawyers, real estate agents and stockbrokers.

Rather than receiving federal reinsurance coverage through the extension, group life insurers and attacks involving nuclear, biological, chemical or radiological weapons got the Dodd-proposed study treatment; a mandate from the government that the President’s Working Group on Financial Markets, the NAIC and insurance experts complete a report on the topics by September 30, 2006.

Text of Terrorism Risk Insurance Extension Act of 2005

We conclude this section by providing a copy of the actual text of the Terrorism Risk Insurance Extension Act of 2005 for your review.

An Act

To extend the applicability of the Terrorism Risk Insurance Act of 2002.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Terrorism Risk Insurance Extension Act of 2005”.

SEC. 2. EXTENSION OF TERRORISM RISK INSURANCE PROGRAM.


(b) MANDATORY AVAILABILITY.--Section 103(c) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2327) is amended--
(1) by striking paragraph (2);
(2) by striking “AVAILABILITY.—“ and all that follows through “each entity” and inserting “AVAILABILITY.—During each Program Year, each entity”; and

(3) by redesignating subparagraphs (A) and (B) as paragraphs (1) and (2), respectively, and moving the margins 2 ems to the left.

SEC. 3. AMENDMENTS TO DEFINED TERMS.

(a) PROGRAM YEARS.--Section 102(11) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2326) is amended by adding at the end the following:

“(E) PROGRAM YEAR 4.—The term “Program Year 4” means the period beginning on January 1, 2006 and ending on December 31, 2006.

“(F) PROGRAM YEAR 5.—The term “Program Year 5” means the period beginning on January 1, 2007 and ending on December 31, 2007.”.

(b) EXCLUSIONS FROM COVERED LINES.--


(A) in clause (vi), by striking “or” at the end;

(B) in clause (vii), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

“(viii) commercial automobile insurance;

“(ix) burglary and theft insurance;

“(x) surety insurance;

“(xi) professional liability insurance; or

“(xii) farm owners multiple peril insurance.”.

(2) CONFORMING AMENDMENT.--Section 102(12)(A) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2326) is amended by striking “surety insurance” and inserting “directors and officers liability insurance”.

(c) INSURER DEDUCTIBLES.--Section 102(7) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2325) is amended--

(1) in subparagraph (D), by striking “and” at the end;

(2) by redesignating subparagraph (E) as subparagraph (G);

(3) by inserting after subparagraph (D), the following:

“(E) for Program Year 4, the value of an insurer's direct earned premiums over the calendar year immediately preceding Program Year 4, multiplied by 17.5 percent;

“(F) for Program Year 5, the value of an insurer's direct earned premiums over the calendar year immediately preceding Program Year 5, multiplied by 20 percent; and”;

(4) in subparagraph (G), as so redesignated, by striking “through (D)” and all that follows through “Year 3” and inserting the following: “through (F), for the Transition Period or any Program Year”.

SEC. 4. INSURED LOSS SHARED COMPENSATION.

Section 103(e) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2328) is amended—
(1) in paragraph (1)--
   (A) by inserting “through Program Year 4” before “shall be equal”; and
   (B) by inserting “, and during Program Year 5 shall be equal to 85 percent,” after “90 percent”; and
(2) in each of paragraphs (2) and (3), by striking “Program Year 2 or Program Year 3” each place that term appears and inserting “any of Program Years 2 through 5”.

SEC. 5. AGGREGATE RETENTION AMOUNTS AND RECOUPMENT OF FEDERAL SHARE.

(a) AGGREGATE RETENTION AMOUNTS.--Section 103(e)(6) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2329) is amended--
   (1) in subparagraph (B), by striking “and” at the end;
   (2) in subparagraph (C), by striking the period at the end and inserting a semicolon; and
   (3) by adding at the end the following:
      “(D) for Program Year 4, the lesser of--
      “(i) $25,000,000,000; and
      “(ii) the aggregate amount, for all insurers, of insured losses during such Program Year; and
      “(E) for Program Year 5, the lesser of--
      “(i) $27,500,000,000; and
      “(ii) the aggregate amount, for all insurers, of insured losses during such Program Year.”.

(b) RECOUPMENT OF FEDERAL SHARE.--Section 103(e)(7) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2329) is amended--
   (1) in subparagraph (A), by striking “, (B), and (C)” and inserting “through (E)”; and
   (2) in each of subparagraphs (B) and (C), by striking “subparagraph (A), (B), or (C)” each place that term appears and inserting “any of subparagraphs (A) through (E)”.

SEC. 6. PROGRAM TRIGGER.

   (1) by redesignating subparagraph (B) as subparagraph (C); and
   (2) by inserting after subparagraph (A) the following:
      “(B) PROGRAM TRIGGER.--In the case of a certified act of terrorism occurring after March 31, 2006, no compensation shall be paid by the Secretary under subsection (a), unless the aggregate industry insured losses resulting from such certified act of terrorism exceed--
      “(i) $50,000,000, with respect to such insured losses occurring in Program Year 4; or
      “(ii) $100,000,000, with respect to such insured losses occurring in Program Year 5.”.
SEC. 7. LITIGATION MANAGEMENT.

Section 107(a) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2335) is amended by adding at the end the following:

“(6) AUTHORITY OF THE SECRETARY.--Procedures and requirements established by the Secretary under section 50.82 of part 50 of title 31 of the Code of Federal Regulations (as in effect on the date of issuance of that section in final form) shall apply to any cause of action described in paragraph (1) of this subsection.”.

SEC. 8. ANALYSIS AND REPORT ON TERRORISM RISK COVERAGE CONDITIONS AND SOLUTIONS.

Section 108 of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note; 116 Stat. 2336) is amended by adding at the end the following:

“(e) ANALYSIS OF MARKET CONDITIONS FOR TERRORISM RISK INSURANCE.--

“(1) IN GENERAL.--The President's Working Group on Financial Markets, in consultation with the National Association of Insurance Commissioners, representatives of the insurance industry, representatives of the securities industry, and representatives of policy holders, shall perform an analysis regarding the long-term availability and affordability of insurance for terrorism risk, including--

“(A) group life coverage; and

“(B) coverage for chemical, nuclear, biological, and radiological events.

“(2) REPORT.--Not later than September 30, 2006, the President's Working Group on Financial Markets shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives on its findings pursuant to the analysis conducted under subsection (a).”.
Possible Alternatives to TRIA

Where Do We Go From Here?

Even after all of the passionate lobbying by insurers, real estate professionals and other parties to extend the benefits of TRIA beyond its initial expiration date, the end result of that effort was a revised law that prolonged federal terrorism insurance for only two years. In a bit of ominous news for people who supported an insurance backstop, the Terrorism Risk Insurance Extension Act contained no mention of a possible extension. Either because of that potential problem or because of displeasure with the extension in the first place, a variety of lawmakers, insurance professionals and other interested parties suggested alternative ways, some elaborate and some simple, to solve the American terrorism insurance predicament. The next several sections provide the reader with a sampling of some of those alternatives.

The Commission on Terrorism Risk Insurance Act of 2005

On the same day that the House approved the Dodd bill for TRIA’s extension, six House members, all of them from New York, sponsored the Commission on Terrorism Risk Insurance Act of 2005, aiming to alter TRIA specifically to assist areas of the country already affected by terrorist attacks. Perhaps realizing that TRIA could not continue forever and that certain areas of New York City could struggle for many years to obtain affordable terrorism insurance, these lawmakers wanted to establish a panel of experts that would have worked to ensure the affordability and availability of terrorism coverage for previous targets without bombarding the government with greater responsibility. The 11-person commission would have consisted of the following:

- One member of the Treasury Department.
- One NAIC-appointed state insurance commissioner.
- One representative for state workers’ compensation.
- One representative of property and casualty insurers with direct earned premiums of $1 billion or less.
- One representative of property and casualty insurers with direct earned premiums of more than $1 billion.
- One representative of multi-line insurers.
- One representative of independent insurers.
- One representative of insurance brokers.
- One representative of policyholders.
- One representative of September 11 victims.
- One representative of the reinsurance community.

Six months after its formation, the Commission on Terrorism Risk Insurance would have provided the government with a report, which would have made specific recommendations regarding alternate approaches to terrorism coverage. The commission would have also examined the availability of insurance to people who wished to rebuild properties damaged by terrorists. If, in the commission’s opinion, reasonable coverage for these rebuilding projects could not have been found, the government would have extended the benefits of TRIA for those real estate endeavors until adequate changes in the market occurred.
Under the act, total TRIA coverage for a policy would not necessarily have been absolute. The Secretary of State could have opted to extend coverage to only certain lines of insurance based on the specifics of developers’ problems. Besides needing to be related to a previously damaged piece of property, a policy could have been eligible for the TRIA extension only if the insurance had been issued on or before December 31, 2008.

**Catastrophe Bonds: A Worthy Option?**

Another TRIA alternative relied less upon government and more upon financial markets. Problems related to insuring properties against natural disasters in the mid-'90s led to the gradually increasing role of catastrophe bonds in the risk business. In some cases, catastrophe bonds provide insurers with a cheaper alternative to reinsurance. Insurers issue the bonds to investors, who pay for them upfront. Issuers of catastrophe bonds then invest the buyers’ money conservatively, allowing those funds to collect interest. If no catastrophe occurs, investors eventually get their money back along with accumulated cash. If, on the other hand, a catastrophe arises, the issuer of the bond can use the invested money and, if necessary, the interest in order to pay for damages.

Insurers sometimes like catastrophe bonds because these financial mechanisms allow them to verify that a certain amount of money will be available for reimbursements. To the benefit of investors, the bonds can be infinitely divided among various parties, thereby decreasing the burden of risk on individual buyers. But success via catastrophe bonds is often difficult for insurers to achieve.

The reinsurance crisis brought on by September 11 caused some insurance experts to wonder if catastrophe bonds would serve as alternate means of sharing terrorism-related risks. Indeed, according to the publication Business Insurance, issuance of catastrophe bonds hit $1.22 billion in 2002, an all-time high at that point. But the popularity of the bonds did not extend as far into the insurance industry as some people had predicted, possibly due to unrealistic expectations regarding the hardening of the market. Catastrophe bonds did, however, get international attention when FIFA, the organization in charge of the World Cup, insured the 2006 Berlin games through the bonds. Although the bonds financially secured the games against several types of catastrophes, insurers might find it interesting that FIFA’s bonds also covered terrorism risks.

**Back in the Pool**

Providers of workers’ compensation planned for a non-TRIA future in their own way. As mentioned previously, nearly every state requires most businesses to carry workers’ compensation insurance. Even the insurance regulators who permitted exclusions for terrorism coverage after September 11 refused to touch workers’ compensation, and the writers of TRIA took the same position, including the line in its list of mandatory, covered forms of property and casualty coverage. With those developments taken into consideration, one can argue that underwriters of workers’ compensation are among those insurers that are most affected by the existence of TRIA and among those who would be most affected by its repeal or expiration.

In 2004, roughly 40 percent of workers’ compensation providers sponsored an investigation by Tillinghast and Towers Perrin, called the Workers’ Compensation Terrorism Reinsurance Pool Feasibility Study. Although the report convinced workers’ compensation insurers that a pool arrangement like the one implanted in Great Britain was not yet a wise option for terrorism risk-sharing in the line of workers’ compensation insurance, the study did raise several important issues that could someday benefit the United States if the country ever wishes to authorize a similar arrangement.
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The study stressed the positive aspect of a pool; its ability to remove portions of risks from one insurer and to place them upon another. But a pool’s strength is determined by that of its members. If only high-risk insurers participate in a pool, they could threaten confidence in the program, creating a situation in which parties merely exchange risks instead of sharing and minimizing them. The study argued that a successful voluntary pool must strive to promote supreme levels of fairness and stability, and the prospective participants must somehow be convinced that the benefits of joining the pool outweigh the risks.

The insurers involved in the study contemplated the creation of either a “first-dollar plan” or an “excess plan.” First-dollar plans, as their name suggests, promptly ease the financial needs of the insurer by providing coverage of immediate losses. Excess coverage, by contrast, kicks in either after losses have reached a certain amount or after insurers have satisfied a deductible. Although excess coverage may be a pain in the wallet, particularly for less-profitable participants, the report argued that this type of plan served fairness better than a first-dollar arrangement because it took into account the fact that each insurance company has its own procedures, standards and opinions in terms of underwriting.

The workers’ compensation report also addressed the pros and cons of pre-funded and post-funded pool arrangements. If insurers contribute money to a pool before a terrorist attack occurs, they will be bound by more than their word and will help to ensure that the pool can make at least some reimbursements in a timely manner. Although no one can say for certain how a terrorism pool (or even TRIA for that matter) will function if terrorists actually strike the United States again, a pre-funded program could also promote organization, perhaps smoothing out the bureaucratic bumps that the industry would encounter faster than a pure contingency-based, post-funded plan ever could.

One can argue, however, that funding the program upfront would involve headaches that might not even be necessary, considering that no one knows if September 11 was a fluke or a foundation of more danger to come. Under a pre-funded arrangement, the pool would need to determine membership fees before any tangible financial damage occurs. Plus, money set aside to cover attacks in the future would almost certainly be taxed by the government in the present.

A post-funded arrangement, which would require insurers to chip in after an attack, would benefit pools that struggle to build reserves. But, according to the workers’ compensation report, a program that relies mainly upon post-funding could endanger the existence of confidence in the pool because insurers could never be absolutely certain that their fellow members would make all of their required payments after a terrorist incident. If a company ever becomes insolvent, for reasons related to terrorism or otherwise, reimbursement for industrial losses would become increasingly complicated.

The workers’ compensation study ultimately focused on a prototypical excess terrorism pool that, if put into practice, would have absorbed 90 percent of losses after an insurer met an individual retention amount that ranged from $5 million for small participants to $90 million for large companies. The proposal called for an industry-wide cap on total losses, which would have increased contingent upon the pool’s fruitful harvesting of funds, but no caps would have existed for individual insurers. Members could have utilized the pool to cover acts, such as those involving domestic terrorism or NBCR weaponry, that the government was not yet insuring through TRIA.

In order to promote membership early in the program, the pool would have charged higher fees to those insurers who bided their time for years and opted in and out of the arrangement based upon perceived levels of terrorism risks. To instill confidence among its members, the pool would have attempted to weed out prospective, unstable participants by enforcing credit
restrictions. Potential members would have needed to possess credit ratings of no lower than A- unless insurers submitted a letter of credit backing the insurers’ obligations to the pool. If an insurer failed to satisfy its obligations, the pool’s administrators would have been able to draw upon the letter of credit to recover all or at least a portion of the required amount.

The workers’ compensation pool would have based members’ premiums and other fees upon insurers’ risk. The study determined that the fairest way to assess risk in the pool was to quantify the number of employees insured in geographic locations. Presumably, an insurer who covered 50,000 workers in high-risk New York City and 25,000 in low-risk Topeka, Kansas would have paid more to the pool than an insurer who covered 50,000 employees in Topeka and 25,000 in New York City.

Money from the fund would have come from a combination of pre-funded and post-funded arrangements that would have ideally produced hefty finances in relatively little time while gradually easing the pre-attack burden on participants. If an attack had occurred during the program’s first year of existence, insurers would have paid post-terrorism fees to the pool that equaled up to 50 percent of their regular pre-funded premiums. Insurers would have paid a post-attack charge of up to 25 percent of their pre-funded premiums if terrorists struck the United States in the pool’s second year. Beginning in its third year, the pool would have required no post-funding from members unless it ran out of money.

In a move related to premiums and early membership, the pool proposal provided that any collected premiums that stayed in the fund unused for ten years would return to the insurer. This practice of giving money back to contributors would not have begun until the pool accumulated a target total of funds. In terms of absolute dollars and cents, the target amount of pool funds would differ depending upon the terrorism risk model used to calculate it. But, as stated in the report, any pool should feel secure in its ability to absorb losses only if it has enough resources to cover an event with a probability of 0.2 percent. In other words, if there is a 1-in-500 chance of a terrorist attack causing damages of up to $40 billion, a pool should at least possess that much capital.

After six months of study, providers of workers’ compensation decided that their pool arrangement, as detailed in the report, would not effectively solve their problems associated with terrorism coverage. Even with the combination of pre-funding and post-funding, several years would have passed before the collective arrangement secured enough money to handle that 1-in-500 risk. Because of these findings, issuers of workers’ compensation turned away from the pool and moved toward a fully focused campaign to renew TRIA.

Yet, the study only determined that a pool arrangement for workers’ compensation was not a feasible option for terrorism coverage at that time. It did not rule out the workability of a future pool arrangement that covered other lines of property and casualty insurance. Nor did it stress that a similarly structured program with different details would not be an option for the industry if TRIA were ever repealed or allowed to expire.

Based on J. Robert Hunter’s previously mentioned July 27, 2005 testimony before the House, the CFA also considered the possibility of a pool for terrorism insurance to replace TRIA. As with its position on the Act’s extension, the organization had conditions that it wanted met before providing its support to a potential terrorism insurance program:

- Pools should be formed and administered only by high-risk states.
- A variety of representatives of both the public and private sectors should oversee the state pools.
State terrorism pools should not incorporate coverage for allegedly low-risk lines, such as commercial auto, life and general liability insurance.

State pools’ records should be available for public review.

**Following Florida’s Example**

Some insurers and lawmakers suggested that the answer to the nation’s terrorism coverage problems could have been found at one of the country’s southern tips. The enormity of Hurricane Andrew, the most costly American catastrophe until September 11, instigated a property insurance crisis in Florida with rises in prices and drops in availability. The state dealt with the insurance shortage and high costs in various ways, including providing otherwise uninsurable property owners with coverage through the Florida Windstorm Underwriting Association and the Florida Residential Property and Casualty Joint Underwriting Association. Eventually, these two entities merged to form the Citizens Property Insurance Corp. (more simply referred to as “Citizens”) and affected roughly 500,000 policyholders at the time, most of them from the state’s southern coast.

Citizens offers everything from all-peril to wind-only policies to commercial and personal property owners. People who cannot fully cover their personal property risks through the traditional insurance market can secure coverage through Citizens. With the exceptions of condominiums, cooperatives and homeowners associations that can obtain surplus policies, any offer by an insurer to absorb a commercial risk disqualifies that risk from Citizens coverage. No customer can obtain wind-only coverage from the corporation if another insurer makes it available.

Before Florida established Citizens, the price of windstorm insurance in the state was set to increase by 40 percent. The legislation that ushered in the corporation capped the expected rise in premiums at 10 percent. But that temporary stipulation was not the only big news regarding Citizens. Whereas Citizens’ two predecessors paid a combined estimate of $100 million in taxes in 2002 before the merger, the successor corporation is generally exempt from taxes. As a result, Citizens can utilize a greater percentage of its money than other insurers to pay off losses and to build reserves. Plus, low-interest bonds issued by the corporation are attractive to some investors because the bonds, too, are tax-free.

On the negative side, Citizens’ insurance policies are the most expensive in the state. In determining a premium, according to a Florida statute, the corporation compiles prices for similar properties from the top 20 insurers in each county and charges the highest amount. Most controversially, the rest of Florida’s insurance companies must pay for Citizens’ claims if the corporation runs out of money. This is bad news for consumers because, when faced with responsibility for Citizens’ debts, other insurers are likely to either raise premiums or charge customers additional fees in order to reimburse themselves. The corporation can avoid the wrath of insurers and statewide policyholders by taking out loans to pay for any deficits, but those loans are taxable.

If Citizens encounters a deficit and cannot pay claims, the corporation charges an assessment fee to insurers based on participation ratios, which are calculated as a percentage of statewide direct-written premiums from the preceding year. If, for example, an insurer accounted for 2 percent of direct-written premiums for commercial insurance during the year before Citizens is unable to honor a commercial policy, that insurer is responsible for 2 percent of resulting assessment fees.

The amount and duration of aggregate assessment fees depends upon the size of the deficit. When the deficit is less than or equal to 10 percent of the previous year’s direct written premiums, the corporation imposes total assessment fees equal to that amount. If a deficit is
more than 10 percent of the previous year's direct written premiums, the corporation must impose total assessment fees that are the greater of 10 percent of the previous year's direct written premiums and 10 percent of the deficit. If a deficit still exists after the imposition of these fees, Citizens may collect additional money (called "emergency assessments") until the corporation's accounts come out of the red. Within six months of any assessment, Citizens must impose fees upon its own customers in the form of "market equalization surcharges," which affect new or renewed policies for one year.

For the property insurance customer who could not obtain adequate coverage after Hurricane Andrew, Citizens has been an effective, albeit expensive, provider of high-risk policies. By October 2004, the corporation was insuring 13 percent of Floridian property, and a June 25, 2005 article from Knight Ridder Tribune Business News reported Citizens was the state’s number-two insurer. From a pure availability standpoint, the corporation has clearly served its purpose.

And yet, that purpose has perhaps been served all too well. Although most insurers would love to be known as the second-largest provider in their area, they would want to achieve that status through diversification of risks. The purpose and setup of Citizens, though, seems to limit its ability to remain a stable financial entity following catastrophic events. The corporation's clients have all turned to it for the same basic reason: The high risks associated with their properties have prevented them from obtaining coverage elsewhere. Of course, some properties insured by the corporation exhibit lower risks than others, but none of the Citizens-backed structures can be termed low-risk when compared to average sites insured by other providers. The Florida statute that created Citizens also authorized yearly studies of the corporation's absorption of risk. If the insurer's level of risk becomes too high, Citizens must cut back on its business. This stipulation forced Citizens to lessen its exposure to risk by 2007 in the amount of 25 percent.

The brains behind Citizens realized the dangers involved with taking on only relatively high-risk customers. By charging the highest premiums in Florida and by refusing to take on many customers who receive offers of coverage from other insurers, Citizens distinguishes itself as a non-competitor in the industry. In an ideal situation for the state, other insurers would decide that Citizens' business is out there for the taking and that all they have to do is dare to absorb greater policy risks. In a perfect balance between consumer contentment and business strength, premiums on the traditional market would even drop for high-risk policies as more of the true competitors sucked up some of their fear and fought one another for these customers.

But, as has been the case with terrorism insurance, Floridian underwriters’ guts still tell them to play it extremely safe when billions of dollars could be lost with a few or even one cruel catastrophic incident. The old Florida Residential Property and Casualty Joint Underwriting Association had enticed other insurers to absorb many of its customers by dangling $300 in front of them for each policy they picked up, but Citizens’ attempts to shrink itself have been less effective. To use a sports metaphor, Citizens is the reluctant basketball player who does not want the ball. But no one else on the team of insurers can get open, so the passes keep coming its way.

The corporation’s low diversification of risk and its inability to adequately shed customers proved costly during the 2004 hurricane season. Citizens officials insisted that they could handle insured losses from Hurricane Charley, but the additional triple whammy of tropical cyclones Ivan, Frances and Jeanne eventually produced a deficit of several millions of dollars. Those losses undoubtedly did nothing to ease the worries of insurers with potential
catastrophic financial collapse on their minds, and some Florida residents started becoming a little more vocal about their preference for some alternate form of windstorm coverage.

Citizens has proven that a government-supported insurance program for catastrophes can solve availability problems, which should, at least to a certain degree, please proponents of a terrorism risk arrangement. But the corporation’s fiscal struggles following those four catastrophes in 2004, as well as the program’s admittedly complicated setup, arguably make Citizens both a useful and faulty blueprint for a terrorism insurance program, depending on one’s perspective.
Another TRIA Renewal

A Bolder Approach

Despite the successful passage of a TRIA extension, proponents and critics of government-backed terrorism insurance understood that a two-year continuation hardly settled the issue, and both sides wasted little time before turning their attention to the extension’s December 31, 2007 expiration date. By early 2006, the CFA was already encouraging insurers and legislators to leave TRIA behind and turn their attention to pool arrangements and state-fostered solutions to coverage problems. Meanwhile, various politicians, including Senator Charles Schumer of New York and Senator Dodd of Connecticut were hoping that Congress would put an end to all the on-again, off-again fighting over TRIA extensions and simply make the law permanent.

The terrorism insurance market had clearly evolved since the beginning of TRIA in 2002. Industry reports concluded that coverage had become increasingly popular, with more than half of all big and midsize businesses electing to purchase terrorism insurance in 2005, according to Marsh Inc. In addition to the TRIA-supported benefits found in many property and casualty policies, people were finding and buying more stand-alone terrorism policies, which sometimes insured them against risks that TRIA did not cover. In attempts to encourage renewals among their clients, some insurers were even offering modest economic protection from nuclear, biological, chemical and radiological threats.

It could be said that various government officials’ attitudes toward terrorism insurance had changed over that time, too. A joint hearing on terrorism insurance held by the House Financial Services Committee and the House Homeland Security Committee in July 2006 was significant because it showed publicly that there was indeed a connection between national defense and the availability of affordable insurance. At the White House, President Bush had gone from a strong TRIA supporter in 2002 to one of the legislation’s critics. In one of the law’s obligatory studies, the President’s Working Group on Financial Markets claimed TRIA had originally helped stabilize the private market for terrorism insurance but that the law’s continuance had ultimately prevented the market from reaching its full potential. The executive branch did not publicly call for an immediate end to the government’s terrorism insurance program. Instead, the administration said it had its own goals in mind for any post-2007 version of TRIA. Among them, the federal insurance program would need to continue to be temporary, insurers would need to pay more claims on their own and coverage would not be expanded in any way.

Many members of Congress and others, however, had a different idea of what should be done with TRIA and saw the 2007 renewal debate as an opportunity to make bolder changes to the law. The President’s Working Group on Financial Markets and the Government Accountability Office had both concluded that insuring against nuclear, biological, chemical and radiological attacks would be a challenge for the private market, and some legislators thought it was time for NBCR risks to become part of TRIA. Terrorist attacks in London in 2005 by British citizens brought back the issue of domestic terrorism, with people like New York Mayor Michael Bloomberg pointing out that a similar attack in the United States would not have been covered by either the original law or its 2005 extension. Along with various New York representatives in the House and Senate, Bloomberg also said coverage under TRIA would not be guaranteed if an act of terrorism was committed by a U.S.-based group with ties to foreign organizations. As the deadline for a TRIA extension grew nearer, it seemed increasingly likely that any 2007 extension would include a change in the law’s definition of “acts of terrorism.”

The Terrorism Insurance Revision and Extension Act of 2007
The first major terrorism insurance bill to get traction in Congress after the 2005 renewal—the Terrorism Insurance Revision and Extension Act of 2007—contained those bolder changes and more. The act would have added group life to the list of covered lines under TRIA, would have decreased deductibles for insurers that issued coverage in areas where terrorist attacks had already occurred and would have made TRIA benefits accessible to insurers when insured losses from a terrorist attack amounted to $50 million. Under the proposed act, insurers that were covered by TRIA would have needed to begin offering NBCR coverage beginning in 2009 and would have paid a 7.5 percent deductible in exchange for government-backed NBCR reinsurance. The requirement to offer NBCR coverage would not have applied to insurers with direct earned premiums under $50 million if they could demonstrate that providing the insurance would be overly burdensome to them. Perhaps most surprisingly to all sides, including a very pleased insurance lobby, the act would have potentially made TRIA a non-issue in Washington for several years by extending the government’s terrorism insurance program for another 15 years. When the House passed the act a few months before the end of 2007, the White House responded by threatening to veto the legislation.

The Terrorism Risk Insurance Program Reauthorization Act of 2007

Support for a broader version of TRIA was less widespread in the Senate, where Senator Dodd’s hope for a permanent terrorism insurance program faded away even as he took over as the head of the chamber’s Committee on Banking, Housing and Urban Affairs. The Senate’s main response to a second TRIA extension—the Terrorism Risk Insurance Program Reauthorization Act of 2007—mirrored the House’s main proposal in its coverage for domestic terrorism and also would have kept TRIA alive for several more years. But as a seven-year extension that did not rock the boat by including group life insurance, NBCR coverage and smaller deductibles, the Senate proposal was more palatable to the White House than the changes proposed by the House. The industry, too, was generally pleased with the Senate’s choices, and, following a few modifications, the Terrorism Risk Insurance Program Reauthorization Act was approved by both houses of Congress on December 19, 2007 and sent to the White House.

The Extension as Law

As signed into law, the Terrorism Risk Insurance Program Reauthorization Act extended TRIA through 2014 and lifts the coverage ban on domestic terrorism. This means that, in contrast to TRIA’s original text, the government’s terrorism insurance program will now cover acts of terrorism that are committed by Americans. Other than that, perhaps the biggest story about the 2007 extension is that very little else was changed this time around. Insurers’ deductibles will remain at their 2007 level (20 percent of direct earned premiums) throughout the extension period. As in 2007, TRIA coverage will be triggered when terrorist attacks produce $100 million in insured losses in a year, and neither the government’s insurance program nor insurers will be responsible for insured losses above $100 billion. Due to amendments to TRIA in 2007, insurance companies must disclose the existence of the $100 billion cap to their new terrorism insurance clients. This disclosure must be made when a TRIA-sponsored policy is offered to a client, when a client purchases TRIA-sponsored terrorism insurance and when a client renews TRIA-sponsored terrorism insurance.

Some parts of the revised Act seem to have been included in order to help the government keep tabs on its expenditures in the event of an attack. No later than 15 days after a certified act of terrorism, the Treasury Secretary must report to Congress and say whether or not insured losses from the attack are likely to exceed TRIA’s $100 billion cap. No later than 90 days after an attack, the Secretary must evaluate the amount of insured losses so that the government can determine whether or not insurers should be subjected to mandatory
recoupment. The 2007 extension also sets deadlines for the government to collect terrorism risk-spreading premiums from insurance companies in the event of mandatory recoupment. These deadlines will depend on when a certified act of terrorism occurred, with different years corresponding with different requirements. Under the 2007 extension, the Secretary became responsible for developing regulations related to the collection of these premiums.

As the reader might have guessed, the 2007 amendments to TRIA required the government to complete another batch of studies. Reports on the availability of terrorism insurance in the United States and the availability of NBCR coverage became mandatory, as did additional reports by President’s Working Group on Financial Markets.

**Text of Terrorism Risk Insurance Program Reauthorization Act of 2007**

We conclude this section by providing a copy of the actual text of the Terrorism Risk Insurance Program Reauthorization Act of 2007 for your review.

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**One Hundred Tenth Congress**

**of the**

**United States of America**

**AT THE FIRST SESSION**

Begun and held at the City of Washington on Thursday, the fourth day of January, two thousand and seven

An Act

To extend the Terrorism Insurance Program of the Department of the Treasury, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) Short Title- This Act may be cited as the “Terrorism Risk Insurance Program Reauthorization Act of 2007”.

(b) Table of Contents- The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Definition of act of terrorism.
Sec. 3. Reauthorization of the Program.
Sec. 4. Annual liability cap.
Sec. 5. Enhanced reports to Congress.

**SEC. 2. DEFINITION OF ACT OF TERRORISM.**

Section 102(1)(A)(iv) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended by striking “acting on behalf of any foreign person or foreign interest”.

**SEC. 3. REAUTHORIZATION OF THE PROGRAM.**

(a) Termination Date- Section 108(a) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended by striking “2007” and inserting “2014”.

(b) Additional Program Years- Section 102(11) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended by adding at the end the following:

“(G) ADDITIONAL PROGRAM YEARS- Except when used as provided in subparagraphs (B) through (F), the term “Program Year” means, as
(c) Conforming Amendments- The Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended--

(1) in section 102(7)(F)--
   (A) by inserting “and each Program Year thereafter” before “the value”; and
   (B) by striking “preceding Program Year 5” and inserting “preceding Program Year”;
(2) in section 103(e)(1)(A), by inserting “and each Program Year thereafter” after “Year 5”;
(3) in section 103(e)(1)(B)(ii), by inserting before the period at the end “and any Program Year thereafter”;
(4) in section 103(e)(2)(A), by striking “of Program Years 2 through 5” and inserting “Program Year thereafter”;
(5) in section 103(e)(3), by striking “of Program Years 2 through 5,” and inserting “other Program Year”; and
(6) in section 103(e)(6)(E), by inserting “and any Program Year thereafter” after “Year 5”.

**SEC. 4. ANNUAL LIABILITY CAP.**

(a) In General- Section 103(e)(2) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended--

(1) in subparagraph (A)--
   (A) by striking “(until such time as the Congress may act otherwise with respect to such losses)”; and
   (B) in clause (ii), by striking “that amount” and inserting “the amount of such losses”;
(2) in subparagraph (B), by inserting before the period at the end “, except that, notwithstanding paragraph (1) or any other provision of Federal or State law, no insurer may be required to make any payment for insured losses in excess of its deductible under section 102(7) combined with its share of insured losses under paragraph (1)(A) of this subsection”.

(b) Notice to Congress- Section 103(e)(3) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended--

(1) by adding at the end the following: “The Secretary shall provide an initial notice to Congress not later than 15 days after the date of an act of terrorism, stating whether the Secretary estimates that aggregate insured losses will exceed $100,000,000,000.”; and
(2) by striking “and the Congress shall” and all that follows through the end of the paragraph and inserting a period.

(c) Regulations for Pro Rata Payments; Report to Congress- Section 103(e)(2)(B) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended--

(1) by striking “For purposes” and inserting the following:
   “(i) IN GENERAL- For purposes”; and
(2) by adding at the end the following:
   “(ii) REGULATIONS- Not later than 240 days after the date of enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2007, the Secretary shall issue final regulations for determining the pro rata share of insured losses...
under the Program when insured losses exceed $100,000,000,000, in accordance with clause (i).

"(iii) REPORT TO CONGRESS- Not later than 120 days after the date of enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2007, the Secretary shall provide a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives describing the process to be used by the Secretary for determining the allocation of pro rata payments for insured losses under the Program when such losses exceed $100,000,000,000.".

(d) Disclosure- Section 103(b) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended--

(1) by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively; and

(2) by inserting after paragraph (2) the following:

"(3) in the case of any policy that is issued after the date of enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2007, the insurer provides clear and conspicuous disclosure to the policyholder of the existence of the $100,000,000,000 cap under subsection (e)(2), at the time of offer, purchase, and renewal of the policy;".

(e) Surcharges- Section 103(e) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended--

(1) in paragraph (7)--

(A) in subparagraph (C), by inserting “133 percent of” before “any mandatory recoupment”; and

(B) by adding at the end the following:

"(E) TIMING OF MANDATORY RECOUPMENT-

“(i) IN GENERAL- If the Secretary is required to collect terrorism loss risk-spreading premiums under subparagraph (C)--

“(I) for any act of terrorism that occurs on or before December 31, 2010, the Secretary shall collect all required premiums by September 30, 2012;

“(II) for any act of terrorism that occurs between January 1 and December 31, 2011, the Secretary shall collect 35 percent of any required premiums by September 30, 2012, and the remainder by September 30, 2017; and

“(III) for any act of terrorism that occurs on or after January 1, 2012, the Secretary shall collect all required premiums by September 30, 2017.

“(ii) REGULATIONS REQUIRED- Not later than 180 days after the date of enactment of this subparagraph, the Secretary shall issue regulations describing the procedures to be used for collecting the required premiums in the time periods referred to in clause (i).

“(F) NOTICE OF ESTIMATED LOSSES- Not later than 90 days after the date of an act of terrorism, the Secretary shall publish an estimate of aggregate insured losses, which shall be used as the basis for determining whether mandatory recoupment will be required under this
paragraph. Such estimate shall be updated as appropriate, and at least annually.”; and
(2) in paragraph (8)--
(A) in subparagraph (C)--
   (i) by striking “(including any additional amount included in such
   premium” and inserting “collected”; and
   (ii) by striking “(D))” and inserting “(D);” and
(B) in subparagraph (D)(ii), by inserting before the period at the end “, in accordance with the timing requirements of paragraph (7)(E)”.

SEC. 5. ENHANCED REPORTS TO CONGRESS.

(a) Study and Report on Insurance for Nuclear, Biological, Chemical, and Radiological Terrorist Events- Section 108 of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended by adding at the end the following:
“(f) Insurance for Nuclear, Biological, Chemical, and Radiological Terrorist Events--
“(1) STUDY- The Comptroller General of the United States shall examine--
“(A) the availability and affordability of insurance coverage for losses caused by terrorist attacks involving nuclear, biological, chemical, or radiological materials;
“(B) the outlook for such coverage in the future; and
“(C) the capacity of private insurers and State workers compensation funds to manage risk associated with nuclear, biological, chemical, and radiological terrorist events.
“(2) REPORT- Not later than 1 year after the date of enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2007, the Comptroller General shall submit to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives a report containing a detailed statement of the findings under paragraph (1), and recommendations for any legislative, regulatory, administrative, or other actions at the Federal, State, or local levels that the Comptroller General considers appropriate to expand the availability and affordability of insurance for nuclear, biological, chemical, or radiological terrorist events.”.

(b) Study and Report on Availability and Affordability of Terrorism Insurance in Specific Markets- Section 108 of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended by adding at the end the following:
“(g) Availability and Affordability of Terrorism Insurance in Specific Markets--
“(1) STUDY- The Comptroller General of the United States shall conduct a study to determine whether there are specific markets in the United States where there are unique capacity constraints on the amount of terrorism risk insurance available.
“(2) ELEMENTS OF STUDY- The study required by paragraph (1) shall contain--
“(A) an analysis of both insurance and reinsurance capacity in specific markets, including pricing and coverage limits in existing policies;
“(B) an assessment of the factors contributing to any capacity constraints that are identified; and
“(C) recommendations for addressing those capacity constraints.
“(3) REPORT- Not later than 180 days after the date of enactment of the Terrorism Risk Insurance Program Reauthorization Act of 2007, the Comptroller General shall submit a report on the study required by paragraph
(1) to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives.

(c) Ongoing Reports- Section 108(e) of the Terrorism Risk Insurance Act of 2002 (15 U.S.C. 6701 note) is amended--

(1) in paragraph (1)--

(A) by inserting “ongoing” before “analysis”; and

(B) by striking “, including” and all that follows through the end of the paragraph, and inserting a period; and

(2) in paragraph (2)--

(A) by inserting “and thereafter in 2010 and 2013,” after “2006,”; and

(B) by striking “subsection (a)” and inserting “paragraph (1)”.

Conclusion

No matter how the United States ultimately opts to address terrorism coverage beyond the lifespan of the 2007 TRIA extension, if the short history of this issue teaches us anything, it is that an increased level of confidence must exist in the insurance industry and in Washington for any plan to truly please the two sometimes opposing sides. The industry must develop confidence in some combination of its underwriting, its terrorism models, its financial stability, the competency of U.S. intelligence workers and the willingness of the government to offer a helping hand during crises. At the same time, the government must be convinced that insurers are doing everything in their power to make coverage available at reasonable prices to consumers and that the industry’s pleas for a helping hand are not masked solicitations for a handout.

Terrorism, of course, has its name for a reason. Violent, generally unexpected attacks are designed to instill fear into their targeted communities, ideally convincing the public that the world is forever unsafe. The United States might never feel completely safe in a post-September 11 world, and perhaps that is a blessing in disguise because moderate levels of fear should keep people alert and aware of potential threats. Terrorism does not psychologically conquer a society unless those moderate levels of fear progress into chaotic levels of anxiety. Obviously, the country has concerns related to terrorism that outrank insurance issues in the hierarchy of national security, and a terrorism insurance plan will not be the ultimate factor in restoring a tone of safety to the land. But if groups such as insurers and legislators at least nurture greater confidence in each other, if they can develop an amicable plan to deal with disasters related to terrorism, they might be able to aid the resiliency of a threatened United States and help prevent people’s understandable shock and fear from turning into absolute disorder and doom.
CHAPTER 2 – COMMERCIAL INSURANCE

Introduction to Commercial Insurance

Commercial insurance is not unlike personal insurance in the types of coverage offered and in the different variations of the basic plan. For example, commercial insurance offers protection for property loss and liability. Also, as with personal insurance, a business owner can purchase additional coverage to supplement the coverage of his or her basic policy.

However, despite any similarities that these two types of insurance share, business owners must carry commercial insurance, or insurance that is designed for businesses, since they may be exposed to considerably more loss than the personal insurance policyholder because of employees, inventory, and the constant stream of people entering the establishment.

The term multiple-line, or multiple-peril, is used to describe an insurance policy that combines different lines of insurance in a single package. Those who purchase this type of insurance are actually buying several policies for one premium. Property and liability is commonly sold as a multiple-peril policy. This type of policy is more comprehensive than a single-line policy, which offers only one type of insurance. For example, a single-line policy might offer coverage for liability or property, but it does not offer coverage for both liability and property. Finally, because this package insurance policy exists as a single entity, it may not be subdivided into several separate policies. If a person does not wish to purchase the entire package, he may consider opting for a single-line policy although he will lose the discounted price and convenience of the package policy.

In this chapter we will explore two types of commercial multi-peril policies: the special multi-peril policy (SMP) and the business-owners policy (BOP).

History of the Commercial Package Policy Concept

Package policies have been an integral part of the insurance industry for decades. Even the simple fire and extended coverage policy, one of the first insurance policies ever available, is a package in that the extended coverage endorsement (additional insurance that an insured has the option of adding to his basic policy to broaden coverage) combines a number of separate perils (wind, hail, explosion, impact by vehicles or aircraft, and riot and civil commotion) into one package. Since then, many different packages of insurance coverages have been introduced and implemented as important components of the insurance industry.

The first real commercial multi-peril packages offering protection for both property and liability did not appear until the early 1960s. Part of the reason for the late arrival of these types of policies was governmental regulations of insurance and because insurance at that time, with the exception of homeowners policies, had changed very little. For instance, for quite some time, many states were forced to comply with laws that required insurance agents to be licensed in the single-line form of insurance since most insurance companies were required to offer only single-line insurance. In other words, companies who specialized in property insurance were not allowed to sell liability coverage; therefore, insurance companies only hired agents who were licensed to sell property insurance. The same was true for other single-line policies such as liability, marine and aircraft policies. These regulations were slowly relaxed during the 1950s because by that time it was evident that many buyers of the homeowners package policy welcomed the “new” package policy.

Naturally, business owners, many of whom were also homeowners, complained that they, too, could benefit from the reduced cost and the convenience of the package policy. Up to that time business owners were only able to purchase single-line policies, just as
homeowners had done until the 1950s. Furthermore, because of the increased risks of store or company ownership, business owners had to purchase a much larger number of separate policies than a homeowner had ever had to buy. In the 1960s, one decade after homeowners insurance had been available, some insurers, together with agents and brokers, focused on the desires of potential commercial policyholders and created the package concept for businesses. Only a few innovative, aggressive insurance companies had worked to develop these new packages. Therefore, when the business package policies were finally approved, these few companies, taking advantage of the principles of free enterprise, were the first to market them, thereby jumping ahead of their competitors, and attracting more business.

**Structure and Terminology of Commercial Insurance Policies**

As with any type of insurance policy, an understanding of the basic terminology that one will encounter in the policy is crucial to understanding the policy itself and its coverages.

**Structure of the Policy**

Commercial policies contain at least two sections, property, and liability. These are referred to, respectively, as Section I and Section II. Depending on the type of policy, some insurance contracts contain other sections (such as theft and burglary) that are a part of the basic policy. These sections may describe a particular type of optional coverage or endorsement, or additional coverages that the purchaser may consider adding to extend the basic coverage of his policy. Regardless of how many sections the policy might contain, each section describes in detail the specific types of protection that the policy covers and the specific types of damages that are excluded, or not covered, under the policy.

**The Named Insured**

The “named insured,” usually stated as item one on the policy’s declarations page, is the person(s) or organization that is protected by the policy’s coverage as long as the named insured is acting either in the business’s interest or according to his role in that business.

Many times, the word “insured” is quite broad, but the term can apply to any of the following:

- A sole proprietor and his spouse.
- A partnership or joint venture.
- An organization or any executive officer.
- A member of the board of trustees, directors or governors.
- Any stockholder; any employee of the named insured.
- Any person or organization who acts as the real estate manager for the named insured.

**Named Peril Form vs. All-Risk Form**

Under the standard form policy, businesses are protected against the usual named perils, but there are special form policies that protect against multiple risks, and this type of protection is called all-risk coverage.

Named peril insurance means that the insurance policy specifically names those perils from which the business owner is protected. All-risk insurance policies state that the business is protected against all risks except those that are specifically excluded, such as earthquake coverage.

The named peril form states specifically which perils are covered, and if a policyholder feels that additional coverage is necessary, he can usually add these by endorsement or by
optional coverage to broaden the coverage of his policy. The all-risk form works differently. This type of policy covers all situations except for those that are specifically excluded under the policy. As with the named peril form, additional policies, endorsements, or optional coverage may be added to the all-risk form so that insureds may more fully cover their exposures to risk.

**Actual Cash Value vs. Replacement Cost**

Replacement cost means that damaged or destroyed property is covered for the amount that it actually costs to replace or to restore the item to its original condition rather than its actual cash value (ACV), which is its current market or depreciated value.

For instance, if a policy states that property is covered according to its replacement cost and if a business has a computer that originally cost $2,000, the insurance company will replace the damaged or destroyed computer with a new, similar computer even if that computer in today’s market is now worth $3,000. The insurance company does not consider that perhaps the damaged or destroyed computer is really only worth $1,500 (the original cost of the computer less its depreciation) as it would if the policy stated that damaged or destroyed property would be replaced or covered according to its present market value, or its ACV. Using the same example, when calculating an insurance company’s obligation to cover part of a loss according to the ACV method for calculation, the insurance company would pay the insured business owner $1,500, the original cost of the computer less its depreciation.

Whether the policy provides for replacement cost or ACV, the business owner is responsible for paying the deductible.

**Assessing Insurance Risks and Needs**

Agents must help business owners to carefully assess their insurance needs from two standpoints. First, a business owner must examine his business’s exposure to loss or risks (pertaining to both property and liability) from which he wishes to be protected. If the basic policy does not include coverage for the type of risk to which a business is exposed, business owners can usually add the necessary coverage for the risk by purchasing an endorsement or optional coverage for added protection. Secondly, business owners should also consider the limits of liability that the policy contains. Like increased protection for exposure to risk, most liability limits can be raised by endorsement or optional coverage.

Considering exposure to risk is essential since many types of exposures such as fire can severely impair the business’s normal activities or may even cause business operations to cease altogether. All risks, even those which seem unlikely, must be anticipated.

Business owners must carefully weigh the advantages of lower annual, monthly, or quarterly, premiums against having high deductibles or low limits of protection. While it is less expensive to purchase an insurance policy that has a $1,000 deductible than one which has a $250 deductible, a business owner must decide whether the higher premium for the lower deductible makes good sense for the business.

Companies that offer commercial insurance often have questionnaires that a potential policyholder must fill out. Using the information from the questionnaires the company’s agent can help the business owner pinpoint the insurance needs of the business and then suggest the best coverage to meet those needs.

**The Special Multi-Peril Policy (SMP)**

As stated earlier, the evolution of commercial package policies and programs can be traced to the development and implementation of the homeowners’ package which protects an individual’s personal property and personal liability.
When the first commercial policies, which were (and still are) called the special multi-peril policy (SMP), became available, small, medium and large businesses were rated in exactly the same way. The SMP was the sole commercial policy package on the market.

Thus, a small business with only ten employees and a large company with hundreds of workers were rated in the same way and were insured under identical SMP forms.

Although the SMP covered many perils, for some small and medium sized businesses, the coverage included protection against risks that these business owners would never require because these businesses, by their very size, are exposed to fewer risks than large companies. As a result, small and medium sized business owners paid for coverage they did not need and paid the same premiums that large companies paid. The SMP was a convenient, discounted policy since it combined several single-line forms of insurance. Unfortunately small and medium sized business owners wasted money because they were paying for coverage that they would likely never use.

Once rating changed to recognize the relative levels of risk for differently sized business, the SMP became the most popular policy for small and medium sized businesses.

While many small and medium sized businesses find the coverages of the SMP to be the best policy for insuring their businesses, many large businesses also find the SMP to be a viable way for insuring itself against property or liability. Although some of these large companies are not eligible for the SMP program, many large businesses do indeed qualify for the program. However, some large companies, which are otherwise eligible, have insurance requirements beyond the scope of the SMP program. This is, of course, to be expected if these companies are exposed to risks that the SMP does not include as part of its protection. Or, interested business owners who operate large companies may discover that even though they are interested in the plan, they are not able to purchase the additional required coverage through endorsements or optional coverages.

**Advantages of the SMP Approach**

When deciding whether to go with a single-line or a multiple-line type of coverage, the commercial policyholder will discover that when his insurance needs are combined as a multiple-line package, he will benefit from lower costs, from more complete coverage in a single policy contract, and from flexibility of choice when selecting optional coverages.

**Reduction in Cost**

Reduction in cost, the first advantage, is probably the most important and most attractive feature of the SMP program. The reduction in premium costs can be ascribed to the following elements: the selection process, the handling of just one policy, careful examination of class characteristics and through the reduction of risks.

- Reducing costs through the selection process.

  Eligible policyholders are screened during the underwriting selection. For example, businesses involved in industries experiencing a higher degree of risk will probably be eliminated immediately. Insurance companies who screen applicants so that their underwriters eliminate poor risks and select only the better risks usually will benefit from cost reductions ranging from 15 to 30 percent. These are up-front reductions in initial premiums. Because SMPs are written by both dividend and non-dividend paying insurance companies, policyholders with some dividend companies may gain additional savings through receiving earned dividends.

  Another factor in cost reductions is that the insurance company’s selection process tends to ensure that a particular group of policyholders will statistically show a better than
average loss ratio, meaning that SMP policyholders have less exposure to risk and, therefore, file less claims.

- Reduced paperwork and lower losses.

Cost reduction is also attributable to two additional factors. First, both the insurance company and the insurance agent or broker benefit from savings in processing reductions since they will manage only one policy instead of perhaps two to ten policies as they would have to do with single-line policies. Second, another cost reduction occurs because, overall, the losses suffered by the SMP class are less costly and fewer in number than the losses suffered by other classes with similar coverage that is written under a series of separate policies. These savings, both the cost of handling one policy rather than several and the decreased chances of the SMP class suffering a loss, are passed on to the policyholder, usually in the form of reduced premiums.

- Reducing costs by cutting risks.

The selection process, as described above, is repeated at renewal time. At that time, the loss experience (claims filed and losses suffered) and inspection reports of the condition of each business owner’s property and equipment (among other areas of examination) are taken into account when deciding whether each business still qualifies for the SMP program and its discounted premium.

Obviously, it is necessary for an SMP policyholder to maintain his premises in excellent condition and to demonstrate that he is receptive, concerned, alert to loss prevention recommendations, and willing to implement suggested improvements in an effort to reduce exposure to loss. He must exhibit these desired characteristics if he wishes to continue benefiting from the reductions in insurance costs that an SMP provides.

To illustrate this point, suppose that a business owner is advised by the insurance company’s representative to buy and to install a better locking mechanism for the cabinet where he stores the guns that he sells. The representative may even urge the policyholder to purchase one of several products that the insurance company has already deemed to be the best, or the most effective, locking mechanisms available in the current marketplace. The policyholder should comply with the representative’s suggested improvement since the representative will probably note in the policyholder’s file that the recommendation was made on a particular date. Sometimes, the representative, because he considers the risk of damage or loss to be significant, may even mandate that the locking mechanism must be installed by a specific time on a named day.

This does not mean that the insurance company will constantly be making suggestions for improvement to the business owner’s property or that the insurance company will infringe upon the business owner’s right to conduct business as he sees fit. Rather, it is one of the insurance company’s methods for reducing exposure to risk, thereby lowering premiums and reducing the chances of a loss occurring. In that way, the class’s loss experience is reduced, or at the very least not increased, because businesses are willing to implement the insurance companies’ recommendations for risk reduction.

Finally, not complying with such suggestions could mean that the business might lose its SMP coverage since the insurance company may determine that the business owner is, in effect, increasing the chances of risk and loss for his class.

**Single Policy Contract**

A second main advantage of the SMP policy is that this policy covers most of the business operation’s exposure. One policy means only one expiration date to worry about, one
premium payment (or one planned series if a payment plan is used), one insurance policy file, and, consequently, low probability that the business owner will have periods of time where coverage lapses. Also, one policy combining several coverages gives the policyholder's account a higher profile with the insurance company’s underwriter.

Theoretically, a well-written SMP, together with a workers’ compensation policy and an appropriate automobile for business usage policy, encompasses in one document all of the insurance needs (other than employee benefits) for most small to medium sized business enterprises.

However, an SMP is not a package which automatically provides business owners with all of their necessary coverages. Selecting a policy requires thoughtful decisions, review, and updating as the business owner’s situation changes. An effective insurance agent can greatly assist the business owner through this process.

**Flexibility of Choice**

Flexibility of choice, the third advantage, makes it necessary for the policyholder and his agent or broker to carefully review his business needs to ensure that selected coverages respond adequately to his needs.

For example, in the mandatory property section, an insured must decide whether the desired coverage is going to be all-risk, named peril, or just fire and extended coverage. If the insured chooses the latter coverage, then he must determine whether there is a need for protection against sprinkler leakage or some other water or earthquake protection by way of either an endorsement or as an optional coverage. Finally, business owners who choose either the named peril or the all-risk form must review available optional coverages or endorsements before deciding whether these extra coverages are necessary.

**Businesses That Qualify For an SMP**

Today’s SMP policy program consists of eight different classification groups, each group offering its own package discount. The group in which a business is placed affects the premium that the business owner will pay. For the most part, the same policy forms are employed for each of the eight groups. The eight groups are:

- Apartment houses.
- Contractors.
- Motel-hotel operations.
- Industrial and processing plants.
- Institutions.
- Mercantile operations.
- Offices.
- Service firms.

The package discounts that apply to each group vary by group and by state. Discounts are periodically recalculated to reflect the loss experience of the group or of the class as a whole. For example, it is possible for a group to have a package factor of 1.00 (no discount) or, if the loss experience of the group is low, a factor of perhaps .65 (a discount of 35 percent).
Businesses That Do Not Qualify For an SMP
Eligibility rules for the SMP program now permit an expansive class of insureds to qualify for the program. Only a few classes are excluded from purchasing an SMP. These include:

- Boarding or rooming houses and other residential properties that consist of fewer than three apartment units.
- Farms and farming operations (this is because a separate commercial package policy exists for farmers).
- Automobile filling or service stations; automobile repairing or rebuilding operations; automobile, motor home and motorcycle dealers; and parking lots or garages unless they are incidental to the otherwise eligible class.
- Grain elevators, grain tanks and grain warehouses.
- Properties or businesses which can be categorized in one of five ways:
  - Highly protected risks.
  - Petroleum properties.
  - Petrochemical plants.
  - Electric generating stations.
  - Natural gas.

Of course, this list does not indicate that these categories of business are ineligible for any type of commercial insurance; it only defines those establishments that are ineligible for participation in the SMP program. Other policies that more adequately and comprehensively address the coverage needs of these types of businesses have been created specifically for that purpose and are available at most insurance companies that offer business owners' insurance.

Defining the Two Types of Property
There are two broad categories of property which must be considered: Real and personal business property. The agent must recognize the differences in these types and be able to clearly explain them to the business owner as this is essential for understanding property coverage.

Real Property Coverage
“Buildings” as defined in the SMP coverage forms include more than just buildings. The definition includes each of the following:

- Buildings.
- Structures.
- Additions.
- Fixtures.
- Permanent equipment and machinery used for maintenance and/or service of the building.
- Materials and supplies intended for use in construction.
- Alterations or repairs.
• Yard fixtures.
• Fire extinguishing apparatus.
• Appliances used for refrigeration, ventilating or cooking.
• Dishwashing and laundering equipment.
• Floor coverings.

All of these property types must be located on the insured’s premises if the business owner is to benefit from the policy’s protection.

Basic exclusions from building equipment are swimming pools, fences, piers, docks, wharves, walks, cost of excavation, building foundations and underground pipes. These types of properties, like other exclusions, may be protected against loss by purchasing a separate policy (depending on the type of property that it is), an endorsement, or optional coverage, depending on the type of property.

Business Personal Property Coverage

Coverage is available through the SMP for business personal property which is usual to the insured’s occupancy or to business operations. Included also are tenant improvements in buildings that are not owned by the insured, and limited extension to the personal property of others that is in the care, custody, or control of the insured at the time of the loss. In most situations personal property coverage is limited to property that is located on the insured premises.

SMP (Section I) Property Coverage

The type of personal property covered under Section I consists of, but is not limited to, stocks (inventories) of merchandise and of raw materials, supplies and fittings, and furniture, fixtures, equipment, and machinery.

Basic exclusions are animals and pets; watercraft; automobiles, vehicles or trailers licensed for highway use; aircraft; personal property while waterborne; household and individual personal property; and accounts, bills, currency, deeds, evidence of debt, money and securities. Valuable papers, money, and securities coverage is available under Section III or by means of various crime endorsements. Each of the above exclusions may be included if the business owner opts to purchase a separate policy (if required), an endorsement or optional coverage.

There are two types of SMP forms from which a business owner might choose. A business owner might choose the standard, or named peril approach, or he may opt for the all-risk approach. Each of these forms covers different perils, so a business owner must carefully weigh whether the additional cost of the all-risk form better suits his insurance needs than the less expensive, but also less comprehensive, named peril form.

The Standard (Named Peril) Form of Property Coverage

Coverage for both buildings and personal property is provided by combining several different peril forms. The basic forms are the general building form and the general personal property form. Under these two forms, insurance coverage is on a named peril basis. These perils include fire, lightning, windstorm, hail, explosion and smoke; aircraft or vehicle damage; riot, riot attending a strike, or civil commotion; and vandalism or malicious mischief. Coverage is limited by exclusions of electrical injury, interruption of power, earth movement, flood, or any enforcement of ordinance or law regarding the use, the construction, or the repair of a building.
At the insured's or insurance company's request, vandalism and malicious mischief, which is usually covered, may be excluded, which deletes this peril from the general form.

**The All-Risk Form of Property Coverage**

As an alternative to the named peril approach, an insured may consider coverage on an all-risks basis. The special building form and special personal property forms provide these types of coverages at an additional cost. Although the all-risk form offers a wide variety of coverage, certain exclusions will always be included as part of the policy.

The exclusions are losses that are caused by the following:

- Enforcement of local or state ordinances regulating construction.
- Electrical injury to electrical appliances caused by an artificially generated current.
- Flood, earthquake, sewer backup, or water below the surface of the ground.
- Wear and tear, gradual deterioration, rust, corrosion, mold, wet or dry rot, or inherent or latent defect.
- Smog.
- Smoke, vapor, or gas from agricultural or industrial operations.
- Mechanical breakdown, including rupture or bursting caused by centrifugal force.
- Settling, cracking, shrinkage, bulging, or expansion of pavements, foundations, walls, floors or ceilings.
- Animals, birds, vermin, or other insects.
- Explosion of steam boilers, steam pipes, or engines.
- Vandalism and malicious mischief to any building that is vacant or that is unoccupied for more than 30 days.
- Continuous or repeated seepage or leakage from water or steam from plumbing, heating and air conditioning or other equipment.
- Theft of any property that is not an integral part of a building at the time of the loss.
- Unexplained or mysterious disappearance of property.
- Loss that is caused directly or indirectly by an interruption of power.

**Additional Optional Coverages**

An insured may purchase added endorsements or optional coverages so that he may more adequately meet his insurance needs. Because the policyholder is adding coverage to his basic policy, the business owner must pay an additional cost for each of these endorsements or optional coverages. An insured’s endorsements are usually found on the declarations page of his policy, so when the purchaser receives his policy, he must make sure that all the additional coverages he purchased are specifically listed on the declarations page so that he does not misunderstand his policy’s coverage.

**Accounts Receivable, Valuable Papers, and Records Endorsements**

These endorsements provide coverage on an all-risk basis and are examined on an individual basis.
The accounts receivable endorsement provides coverage for all money that customers owe a business, and these figures include interest and collection expenses in case the insured is unable to make collection because of a direct loss or because of damage to the accounts receivable records. Depending on the needs of the insured, both reporting and non-reporting forms, which are discussed below, are obtainable.

The valuable paper and records endorsement provides business owners with insurance coverage for valuable papers and records while these are on the insured premises. Included are documents and records, books, maps, films, drawings, abstracts, deeds, mortgages, and manuscripts. However, money and securities are excluded.

The perils insured against are protected on an all-risk basis from direct physical loss. A separate limit of liability is allowed for specific articles, and a blanket limit is available to provide coverages for all items which are not specified. There also exists a limited extension provision for coverage of such property while away from the insured premises (usually 10 percent of the combined limits not to exceed $5,000).

**Broad Form Storekeepers Endorsement**

Designed to provide limited fidelity and burglary coverage for small mercantile stores, this endorsement is applicable to business owners who employ less than five employees.

**Business Interruption Insurance**

Business interruption insurance includes a broad category of specific losses of use or time element insurance coverage. These are designed to indemnify, or to compensate financially, the insured for a loss of earnings (as the policy defines loss of earnings), tuition fees, rents, or the extra expenses involved in continuing operations in case an insured's premises are damaged by an insured peril. Under the SMP program, several business interruption forms are available so that business owners may better select the necessary business interruption endorsement that their businesses require.

For example, coverage may be added to business interruption insurance by adding to the policy a gross earnings endorsement, which covers gross earnings less non-continuing expenses, for the actual loss sustained by the insured from the interruption of business. As with all gross earnings forms, included as part of the policy’s coverage is a coinsurance (sometimes called a contribution) clause in the amount of 50, 60, 70, or 80 percent of the business’s annual gross earnings. Failure of any kind to maintain an adequate amount of insurance in respect to the selected coinsurance percentage will result in a claim payment penalty for a sustained loss.

Coverage for ordinary payroll expense either may be excluded or limited to a period of 90 consecutive days following damage to the insured premises. If not specifically included in the policy as a coverage the business owner’s employees will not be paid unless he can prove that paying the payroll is essential to continuing or to speeding the resumption of business operations.

Business interruption coverage also may be written on an earnings endorsement, which protects the business owner against actual losses suffered (gross earnings less non-continuing expenses) with no coinsurance requirement. However, recovery is restricted to a percentage of the limit of liability that is applicable on a monthly
basis. The business owner may select 16.67 percent, 25 percent, or 33.33 percent depending on how long he estimates that it would take to repair or to restore the premises to its original condition. Coverage under this endorsement ensures that the insured is protected against perils that might damage or destroy the building and/or its contents.

**Builders’ Risk Endorsement**

Another endorsement, the SMP builders’ risk endorsement, consists of two forms which can be applied either to the named peril or to the all-risk policy. For named peril policyholders, the appropriate form is called the completed value form, and for business owners who carry an all-risk policy, the SMP special builders’ risk completed value form is available. The builders’ risk endorsement is designed to provide property insurance coverages for builders’ risk exposures while they are constructing a new building or an insignificant addition. All but insignificant additions or new buildings must be specifically added by endorsement.

**Church Theft Endorsement**

This endorsement is designed to provide coverage for a church against theft or attempted theft of money, securities, or any other property while at the church, in a bank or night depository, or in the care or custody of an authorized person. The form is subject to definitions and exclusions which should be reviewed. Coverages can be provided at an agreed value for specified articles and/or at a specified limit for all other property.

**Combined Business Interruption and Extra Expense Endorsement**

The combined business interruption and extra expense endorsement provides coverage for both business interruption and for extra expense losses with a single, specified limit of liability which is explicitly stated in the endorsement. An insured may select from specified percentage options such as those found in the business interruption’s gross earnings endorsement. Usually, these percentages are based on the amount of time that a business owner estimates would be necessary for restoration.

**Condominium Operations Endorsement**

The condominium operations endorsement has been developed through the use of several special arrangement forms which are intended to meet the needs of certain insureds.

The SMP condominium operations endorsement (an additional policy provisions endorsement) is available to provide named peril or all-risk property coverage for condominium operations. These forms follow the named peril and the all-risk forms discussed earlier with special terms and conditions that have been included to meet the needs of the condominium association that oversees the maintenance and general upkeep of its premises.

**Earthquake Extension Endorsement**

An earthquake extension endorsement can be added to afford coverage that is intended to meet the needs of certain insureds both under the named peril and the all-risk forms. This coverage is applicable only to the insured premises.
Extra Expense Endorsement

Some companies might find it advantageous to purchase insurance protection for extra expenses incurred so that they can continue their operations should their insured premises be damaged or destroyed. The extra expense endorsement available under the SMP program provides this type of coverage.

This coverage should be considered either in lieu of or in addition to business interruption insurance for those businesses where a shutdown is unacceptable and would cause a complete cessation of business activities. In such situations, the insured will incur expenses for leasing temporary facilities and for resources that will be necessary and that enable the insured to continue servicing customers. Coverage is limited on a monthly basis (not more than 40 percent of the endorsement's limit for any one month or less) and generally follows the perils insured in Section I.

Remember that the expense portion of business interruption policies only covers extra expenses incurred to the extent that they reduce the loss of net profit. Accordingly, some types of businesses might need this endorsement in addition to the business interruption endorsement.

Inland Marine Coverage Endorsements

There are several optional inland marine coverage endorsements which can be added to Section I.

These provide coverage for both personal property and for the property of others that is in the care, custody, or control of the insured. Coverage is provided on an all-risk basis and is limited by specific exclusions, terms, and conditions. These endorsements closely follow the usual inland marine property floater contracts. The specific endorsements available are the radium floater, the fine arts floater, the musical instruments floater, the neon sign endorsement, the glass coverage endorsement, and the physicians and surgeons equipment endorsement.

Liability for Guests' Property Endorsement

Although this endorsement contains specific exclusions and limitations, the liability for guests' property endorsement provides coverage for an innkeeper's liability for loss or damage to property of guests while this property is within the insured premises or while in the possession of the insured’s care, custody, or control.

Loss of Rents Endorsement

This endorsement provides coverage for loss that an insured might sustain if tenants are unable to rent his insured property because of damage or destruction to the premises by an insured peril.

Coverage is usually bound by the enacting of a predetermined contribution clause which essentially functions as a coinsurance clause. Also, the insurance company is not liable for a greater proportion of any loss than the stated limit of liability; this amount is produced by multiplying the rental values from the previous 12 months by the pre-determined coinsurance clause.

Mercantile Open Stock Burglary Endorsement

Because a business's personal property may be exposed to loss that is caused by burglary, robbery or theft, there are several extension endorsements that can be added to Section I of the SMP policy to protect against loss by crime. These endorsements are available under Section I, or in some cases, under Section III,
which deals exclusively with crime coverages and which will be discussed in greater detail later.

Coverages under this endorsement closely parallel those that a person would find in a separate, or single-line, policy. Also, the mercantile open stock burglary endorsement may be combined with the general personal property form so that coverage is provided for the business owner’s merchandise, furniture, fixtures, and equipment that exists at the insured property. This property is protected against loss caused by burglary or robbery while the premises are not open for business. If personal property is covered by the all-risk form, this endorsement is not needed because that type of policy includes this coverage as part of its basic protection.

**Mercantile Open Stock Burglary and Theft Endorsement**

This endorsement provides coverage for loss or damage to merchandise, furniture, fixtures, and equipment that are located at the insured property in two situations. The first is for burglary or robbery of a watchman while the premises are closed for business, and the second is for protection against theft or attempted theft regardless of whether or not the premises are open for business. As stated in the previous endorsement, this endorsement is not needed if the insured purchases an all-risk form since the all-risk form already protects the insured from this type of loss.

**Mercantile Robbery and Safe Burglary Endorsement**

This endorsement provides coverage for loss of money, securities and other property both inside and outside the insured premises; it includes as part of its coverage the burglary of a safe.

**Optional Perils Coverage Endorsement**

An optional perils coverage endorsement is available on the named perils form for both buildings and personal property protection. Additional perils covered by this form are breakage of glass (which is part of the building and subject to limitations); falling objects (loss or damage to personal property in the open is not included); weight of ice, snow or sleet; water damage and loss caused by collapse of the building structure itself. Coverage is also included for accidental discharge of water or steam from plumbing, heating or an air conditioning system, but discharge from automatic sprinkler systems is excluded from coverage.

**Replacement Cost Coverage Endorsement**

No matter which of the two forms (the named peril or the all-risk) that a business owner chooses, one important consideration is the method for establishing the value of insured property at the time of a loss. Unless specifically endorsed or stated in the coverage form, all property will be valued according to its ACV (actual cash value) rather than on its replacement cost. Also, the precise definition of ACV depends upon the type of property under consideration. There are variations in the application of ACV depending on whether the properties being valued are real or personal property used in the operation of the business or, finished goods or products held for sale by the business.

This basis of adjustment may be modified, however, by the attachment of the replacement cost coverage endorsement. Under this endorsement, insured property involved in a loss will be adjusted on the basis of the amount necessary to repair or to replace the damaged property, and reimbursement is restricted only to the policy’s limit of liability without regard to the actual age of the property at the time of the loss.
Business owners should be aware that this endorsement does not delete or replace any coinsurance requirement and that it is not extended to certain types of property such as stock, property of others, valuable papers, records, or fine arts. The business owner must first pay the deductible, no matter which method for establishing value the policy uses.

**Reporting Forms Endorsement**

Another available provision under both forms is the addition of a reporting form endorsement which converts basic property coverage forms to a reporting basis. Two separate forms comprise the reporting endorsement: the specific rate form and the average rate reporting endorsements form.

This endorsement is convenient for business owners whose personal property values fluctuate and for business owners who have difficulty in determining the correct amounts of insurance to purchase. Business owners who opt for this endorsement are allowed to identify their business cycles, which generally range from peak to slow seasons.

By using a reporting form, a business owner can establish a limit of insurance that sufficiently covers the maximum values of the insured property at a given time. The insured reports the actual value of the business at stated periods and a premium is charged on the average value at risk during the entire year rather than paying high premiums year round because of the increased risks which only exist during particular months of the year.

For example, a Christmas ornament business’s busiest season of course is around the Christmas holidays, when it, therefore, has an increased exposure to risk. Exposure to risk is significantly less during the summer since this type of store is not busy then. To calculate the premium, the insurance company calculates the business’s average risk during the year by averaging its busy times with its slow periods rather than requiring the business to pay a premium that is based solely on the increased business activity during the Christmas season.

As a result, the insured knows that the business has the benefit of adequate coverage during both peak and slower periods. Furthermore, the business owner will pay a fair premium that is based on the actual value of the annual average of risk exposure rather than paying a much higher premium that is based on higher risk exposure during only specific months of the year.

**Sprinkler Leakage Endorsement**

The sprinkler leakage endorsement provides protection for insured property against named perils that cause damage to the business owner’s property from leakage or discharge of water (or other substance) from an automatic fire protection system. It also includes coverage for loss or damage resulting from the collapse of a tank which is part of the sprinkler system. This endorsement contains specified limits of liability, coinsurance percentages, conditions, and exclusions and must be separately requested and priced when developing the SMP contract.

**Tuition Fees Endorsement**

The tuition fees endorsement provides coverage for lost tuition fees that an educational institution might suffer if the school’s physical facilities are damaged and unusable because of loss by an insured peril. The basis of recovery is the amount of the actual loss sustained from the date of loss to the opening of the school year that
begins after the premises’ restoration is complete. Coverage is available on an 80 percent or on a 100 percent coinsurance basis.

**SMP (Section II) General Liability Coverage**

The SMP, in Section II, describes general liability insurance and is a mandatory coverage, just as property coverage is in Section I. Typically, coverage is written on a comprehensive general liability (CGL) basis for any occurrence which is attributable to either of two causes: one is the liability brought on by the ownership, maintenance or use of the insured premises and the second is for the liability created by business operations that are necessary or incidental to the named insured’s commercial activities. Furthermore, the SMP’s liability coverage extends to the business’s products and completed operations unless the insurance policy specifically states that these are excluded for some reason. Coverage is on a combined single limit basis although the insured may purchase separate limits for bodily injury and property damage if he feels that this better suits the particular needs of the business.

Agents and business owners should confer with the insurance companies’ underwriters so that they will be well informed about their liability coverage and whether they carry the standard or the all-risk package in Section II of their policy. The agent should be aware if the insurance company has created its own form which details what is protected on the premises or in the business operations. The insured should be made aware of any other optional coverages or endorsements that are obtainable so they might broaden the scope of the policy’s basic coverage.

In the personal injury section of coverage, the following coverages are included: an employer’s non-owned automobile, an automobile fleet (the agent should know what number of cars determines a fleet), professional liability, comprehensive medical payments, contractual liability, independent contractors, and elevator collision. Of course, policies differ from company to company, so not all of these will be found in every policy’s liability section.

**General Liability Coverage**

General liability covers exposures such as lawsuits occurring because of slips or falls on the insured premises, injuries which occur because of operating equipment, and certain liabilities which are assumed already to be under contract or agreement. As stated above, this coverage also extends to protect a business owner against liability that is caused from the use or consumption of products that the business produces or sells. However, if the underwriters feel that the product’s liability exposure is too severe to be covered under the CGL section, they will exclude the product(s) from the SMP and will require that the business owner purchase a separate products liability policy.

**General and Special Liability Exclusions**

The SMP does not cover claims for injury to employees because this must be covered under a separate workers’ compensation policy. Remember that workers’ compensation is not included in the SMP policy. This is a separate policy, not available under endorsement or optional coverage, which business owners must purchase in addition to their SMP policy. This is true also for employee benefit programs and for liability that occurs as a result of operating automobiles or trucks. These coverages, like workers’ compensation, are not available by endorsement or optional coverage and must be insured under an employee benefits program or under an automobile for business usage liability policy.

Several special exposures such as liability for errors or omissions by professionals are not protected under Section II of the SMP. Section II of an SMP does not cover professional errors in professions such as architecture, engineering, the medical or legal field, or...
accounting. Instead, a separate professional liability policy is necessary if a business owner wants to protect himself against exposure to these risks.

To avoid any future problems and to protect against common and special liabilities, the agent assisting the business owner to set up the policy should become completely familiar with the property and operations of the business.

**SMP (Section III) Crime Coverage**

Crime coverage, available under Section III, is entirely an optional coverage (unlike the mandatory property and liability coverages in Sections I and II of the SMP. Its purpose is to provide coverage for money and securities, negotiable instruments, and employee dishonesty. Protection against loss by crime is intended to closely parallel the single-line coverages which are available under separate policies.

As mentioned in the property section, both property forms, the named peril and the all-risk, exclude crime coverage since it is covered under Section III. Furthermore, the SMP offers only limited coverage for these exposures under the various crime endorsements at an additional cost. Some businesses, however, might decide not to include this section as part of their SMP policy because they might need broader coverage than what is available, they may desire higher limits than what this section offers, or they simply may not even be eligible for coverage under the limited endorsements that they could add because the underwriters have decided that risk of loss is too great for their business. On the other hand, the SMP package discount may make it sensible for some business owners to include the crime coverage in this section.

There are three basic coverages under this section: the comprehensive crime coverage endorsement, the blanket crime coverage endorsement, and the public employers blanket endorsement.

A blanket form is a form of contract between an insured and an insurance company which provides coverage for similar types of property at different locations or for different types of property located at the same location. Also, the public employers blanket endorsement provides coverage for all employees or for a class of employees without their being specifically named.

The main difference between the comprehensive crime and the blanket crime endorsement is that under the blanket form, all insurance agreements, which are broadly defined as the promises made by the insurance company to the insured, are mandatorily protected from loss. Under the comprehensive crime endorsement, the insured may select specific coverage agreements and varying limits of liability and coverage for employee dishonesty on a blanket position basis. The blanket position coverage for employee dishonesty under this endorsement also allows the stated limit of liability to be applied to each employee rather than to the employees as a group.

Therefore, for example, if three employees acted together to steal $30,000, a $10,000 blanket position coverage would cover the loss in full since each of the employees is considered to be a separate entity. In contrast, the blanket limit of liability applies on a per occurrence basis for any one loss, regardless of the number of employees involved. In the previous example, a $30,000 commercial blanket bond would be required to cover the loss in full.

In addition to providing coverage for loss by extortion, unless it has been specifically excluded, the following are coverages that are available under the comprehensive crime endorsement, which consists of five kinds of protection against loss caused by criminal acts. These five categories can be selected separately. In fact, business owners may opt for only
some of these because certain coverages are more comprehensive than others. The five categories are:

- **Employee dishonesty.**
- **Commercial blanket.** This agreement provides coverage for loss of money, securities, and other property because of any dishonest or fraudulent acts by the insured’s employee(s). The stated limit is the amount that can be applied to each occurrence, regardless of the number of employees which may be involved. The limit would typically apply to each occurrence, not to each employee.
- **Blanket position.** Coverage under this agreement is similar to that provided under commercial blanket coverage; however, the limit of liability is applied per employee rather than per occurrence basis. All employees of the insured are covered and are considered to be a separate entity.
- **Money and securities loss inside the premises.** This provides coverage up to the specified limit for loss of money and securities by destruction, disappearance, or wrongful abstraction inside the insured premises or at any banking premises.
- **Money and securities loss outside the premises.** Coverage under this agreement is the same as that available under the prior coverage, except that it covers money and securities that are outside the premises that are being transported by a messenger, that are in the home of a messenger, or that are in an armored car.
- **Money orders and counterfeit paper currency coverage.** This agreement provides coverage for the insured against loss due to the acceptance, in good faith, of any counterfeit money or money orders while in the course of business.
- **Depositor’s forgery coverage.** Coverage under this agreement is provided for the insured or for a bank, when a savings or checking account is maintained, for loss that occurs as a result of forgery of checks, drafts or other negotiable instruments.

Coverage under these agreements is not always inclusive. Business owners must carefully review these forms for the endorsement's specific limitations and exclusions. In addition, the consideration of deductibles should not be overlooked.

**SMP (Section IV) Boiler and Machinery Coverage**

Boiler and machinery coverage, Section IV of the SMP, is optional and, if selected, is eligible for the SMP package discount. Usually coverage is provided or recommended on the basis of a survey that is completed by the insurance company and is based on a business owner’s responses. The specific limits, locations, and terms are outlined on a separate declarations endorsement.

When setting up a policy, the agent should always have the business owner describe the business operations in detail because the owner may not realize that normal business operations may require his purchasing insurance which protects boilers, refrigeration equipment, electrical apparatus and other kinds of machinery. By disclosing information about the way his company operates, the owner avoids future disaster that might have been protected against had he carried the proper insurance coverage.

Some insurance companies will not insure this type of coverage but, will obtain a cooperative arrangement through another insurance company who specializes in this area of insurance. The company that specializes in boiler and machinery insurance will provide the underwriting, pricing and loss control services. In fact, even though the insurance is provided
through another company, this endorsement may be added to the business owner’s policy and the owner will receive a package discount.

Finally, coverage is written on an ACV basis unless the business owner prefers protecting equipment on a repair and replacement cost basis, which must be added by endorsement.

- Boilers

  The SMP boiler and machinery coverage endorsement includes coverage for all boilers, unfired pressure vessels and piping that are either in use or that are connected and ready for use. Because almost all fire and extended coverage policies exclude damage that results from explosion of boilers or other pressure vessels, this coverage is needed if insured property contains any heating boiler, process boiler, or any steam generator that operates under pressure.

  Another important consideration when deciding whether or not to add this endorsement is that the liability coverage in Section II specifically excludes liability which occurs as a result of these kinds of explosions. The addition of this protection also includes the insured’s liability for damage to the property of others and any associated defense costs if a lawsuit should be brought against the company or the business owner.

- Machinery

  Machinery coverage insures against damage and costs that result from the breakdown of machinery while it is on the premises. The equipment to be insured must be scheduled, or itemized, on the policy. Business owners, in an effort to protect their business operations, usually insure only those machines that are abnormally expensive, time consuming to repair or are critical to their business operations.

  The coverage extends to damage to surrounding property, which is excluded in basic fire and extended coverage policies. It is wise to ask if the insurance company has a good boiler and machinery inspection service, for these inspections can be as important as the coverages themselves.

  Coverage on other types of machinery is usually available through an additional object groups endorsement. Equipment under this endorsement must be scheduled on the policy.

Additional Coverages

Business interruption coverage may be available under Section IV on a daily or a weekly indemnity basis. Extra expense coverage also may be purchased for the period a business owner estimates it would take for him to continue his operations elsewhere while his usual premises are being restored to their original state. In addition, coverage may be available for prevention of occupancy and consequential damage that might occur by a company who leases its premises or which occurs if a business must continue its operations at a different location while the premises are being restored to their original state.

Impact and Future of the SMP Program

The impact of the SMP program has been significant. This is evidenced by the notable increase in premium dollars that insurance companies have written for their policyholders. Also, one must remember that two other successful policies, the Business Owners Policy and Farmers’ Insurance, originated from the SMP.

It is unlikely there will be significant change to coverage or eligibility in the SMP program. However, periodic minor changes and updates will be made to its current form. Eligibility is now quite broad, the coverage options are stabilized, and cost savings have been
established. The only likely adjustments in the foreseeable future might be slight modifications made to package discounts for individual business groups.

**The Business Owners Policy Plan (BOP)**

The business owners policy plan, or BOP, is written in a way that is easy to understand and is a simple policy structure offering broad coverage at a competitive price. Attractive features of the BOP include coverages for:

- Replacement cost without coinsurance.
- Loss of income.
- The property of others in the insured’s care, custody, and control.
- Transit.
- Peak season.
- Broad business liability.
- Employees as additional insureds.

**History of the Policy**

In an effort to meet the insurance needs of small and medium sized business owners, one independent insurer in 1974 filed a simplified version of the SMP. This simplified, new approach, with its simple rating structure, fixed coverages, and fixed limits of liability, was called the business owners policy, or BOP. In fact, eventually two forms of the BOP, the named peril and the all-risk, were created to satisfy the needs of these types of businesses.

Although a business must meet certain eligibility requirements to purchase a BOP, its simplified rating approach, and coverage format quickly enabled the BOP to become an important policy in meeting the insurance needs and coverages for eligible business operations.

**Determining the Premium**

Several factors are considered when an insurance company determines the premiums its policyholders will pay. One factor is the insurance company’s rating procedure, and another factor is based on the information an agent gathers about a business’s background and its operations during a site visit. Lastly, some policyholders may be issued credits or debits that are applied to premiums, which lower the total premium that they must pay.

**The Rating Procedure**

A definitely attractive feature of the BOP is its simple rating procedure. The package premium is developed from the amounts of insurance that are placed on the building (if the business owner actually has ownership of the premises) and the business’s personal property. If any optional coverages or endorsements are necessary to extend or to broaden the policy’s coverage, the business owner can add these for a separately determined additional charge. The rates for the special BOP are higher than those for the standard BOP since it is an all-risk policy which offers more comprehensive coverage.

**Inspection of the Site to Determine Insurance Needs**

The underwriting and rating of a business heavily relies on the information the insurance representative collects in order to best determine what types of coverage and the limits of coverage a business must have to protect itself against loss.
The insurance company’s representative usually conducts at least one fact-finding visit to the business to analyze the conditions of the premises, its equipment, and its operations. When the representative conducts the inspection, the business owner should be prepared to relay all necessary information about the business so the basic application is complete and so the business owner’s BOP premium can be determined.

Each of the following is among the information which the business owner may be asked to disclose:

- Background information about the business.
- The name of the business and its owners.
- The type of business to be insured.
- The square footage of the building.
- The percentage of the building occupied by the business.
- The grade of fire protection at the site where the business operates.
- The building and contents replacement cost values.
- The value of outside signs (if any).
- The amount of external glass.
- The preferred BOP form (named peril or all-risk).
- The policy’s effective date (if purchased).
- Information regarding the handling and storage of money.
- Any burglar alarms that might have been installed.
- The quality of protective devices such as door locks.
- Any other measures the business owner might have taken to reduce exposure to loss.

**Lower Premium Debits and Credits**

One final point which should be noted about BOP premiums is the possibility for premium credits or debits which are based on certain underwriting factors, including the following:

- Business’s management.
  The business must be willing to cooperate in matters of safeguarding and proper managing of the property that is to be covered by the policy.
- Location.
  Location refers to the accessibility and the environment of the premises.
- Building features.
  Building features include the air-conditioning or any unusual structural features.
- Premises and equipment.
  Insurance companies might issue credits if a business's premises and equipment are in excellent condition, are well cared for, and are the appropriate type that is necessary for operating the business.
• Employees.

Business owners may also be questioned about the selection, training, supervision, and experience of their employees.

• Type of protection that is desired.

Business owners will be asked what other, if any, types of insurance protection they already have or if there is any coverage they would like to add that is not specifically mentioned in the BOP policy.

Finally, special credits and debits may be applied to accounts which carry a premium of $500 or more. These credits and debits are intended for use when the special characteristics of the business in question do not seem to be fully covered or recognized in the basic BOP rate structure. The maximum premium deviation for all credits and debits combined generally is limited to 15 percent.

Qualifications for Eligibility

The type of business a person owns determines whether or not that person is eligible to purchase this type of business insurance. Major insurance firms usually allow apartment and office complexes, motels, religious institutions, and certain mercantile businesses to purchase this policy. However, not all businesses qualify for a BOP.

Generally, to qualify for the BOP program, insurance companies consider a number of factors. Most, but not all, insurance companies take into consideration the following: the building’s square footage, the amount of liability that will be needed to protect the business against loss, the type of business, and the extent of its off-premises servicing and processing activities.

Also, the Insurance Services Office (ISO) has developed its own set of eligibility standards, which some insurance companies use as their standard. For example, to qualify, an apartment building may not be more than six stories tall, must consist of no more than 60 dwelling units, and may not contain more than 7,500 square feet of mercantile space. An office building may not exceed three stories, must encompass no more than 100,000 square feet, and is limited to 7,500 square feet of mercantile space. Retail stores, which include all buildings at the same location, may not have more than 7,500 square feet for the total area. Basement areas that are closed off from the public are not included in calculating the total area in any of these situations.

Businesses That Might Qualify For A BOP

Some types of businesses that might qualify for a BOP are hobby stores, barber/beauty shops, bookstores, churches, direct sales shops, dry cleaners, fabric shops, ice cream shops, opticians, and photo studios. Parking lots and garages that provide parking spaces may qualify only if they are an incidental part of an otherwise eligible business.

Businesses That Do Not Qualify For A BOP

Contractors are usually ineligible for this coverage, but if a hardware store sells merchandise such as materials for building a deck and then installs that merchandise, the hardware store may still qualify for eligibility since the contracting part of the business does not detract from what is considered to be the “essential nature” of the hardware store. In other words, the installation of materials comprises only a small percentage of the business’s revenue.

Other types of small businesses, no matter how small or even if they qualify under most of the eligibility criteria, usually have specialized insurance needs such as high levels of liability in areas for which the BOP does not provide protection.
For instance, companies whose operations are centered on cars, motor homes, motorcycles, or mobile homes are ineligible for purchasing a BOP. Bars, grills, and restaurants are also ineligible for BOP coverage as are condominiums since the ISO has developed separate coverage plans for these types of property.

Buildings which have at least part of them dedicated to manufacturing or processing are not eligible for coverage because the coverage these types of businesses require is beyond the scope of this policy. In fact, even if a business’s operations are spread over several locations, if one of those has manufacturing or processing, the whole company is barred from purchasing a BOP.

Places of amusement: fairs, carnivals, amusement parks, theaters, and bowling alleys are ineligible because their purposes are not primarily involved with the buying and selling of merchandise, which is an eligibility requirement. Finally, wholesalers are ineligible because these businesses are usually large-scale operations, and financial institutions of any sort may not purchase a BOP because their exposure to crime surpasses that of any small to medium sized business.

**Exclusions, General Conditions and Provisions Specific to the BOP**

The BOP program does not rely on the same wording or format of its forerunner, the standard fire policy. However, the essence of those provisions is contained in both BOP policy forms.

The conditions and other provisions a policyholder will find in this section of the BOP policy are basically classified into two categories: one is general exclusions and the second is general conditions and provisions that are applicable to Section I (property) or to Section II (liability). Some of the more important provisions and conditions are discussed in the following text.

**General Exclusions of War Risks, Governmental Action, and Nuclear Catastrophes**

The vast majority of insurance policies exclude coverage for losses that are caused by war risks, governmental action, and nuclear catastrophes. This section of the BOP, as with most other insurance policies, is intended to exclude losses caused by hostile or warlike action in time of peace or war, insurrection, rebellion, revolution, civil war, usurped power, risk of contraband, illegal transport or trade, nuclear radiation, and radioactive contamination. These exclusions incorporate acts of terrorism.

**General Conditions and Provisions**

This section of the BOP policy describes numerous general provisions that are usually, with perhaps slight variances in language, found in most insurance policies. Several of these provisions have been reworded to simplify the language, but the meaning and substance of these provisions remains unchanged.

These provisions deal with:

- “Concealment or fraud,” which voids the policy immediately upon discovery of the wrongdoing.
- “Subrogation,” a term that describes the process by which an injured party pays the deductible and receives payment for the balance from the party’s own insurance company. The insurance company in turn seeks reimbursement, plus its insured’s deductible, from the insurance company of the person who caused the damage.
- “Waiver or change of provisions,” which can only be accomplished if the waiver or if the alteration of the provisions is added to the policy by written endorsement.
• “Liberalization,” which states the policy’s coverages might at any time in the future be extended or broadened to benefit this particular policy as if the policy had been altered by written endorsement.

• “Replacement of forms and endorsements,” which states the insurer may convert old contract forms to new contract forms at the policy’s anniversary date even if the old contract forms stated that the policy was a continuous policy (one without a specific termination date).

• “Inspection and audit,” which gives the insurer the right, but not the obligation, to inspect the insured business.

• “Assignment,” which means the insured cannot sign over his interest in the BOP to another party without the written consent of the insurance company. If, however, the named insured should die within the policy period, the coverage provided by the policy applies:
  
  • To the named insured’s legal representative whose job it is to act in the interest of the named insured, but this is only effective until the legal representative’s duties are completed at which time the policy immediately ceases to be applicable to him.

  • To the person who has temporary custody of the named insured’s property until a legal representative has been appointed and qualified to act in the insured’s interest.

• “Premium,” which states the premium for a BOP policy is to be computed according to the insurer’s rules, rates, and minimum premiums that are in place at the time. Furthermore, the policy may be continued by payment of successive one-year premiums even if the insured pays his premiums on a payment plan.

Provisions Specific to the BOP

Some of the other general conditions found in the BOP are not the same as similar provisions that exist in other types of insurance contracts.

• The cancellation provision.

  The cancellation provision of the BOP enables the named insured to cancel the policy at some future date if the cancellation date is submitted in writing before the effective date of cancellation. Similarly, the insurance company may cancel the policy by giving written notice of the date of cancellation to the insured and to the mortgagee at least 20 days in advance of the policy’s termination.

  The time allowed for cancellation under the BOP policy is much longer than the allowed time period for other policies. For instance, the standard fire policy stipulates only five days’ advance notice is required for either the insured or the insurance company to cancel the policy, and the SMP requires 10 days’ advance notice prior to the date of the policy’s cancellation. The BOP’s longer time period allows the insured, whether he or the insurance company terminates the policy, ample time to find adequate coverage elsewhere without any lapses in coverage.

• Calculating the return premium.

  When a policy is cancelled, the insured is entitled to a return premium, which is the part of the premium already paid. The return premium that the insured receives depends on which party, the insured or the insurance company, cancels the policy. The method for calculating the return premium is the same whether the insured has already paid the premium in full or the premium is paid through a payment plan.
On the one hand, if the insurer cancels the policy, the insured’s return premium is computed on a pro rata, or prorated, basis. To determine this figure, first the total premium is divided by the number of days in the policy period. This number reflects how much the insured is paying per day for this policy. The daily cost is then multiplied by the number of days that remain in the policy period. The product of these two numbers is the return premium that the insured will receive.

On the other hand, if the insured should cancel the policy, he must pay the insurance company 90 percent of the premium that he has not yet used. This, too, is calculated on a pro rata basis. To calculate the insured’s return premium, the total premium is divided by the number of days in the policy period, and this number is then multiplied by the number of days left in the policy period. The insured is responsible for paying 90 percent of this figure, and the insurance company will return the remaining 10 percent to the policyholder as return premium.

Policy Period, Policy Territory, and Time of Inception Provisions

Two other provisions found in the general conditions section of the BOP define the policy period, the policy territory, and the time of inception.

The policy period provision of the BOP states the beginning and ending dates of the policy. The usual time of inception for a BOP is 12:00 noon, but if the BOP is replacing a policy that expires at 12:01 a.m., the BOP inception will be at 12:01 a.m. so that the insured can avoid any lapse of coverage. The policy territory includes the 50 states of the United States, the District of Columbia, and Puerto Rico.

Other Insurance Provision

The other insurance provision notifies the policyholder that his property and that the property of others which is in his care, custody or control is considered to be excess coverage, meaning that the insured’s other policy must first cover any loss and that the BOP will only cover amounts that exceed the limits of the other policy. In other words, the BOP does not work in conjunction with the other policy; it only covers the amount that remains after the other policy has been exhausted.

Unlike property coverage, the BOP’s general liability coverage is meant to be used as primary, not as excess, coverage, and any excess beyond the limits of what the BOP policy will pay may be applied to umbrella coverage since this is how umbrella coverage is intended to be used.

Duplication of Coverage Provision

The final provision states that in the event there is a loss covered by more than one part of the policy, endorsement, or optional coverage, the insurer’s limit of liability is the amount of the loss. This provision is included to enforce the fundamental principle of indemnity.

Available BOP Policies

There are two types of BOP coverage, the standard (or named peril) form, and the special (or all-risk) form. The policies offer similar coverage for property coverage for buildings, business personal property, loss of income, and other optional property coverages as well as comprehensive business liability coverage.

Another similarity is that both BOP forms provide coverage without coinsurance penalties. As stated earlier, coinsurance means that the business owner shares the risk of any loss with the insurance company, and the policyholder is always responsible for paying his deductible before the insurance company will pay its percentage of the specified ratio in the policy.
Furthermore, both policies cover buildings and most business property on a replacement cost basis. However, unlike business property, ACV is an option for buildings. Owners of older buildings for whom replacement cost coverage may be difficult or too expensive to obtain might consider the ACV option. Likewise, a business owner may consider rejecting the ACV option because the building was recently constructed, and little difference exists between its replacement cost and its ACV.

What makes the forms different are the perils that each covers and the options that each offers. For instance, the standard form offers only optional coverage for burglary and robbery, and the special form offers optional coverage for money and securities.

**Standard (Named Peril) Form BOP**

The premium for the standard BOP is less than the premium for the special, or all-risk, form simply because of the differences in approach of named peril and all-risk coverage. However, many businesses find the standard form’s smaller premium attractive. They may also discover that the type of coverage the standard form offers is satisfactory for their insurance needs and thus may opt for the named peril rather than the all-risk form.

**Deductibles in the Standard Form BOP**

Of course, deductibles vary from company to company and certainly from state to state. Generally, however, under most standard BOP forms, direct property losses are subject to a $100 deductible per occurrence. This deductible applies separately to each location with an overall aggregate, or total, of $1,000 per occurrence for all locations. If the loss results from robbery or burglary or from employee dishonesty, a higher deductible of $250 applies to these two optional coverages if the business owner had added these policy endorsements prior to the loss. However, loss of income claims are handled differently; no deductible applies to this type of loss.

**BOP (Section I) Property Coverage**

The property section, found in Section I of the standard BOP policy, insures against direct losses suffered from the following: fire, lightning, extended coverage perils (windstorm, hail, explosion, smoke, aircraft, vehicles, riot, riot attending a strike, or civil disturbance), vandalism or malicious mischief, and sprinkler leakage.

If the property is in transit to another location, in addition to the coverages mentioned above, it is protected against collision, derailment, or overturn of the transporting conveyance, stranding or sinking of vessels, and collapse of bridges, culverts, docks or wharves.

Finally, while many of these named perils are not subject to any limitations, the BOP does limit two classes of property, and the policy also contains several general exclusions.

**General Property Limitations Under the Standard Form BOP**

The standard BOP also limits the coverage of two classes of property. These two classes are:

- Valuable papers and records, meaning books of account, manuscripts, abstracts, drawings, card index systems, and other records (excluding film, tape, disc, drum, cells, and other magnetic recording or storage media for electronic data processing), which are covered for an amount not to exceed the cost of blank books, cards, or other blank material plus the cost of labor incurred by the insured for transcribing or for copying such records.
• Film, tape, disc, drum, cell, and other magnetic recording or storing media for
  electronic data processing which are covered for an amount not to exceed the cost of
  such media in an unexposed or blank form.

While the standard form of the BOP includes this coverage without a specific dollar limitation,
it does not cover the costs of research, which will probably be necessary for the reproduction
or restoration of the lost, destroyed, or damaged records.

**General Property Exclusions Under the Standard Form BOP**

Although the BOP policy covers many types of losses, none of the following are covered:

• Exterior signs.
• Growing crops and lawns.
• Aircraft, cars, motor trucks and other vehicles that are registered as motor vehicles.
• Watercraft (including motors, equipment, and accessories) while afloat.
• Bullion (gold or silver), money, or securities.
• Losses that occur either directly or indirectly when authorities enforce any ordinance or
  law that regulates the construction, repair, or demolition of buildings or structures.
• Losses that result from power, heating or cooling failure unless the failure is the
  product of physical damage to the power, heating or cooling equipment which must be
  located on the premises that are named in the policy.
• Losses caused by perils not otherwise excluded (such as damage resulting from an
  earthquake).
• Losses resulting from riot, riot attending a strike, civil commotion, or vandalism or
  malicious mischief.
• Electrical injury or disturbance of electrical appliances, devices, fixtures or wiring that is
  caused from electrical currents artificially generated unless a fire breaks out as a result
  of that damage.

According to most standard BOP forms, any losses that result, contribute to, or are
aggravated by one of the following are covered:

• Earth movement, including but not limited to, earthquake, landslide, mudflow, earth
  sinking, earth rising or shifting.
• Flood, surface water, waves, tidal water, tidal waves, overflow of streams or other
  bodies of water, or spray from any of the foregoing, all whether driven by wind or not.
• Water which backs up through sewers or drains.
• Water below the surface of the ground including that which exerts pressure on or flows,
  seeps or leaks through sidewalks, driveways, foundations, walls, basement or other
  floors, or through doors, windows, or any other openings in such sidewalks, driveways,
  foundations, walls or floors.
• Delay or loss of market, unless fire or explosion as insured against ensues, and then
  the insurance company will only pay for damages suffered by the resulting fire or
  explosion.
In addition to limiting classes of property and to excluding some perils, Section I of the policy usually breaks down into three subsections: buildings (Section A), personal business property (Section B), and loss of income (Section C).

**Building Coverage (Section A)**

The building coverages offered by the BOP are usually found in Section A of Section I in the policy’s declarations. There are four types of building coverage that this section of the policy discusses; buildings and fixtures, personal property, landscaping and debris removal, and quarterly automatic insurance rates.

**Buildings and Fixtures**

The standard policy includes protection for the insured premises at the replacement cost, not ACV. This coverage also extends to garages, storage buildings and appurtenant structures, which are other types of buildings that might exist on the premises. Additionally, covered under this section are permanent fixtures, machinery, and equipment that the business must use to continue its normal business operations.

**Personal Property**

Personal property of the insured used for maintaining and for servicing the building is covered. This might include, but is not limited to, fire extinguishing equipment, floor coverings, and appliances such as those that are used for refrigeration, ventilation, cooking, dishwashing or laundering. Outdoor furniture and yard fixtures are considered to be part of the building, so they are covered as well.

If an insured is a landlord and furnishes apartments or leased rooms with his own personal property, then this property is also covered. On the other hand, the tenants, if they wish to insure their own personal property, must purchase tenants (or renters) insurance since the landlord’s insurance coverage does not extend to their property.

**Landscaping and Debris Removal**

Trees, shrubs, and plants at the insured premises that are not worth more than $250 are protected against loss. However, the total liability for the company may not exceed more than a total of $1,000 for any loss to landscaping.

The $250 limit that is mentioned above includes the cost of debris removal. However, if an insured would like to have additional removal coverage, it could purchase additional coverage that extends beyond the standard policy’s coverage. Sometimes this coverage can be written with no dollar limit on the total damage.

**Quarterly Automatic Insurance Rates**

Lastly, quarterly automatic insurance rate increases are included in this section of the BOP policy. The exact percentage that the policy may be increased in any one policy term is always included in the policy’s declarations. So if an owner at any time is concerned about how much his premium might increase in the coming year, he only needs to consult his policy to easily find this information.

**Business Personal Property Coverage (Section B)**

Before attempting to establish limits of liability in Section B, the business owner must first understand the definition of personal property coverage. Once he understands this, he can easily identify the policy’s coverages as they apply to property that is in transit, additional areas of coverage that may be available, and seasonal automatic increases that may benefit the policy.
Defining Business Personal Property

Restricted to a specific limit of liability, business personal property coverage is different from the personal property coverage that is included under Section A.

Business personal property is property that is essential to running a business. For example, depending on the type of business, this may or may not include office equipment or other machinery that is needed for the business to function properly. Unlike other insurance policies, the definition of business personal property extends to similar property the insured has in his care, custody, or control. Property that is in the business owner’s care, custody, or control may be either solely or partially owned by another person. Whether it is the insured’s property or someone else’s, to qualify for protection against loss to business personal property, the property must be usual to the occupancy of the insured and on the insured’s premises at the time of the loss.

Although the BOP specifically grants this type of coverage, the amount covered does not increase to reflect that the insured possesses the property of others. To illustrate, if a business owner has an additional $10,000 worth of merchandise on the premises that he has been asked to repair, the coverage that the business owner carries for his own business personal property does not increase by the additional $10,000 that is now in his care, custody, or control.

Lastly, this part of the policy provides for replacement cost coverage for the insured’s business personal property, and the definition of this term applies to similar property the insured has in his care, custody or control but that belongs in whole or in part to others.

Business Personal Property That Is In Transit or Being Moved

To qualify for protection against loss, this property must be usual to the occupancy of the insured and on the premises that are named in the policy. However, business personal property or any similar property that is in the insured’s care is covered while in transit or otherwise temporarily away from the premises which are described in the declarations. Furthermore, business personal property at newly acquired locations is also covered for up to 30 days for amounts not to exceed a specified amount, usually set at $10,000.

Additional Areas of Coverage

The allowable amount also includes the value of labor, materials, and services that are furnished or performed. Also, tenant improvements, sometimes called betterments, are also covered if the business owner wants to use fixtures, alterations, installations, or additions that are found in a part of the building that is occupied, but not owned, by the insured. To qualify for coverage, the business owner must be paying rent for this area, and the insured must not be legally required to remove those improvements.

Seasonal Automatic Increases

Another distinct advantage is that the BOP offers a seasonal automatic increases provision. This provision increases the declared amounts of insurance by an extra 25 percent to provide for seasonal fluctuations in business activity. In fact, the insured does not have to specify in advance which months he expects this peak activity. So, a business person need not predict or even indicate that the Christmas season is busiest. Most policies state “this increase shall not apply unless the limit of liability shown in the declarations is 100 percent or more of the insured’s average monthly values for the 12 months immediately preceding the date of loss, or in the event the insured has been in business for less than 12 months.”
Loss of Income Coverage (Section C)
Loss of income coverage is found in Section C of most BOP policies. Different from most other types of coverage, business owners are not required to pay a deductible, are not bound by a coinsurance clause, and are not bound by a specified dollar limitation. A business person who loses his whole business due to a fire would be able to collect the amount which would otherwise have been earned from the business.

Although this coverage does not state a maximum specified dollar limitation, this coverage may not exceed the reduction in gross earnings less charges and expenses which do not occur during the interruption of business or during the reduction in rents, less charges and expenses which also do not necessarily continue during the period of disuse. For instance, if the business person's business was destroyed by a fire, he no longer would have to pay utility bills. These normal expenses would be deducted from normal gross earnings since he does not pay those bills either during the restoration or during the relocation of facilities.

Coverage is on an actual loss-sustained basis. Loss of income coverage is limited to the period that it would take to repair, to rebuild, or to replace the damaged property, but, no matter what the circumstances are, this period may not exceed 12 months. Also, insurance companies expect the insured to minimize any income losses by resuming full or partial operations either at the premises named in the policy, if possible, or elsewhere, if practical.

The insured is further required to resume business activities as soon as possible and to use all reasonable means not to delay reopening. Obviously, insurance companies are not willing to subsidize a closed business while it should be open for normal business operations.

The BOP also states that the insurer will not be liable for any increase of loss caused by the interference of strikers or by cancellation of any lease or contract unless that loss results directly from the interruption of business.

Available Optional Coverages
In addition to the standard coverages, business owners may want to purchase the following coverages to supplement the standard form's BOP coverages. The costs of these additional coverages are added to the basic premium, and these supplementary coverages must be stated on the declarations page. Depending on the insurance company's policies regarding premium payment, sometimes the business owner pays a separate premium for these types of coverages, and sometimes the cost of the additional insurance is added to the standard form's premium so that the business owner only makes one payment rather than two or more.

Accounts Receivable Coverage
When accounts receivable coverage is available, it is normally subject to a separate deductible provision and to a separate limit of liability. This form of coverage pays all sums that are owed to a business by its customers if those sums become uncollectible because of loss or damage to the firm's accounts receivable records.

Boiler and Machinery Coverage
When this coverage is selected, business owners are purchasing coverage against loss to objects such as boilers, pressure vessels, and air-conditioning equipment (as defined in the policy) when this damage is attributable to an accident (as accident is defined in the policy). Coverage extends to all objects that are owned, leased, or operated under the control of the insured. This optional BOP coverage gives insurance companies the right (but not the obligation) to inspect insured equipment and to suspend coverage (which may only be done
in writing) if dangerous conditions are discovered during that inspection. If suspended, premium credit will be granted on a pro rata basis.

**Burglary and Robbery Coverage**

When burglary and robbery coverage is selected as an optional coverage, a business owner is protecting his company against losses of business personal property (excluding money and securities) on the insured premises for an amount not to exceed 25 percent of the liability in Section B. This coverage protects businesses against losses from money and securities that are in a bank or savings institution for an amount not to exceed $5,000. Finally, money and securities either that are traveling to or from the insured premises, bank, or savings institution or that are contained within the living quarters of the custodian of such funds is covered for an amount not to exceed $2,000.

As with other types of coverage, certain types of property are subject to limited burglary and robbery protection. For instance, fur and fur garments are covered as long as the loss does not exceed an aggregate of $1,000 for any one occurrence. Also, jewelry, watches, watch movements, jewels, pearls, precious and other semi-precious stones, gold, silver, platinum, and other precious alloys or metals are covered but are subject to a limit of $1,000 for any one occurrence. However, this limitation does not apply to jewelry or to watches that are valued at $25 or less per item.

Insurance companies frequently require that certain types of businesses have an acceptable burglary alarm system in order to obtain this optional coverage for protection against burglary and robbery.

**Earthquake Coverage**

Earthquake coverage may be added to most BOPs by endorsement. Some insurers, however, limit the availability of this extension of coverage to the special (or all-risk) policy, which is discussed at length below. When added to a BOP, the earthquake endorsement provides coverage for the business’s building(s), for business personal property, and for loss of income. The limits of liability are the same as those for any other peril that might cause a covered property loss, but the deductible, usually calculated at two percent (2%), is a percentage of the applicable limits of liability.

**Employee Dishonesty Coverage**

When employee dishonesty coverage is included in the policy the declarations page also states the BOP’s limit of liability for employee dishonesty losses.

Employee dishonesty coverage contains several conditions, and the agent should always review these conditions with the business owner. For instance, one important condition excludes coverage for any losses that result from dishonest or fraudulent acts by the business owner or by any partner, officer, director, or trustee. Another condition freezes the amount for which the owner may be reimbursed to the amount that is discovered missing at the time of its discovery. In other words, once a loss has been discovered, the BOP will pay for losses only up to that date, but not for any further loss that is caused by the known culprit. Some BOPs even stipulate that the culprit, when proven guilty, must be fired. Some insurance companies warn the business owner that he now runs the risk of losing this protection should any future losses result from the acts of any employee.

**Exterior Grade Floor Glass Coverage**

This BOP coverage is one of the broadest, most comprehensive glass coverages available under any policy. This optional coverage provides replacement cost coverage for all exterior grade floor and basement glass, including the glass’s lettering or ornamentation and its
encasing frames. This damage must be to the property of the business owner or to others who have placed their property in the care, custody, or control of the business owner. Glass is protected against damages that result from direct physical loss unless the loss is the result of wear and tear, latent defect, corrosion, or rust.

This coverage also includes reimbursement for the expenses of boarding up damaged openings, of installing temporary plates, and of removing or replacing obstructions when necessary. The usual perils and exclusions (except for the war risk, governmental action, or nuclear exclusions) do not apply.

**Exterior Signs Coverage**

The declarations page, as in the above coverage, states the amount of insurance that applies when this optional coverage is in effect. This coverage insures all exterior signs located on the business owner’s premises whether he owns these signs or whether they belong to others who have placed their property in the business owner’s care, custody, or control.

The usual perils and exclusions (except for the war risks, governmental action, and the nuclear catastrophe exclusions) provided by the standard BOP do not apply to this coverage. Although this coverage utilizes all-risk protection against loss, it does exclude normal wear and tear, latent defect, rust or corrosion, and mechanical breakdown.

**The Special (All Risk) Policy**

The special BOP is similar to the standard form; however, the few differences that exist between these two forms are significant. For instance, although both policies describe coverage for buildings, business personal property and loss of income (Sections A, B and C, respectively) in precisely the same way, the special BOP makes coverages available on an all-risk basis, while the standard BOP is a named peril policy.

Furthermore, the special BOP has more subsections than the standard form. For example, the special form also automatically includes money and securities coverage (Section D) in its basic policy, which as discussed above, is available only in the standard BOP as an optional coverage. Finally, primarily because of the difference between the all-risk and named peril approach to coverage, differences between the special and the standard forms are substantial in regard to excluded property and to property that is subject to limitations.

**Property Coverage (Section I, Sections A, B and C)**

As mentioned above, Section I and its subsections (A, B, and C) in both the standard and the special forms define building(s), business personal property, and loss of income in exactly the same way. However, the special BOP covers these categories of property against all risks of direct physical loss rather than on a named peril basis and is bound only to specific exclusions that are included in the policy.

**General Property Limitations under the Special Form**

Like the standard form, the special BOP has two sets of limitations. In fact, the first of these is very similar to the standard BOP; this limits the coverage for valuable papers and records, including film, tape and other forms of electronic data storage media, to the cost of blank cards or other media form. In the case of a manual records system, the coverage also recognizes the cost of labor needed to transcribe or to copy such records, but not to reproduce the electronic data processing types of storage media.
The second set of limitations is exclusive to the special version of the BOP. Coverage for the following areas of property is limited when a loss results from a peril that is not specifically excluded from coverage; however, these limitations do not apply to losses caused by fire, lightning, any of the extended coverage perils or sprinkler leakage.

The limitations are:

- Glass constituting a part of the building is not covered against loss for more than $50 per plate, pane, multiple plate insulating unit, radiant heating panel, jalousie, louver, or shutter, nor for more than $250 in any one occurrence.

- Glass, glassware, statuary, marbles, bric-a-brac, porcelains, and other articles of a fragile or brittle nature are not covered against loss by breakage. This limitation does not apply to bottles or similar containers of property for sale or sold but not delivered or to the lenses of photographic or scientific instruments.

- Fur and fur garments are covered for amounts not exceeding loss in the aggregate of $1,000 for any one occurrence.

- Jewelry and watches, watch movements, jewels, pearls, precious and semi-precious stones, bullion, gold, silver, platinum, and other precious alloys or metals are covered for amounts not exceeding loss in the aggregate of $1,000 in any one occurrence. This limitation does not apply to jewelry valued at $25 or less per item.

**General Property Exclusions Under the Special Form**

The same categories of property are specifically excluded under the special BOP as under the standard policy: exterior signs unless insured under optional coverage, growing crops and lawns, and aircraft, cars, motor trucks, and other vehicles subject to motor vehicle law, registration, or watercraft (including motors, equipment and accessories) while afloat. Another exclusion under the standard BOP (bullion, money, and securities) is specifically covered under the special BOP, coverage D, as discussed earlier.

Business owners will also find that the special BOP form contains the list of perils that are not protected against loss or damage. Usually stated in the following way, losses not protected by the special policy are those which are:

- Occasioned directly or indirectly by enforcement of any ordinance or law regulating the construction, repair or demolition of buildings or structures.

- Caused by or resulting from power, heating, or cooling failure or due to change in temperature or humidity unless the change results from physical damage to the building or to the equipment contained therein caused by a peril not otherwise excluded. Also the insurance company will not cover for any such loss resulting from riot, riot attending strike, civil commotion, vandalism or malicious mischief.

- Caused by any electrical injury or disturbance of electrical appliances, devices, fixtures or wiring caused by electrical currents artificially generated, unless an insured fire ensues, in which case the insurance company will be liable for losses that are caused by the resulting fire.

- Caused by pilferage, appropriation or concealment of any property covered or any fraudulent, dishonest or criminal act done by or at the instigation of the insured, partner, or joint venturer, including any officer, director, trustee, employee or agent thereof, or any person to whom the property covered may be entrusted.
• Caused by leakage or overflow from plumbing, heating, air conditioning, or other equipment or appliances (except fire protective systems) caused by or resulting from freezing while the described building is vacant or unoccupied unless the insured has exercised due diligence with respect to maintaining heat in the buildings or unless such equipment and appliances have been drained and the water supply shut off during such vacancy or occupancy.

• Caused by any of the following:
  • Wear and tear, marring or scratching.
  • Deterioration, inherent vice or latent defect.
  • Mechanical breakdown of machines, including rupture or bursting caused by centrifugal force.
  • Faulty design, materials or workmanship.
  • Rust, mold, wet or dry rot, contamination.
  • Dampness or dryness of atmosphere, changes in or extremes of temperature.
  • Smog, smoke from agricultural smudging, or industrial operations.
  • Birds, vermin, rodents, insects and animals unless loss by fire, smoke (except smoke from agricultural or industrial operations), explosion, collapse of a building, glass breakage, or water not otherwise excluded ensues, then this policy will cover only the resulting losses. If loss by water not otherwise excluded ensues, the policy will also cover the cost of tearing out and of replacing any part of the building covered required to effect repairs to the plumbing, heating or air-conditioning system or domestic appliance, but excluding loss to the system or appliance from which the water escapes.

• Due to any and all settling, shrinking, cracking, bulging or expansion of driveways, sidewalks, swimming pools, pavements, foundations, walls, floors, roofs or ceilings.

• Caused by explosion of steam boilers, steam pipes, steam turbines or steam engines (except direct loss resulting from the explosion of accumulated gases or unconsumed fuel within the firebox, or combustion chamber of any fired vessel or within the flues or passages which conduct the gases of combustion there from) if owned by, leased by, or operated under the control of the insured, or for any ensuing loss except by fire or explosion not otherwise excluded, and then the insurance company is liable for only any ensuing losses.

• Found in steam boilers, steam pipes, steam turbines or steam engines that are caused by any condition or occurrence within such boilers, pipes, turbines or engines (except for direct loss resulting from the explosion of accumulated gases or unconsumed fuel within the firebox or combustion chamber of any fired vessel or within the flues or passages which conducted the gases).

• Found in hot water boilers or other equipment for heating water that is caused by any condition or occurrence within such boilers or equipment other than an explosion.

• Caused by rain, snow, ice or sleet to any property that is out in the open.

• Caused by, resulting from, contributed to, or aggravated by any of the following:
• Earth movement, including but not limited to earthquake, landslide, mudflow, earth sinking, earth rising or shifting.

• Flood, surface water, waves, tidal water, tidal waves, overflow of streams or other bodies of water, or spray from any of the foregoing, all whether driven by wind or not.

• Water which backs up through sewers or drains.

• Water below the surface of the ground including that which exerts pressure on or flows, seeps or leaks through sidewalks, driveways, foundations, walls, basement or other floors, or through doors, windows or any other openings in such sidewalks, driveways, foundations, walls or floors.

• Due to voluntary parting with title or possession of any property by the insured or others if induced to do so by any fraudulent scheme or false pretense.

• Due to unexplained or mysterious disappearance of property or shortage of property disclosed on taking inventory.

• Due to delay or loss of market.

• Due to property sold by the insured under conditional sale, trust agreement, installment payment, or other deferred payment plan, after delivery to customers.

The special BOP automatically includes coverage for theft losses with a $250 deductible. This deductible is consistent with the $250 deductible applicable to related optional coverages such as the employee dishonesty and the burglary and robbery coverages under the standard BOP.

**Money and Securities Coverage (Section D)**

Coverage D, Section I provides protection against on- and off-premises insurance coverage for money and securities that are used in the insured's business. The amount of insurance that applies to this category of coverage is selected by the insured and is listed in the appropriate space on the declarations page.

**Additional Optional Coverages**

The automatic inclusion of theft, money, and securities coverage under the special BOP eliminates the need for the burglary and robbery coverage option that is available under the standard BOP. However, in all other ways, the special BOP offers the same optional coverages as does the standard BOP. Among these are employee dishonesty, exterior signs, exterior glass, and boiler and machinery coverage. Some insurance companies also offer accounts receivable and earthquake coverage with their special BOP while others do not.

**Liability Coverage Under the Standard and Special BOPS (Section II in Both Forms)**

The liability coverage provided by the standard BOP is exactly the same as that provided by the special BOP. While some insurers may permit higher limits of liability under the special BOP, no difference exists in the types of liability covered, nor in the definitions and other provisions discussed in Section II, the liability portion of the policy for both the standard and the special forms. The liability is, in fact, quite broad. The only decision that business owners must make is whether to select the $300,000 or the $1 million limit of liability made available through either form of BOP policy.
Business Liability (Section E)

Section E of the BOP states that it “will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury, property damage, or personal injury caused by any occurrence to which this insurance applies.”

The BOP liability insuring agreement thus provides comprehensive general liability insurance on a per occurrence basis. This includes the usual liability coverage for a business’s “premises and operations.” Coverage for “completed operations” and “products” liability are also specifically included as is coverage for personal injury liability. The latter protects business owners against alleged false arrest, libel or slander, and wrongful entry or eviction or other invasion of privacy. A special fire legal liability provision provides up to $50,000 of coverage per occurrence for all damages resulting from fire or explosion, which damage structures rented to or occupied by the named insured.

The liability coverages are written out in detail in the policy. In addition to the coverages listed above, the business liabilities exclusions section in the BOP covers other forms of liability. These may include employers’ non-owned automobile liability, blanket contractual liability, and host liquor law liability.

Most insurers also provide druggists professional liability coverage when the insured operates a retail drugstore. This coverage protects the named insured, including partners, and executive officers, and the individual pharmacists who work for the insured. This coverage extends to all claims that arise out of goods or products prepared, sold, handled or distributed by the drugstore.

Another extension of coverage nearly always found in the BOP is broad form property damage coverage. This coverage is especially valuable to those businesses that service or install items away from their business location. In essence, this coverage relaxes the usual care, custody and control exclusion to specifically cover damage to property that is caused by the negligent installation or replacement of an equipment or system part. The cost of the negligently installed item is excluded from coverage.

Limits of Liability

As noted, business owners may select liability insurance limits of either $300,000 or $1 million. These limits of liability are on a per occurrence basis and are not reduced by any supplementary payments, which are discussed below. However, the selected per occurrence limit is also limited to a specific total for all occurrences during the policy period that result from completed operations and/or products liability hazards. Fire and legal liability claims are further limited to no more than $50,000 per occurrence.

As with other forms of liability insurance, insurance companies are required to defend any claim or suit against insured business owners by claimants who seek damages that are covered by the BOP even if the suit is false, fraudulent, or groundless. However, the BOP also gives the insurance company the right to investigate and to settle claims as it (the insurer) sees fit. Furthermore, when the BOP’s limits of liability have been exhausted by payment of a judgment or by a settlement, the insurance company is released from any further obligation to defend the insured or to make payments on the insured’s behalf.

Supplementary Payments

Similar to other insurance policies, the BOP agrees to make certain supplementary payments, which, if made, do not count toward the policy’s limit of liability. These types of payments include:

- All expenses incurred by the company.
• All cost incurred by the insured in any suit defended by the company and all interest on the entire amount of any judgment which accrues after entry of the judgment and before the company has paid or deposited in court that part of the judgment which does not exceed the limits of the company’s liability.

• Premiums on appeal bonds in any such suit.

• Premiums on bonds to release attachments in any such suit for an amount not in excess of the applicable limit of liability of the policy.

• Expenses incurred by the insured for first aid to others at the time of an accident for bodily injury to which the policy applies.

• Reasonable expenses incurred by the insured at the company’s request in assisting the company in the investigation or defense of any claim or suit, including actual loss of earnings not to exceed $50 a day.

**Medical Payments (Section F)**

The BOP automatically includes medical payments coverage (Section F) in the amounts of $1,000 per person and $10,000 for all persons requiring medical attention as a result of a single accident. This coverage is provided on a per-accident (as opposed to a per occurrence) basis.

**Conclusion**

Whether the Special Multi-Peril Policy (SMP) or the Business Owners Policy (BOP), it is essential that a business owner purchase commercial multi-peril insurance which offers protection for property loss and liability and any additional coverage that may be needed to supplement the coverage of his or her personally owned policies. By understanding your client’s business and the specific benefits of the different types of commercial property policies, you can offer sophisticated service which will lead your clients to appropriate insurance protection.
CHAPTER 3 – CRIME INSURANCE

Introduction
Whether your client is a homeowner or business owner, often a sensitive and scary subject for the client is the thought of being the victim of a crime. The producer’s knowledge and guidance regarding coverage will go a long way to putting clients at ease and helping them to acquire the necessary coverage for each particular situation.

Policies Including Crime Coverage
A number of insurance policies include coverage against losses incurred due to criminal activity. We will first review the ways in which the following policies protect against loss from crime:

- Homeowners Insurance.
- Tenants (Renters) Insurance.
- Automobile Insurance.
- Property Insurance.
- Business Interruption Insurance.

Homeowners Insurance
There are many types of crime coverage policies. One of the most common forms of crime insurance is found in homeowners insurance. This type of insurance is, in reality, a package policy with a combination of coverages. This policy typically covers the home and its appurtenant structures from a variety of perils, such as fire, vandalism, burglary, robbery, theft and malicious mischief. The property of the insured is likewise covered from these perils. In addition, the policy provides coverage for the insured's liability arising out of the covered premises and includes benefits to cover living expenses in the event the house becomes uninhabitable due to a covered peril.

Typically, under a homeowners policy the insured premises are the residence premises described in the policy declarations. The intent of the policy is to cover losses on the described premises and not on other premises rented by the insured or on business premises.

The homeowners policy covers the described dwelling building, including additions in contact therewith, occupied principally as a private residence. This includes insurance of all building equipment, fixtures and outdoor equipment pertaining to the service of the premises while located thereon or temporarily elsewhere. It also covers materials and supplies located on or adjacent to the premises which are intended for use in construction, alteration or repair of such dwelling.

This policy also covers structures other than the described dwelling building, including additions in contact therewith, appertaining to the premises. This coverage also includes materials and supplies located on the premises or adjacent thereto intended for use in construction, alteration or repair of such structure. This coverage excludes structures used in whole or part for business purposes and structures rented or leased in whole or part.

Generally, property structures are listed and scheduled on the policy, and coverage is clearly determined by inspection of the policy’s declaration sheet. In addition, the policy covers unscheduled personal property usual or incidental to the occupancy of the premises as a dwelling.
The property must be owned or used by an insured while on the described premises, and at the option of the named insured, owned by others while on the portion of the premises occupied exclusively by the insured.

Phrases such as “household goods,” “household furniture” and the like, cover a variety of articles, as long as the articles in question are chiefly associated with the household in their general nature and use. On the other hand, coverage is normally denied where it appears that the articles in question are not ordinarily associated with the household. Objects purchased or brought on the premises after the inception of the policy are generally held to be within the coverage of the policy terms.

Floater policies and endorsements provide coverage for specific goods or classes of property which are easily moveable. Such floaters are governed by all connotations and provisions of the policy to which they are endorsed. Homeowners policies may typically cover certain types of personal property on a worldwide basis, as in the nature of floaters. Floater policies are also used to cover mobile equipment, such as cranes and similar construction machinery, and may provide at-risk coverage to both the lessor and the lessee of the equipment. However, floater policies may exclude coverage for equipment held in permanent storage.

Blanket coverages may be used to cover all items described in the policy, or the term may be used to describe a specific type of policy, such as a blanket crime policy, which covers a wide range of perils.

Reporting form policies are designed to provide more flexible policy limits than a standard policy. This is particularly helpful for insureds who have fluctuating inventories. They only pay premiums on the amount of coverage for the particular monthly period determined by a monthly inventory report, which the insured sends to the insurer.

This policy will generally limit coverage to the amount declared in the last report filed prior to the loss. Such a provision will still be operative despite the failure of the insured to file a report for the previous months in a timely manner. In such a situation, the insurer may look to the last report filed by the insured.

Policies often require that the insured take necessary steps to protect the insured property after a loss occurs. Similarly, the policy may be issued on the basis of assurances that the insured will install or maintain protective safeguards which lessen the risk of loss.

Such provisions are valid and enforceable and may require the insured to use due diligence to exercise all necessary precautions, or to use reasonable care. For example, where a burglar renders a burglar alarm inoperative, coverage will exist for the loss. The insured may be required to maintain records to show that the system was repaired.

This type of policy may exclude loss where the insured fails to exercise reasonable means to preserve the insured property after the loss. The insured’s failure to preserve and protect the insured property is generally a question of fact for a jury. However, where the insurer has the option to repair or replace the damaged property, the insured may be relieved of his duty to protect the property.

**Tenants (Renters) Insurance**

The tenant, or lessee, of any property has an insurable interest in the improvements and betterments that he makes to the leased premises, at least for the duration of the lease. In addition, the tenant has an insurable interest in buildings erected by him on the leased premises, even though he may be prevented from removing such buildings if they become the property of the lessor at the expiration of the lease.
A tenant may elect to purchase “tenants,” or “renters,” personal property coverage, similar to homeowners insurance coverage, only without the coverage of the structure. The renter may insure his personal property, which is incidental to the occupancy of the premises. This will include coverage in the event of loss from crime.

The insured may elect to cover “household goods” and “household furniture” as long as these articles are associated with the household in their general use. Coverage is not afforded where the articles are not ordinarily associated with the household.

Typically, this type of policy affords coverage to the personal property of others while on the portion of the premises occupied exclusively by the insured.

**Automobile Insurance**

Automobile theft insurance policies generally state that they provide insurance against loss resulting from “theft, larceny, robbery or pilferage.” In addition, insurance against loss from theft is frequently provided in the comprehensive coverage provisions of liability and collision policies. Whether a covered loss has occurred will turn most often upon one or both of two factors: first, the nature of the taking, and second, the identity of the taker.

Courts have held that in determining the losses that fall within the coverage under a policy insuring an automobile against theft, the provisions of the policy are to be construed according to the natural import of the language used. Any ambiguities in such language are to be resolved in favor of the insured.

Since automobile theft policies commonly protect the insured against robbery, pilferage, theft and larceny, these coverage terms require some discussion.

- **Robbery**, the courts have recognized, is a form of larceny. To recover insurance benefits for an alleged robbery of a car, all of the elements of the criminal offense of robbery must be shown.

- **Pilferage** is synonymous with petty, or petite, larceny. Because of the nature of the crime of petty larceny and the restrictions with regard to value in connection with this crime, the theft of an automobile would rarely be within the scope of that term.

- It is generally recognized that the theft is roughly, though not exactly, equivalent to a taking that would amount to the crime of larceny. To recover for an alleged theft, the insured has the burden of proving much the same facts that would be required in a criminal prosecution for larceny. Thus, the policyowner must show a felonious intent upon the part of the taker of the car.

- The majority of courts have held that felonious intent to commit larceny is an intent to permanently deprive the insured of the insured’s car. As a result, courts have generally held that there is no theft or larceny if the alleged thief intended to return the car after using it temporarily. However, the mere fact that the taker of a car testifies that he intended to return the car will not constitute sufficient proof that the taker did not commit larceny.

An insurer’s liability is not limited under an automobile theft policy to payment of the value of the automobile which is stolen and then recovered. It extends also to damages or losses sustained by the vehicle after it is stolen and before it is returned to the owner. Thus, if an automobile is stolen and wrecked by thieves, whether by collision or otherwise, and is rendered as having little or no value, there the insurance company will still be liable for the full amount of the loss under the theft coverage in the automobile policy.
When an insured’s automobile is damaged as a result of a collision while in the custody of a police officer who is returning the vehicle from the place where it was discovered after its theft, the insurance company is generally liable for the amount of the damage incurred, even if the policy excludes loss by collision.

Theft provisions of automobile insurance generally refer to the theft of the vehicle itself, and not to personal property contained in or on such vehicles. Coverage of personal property generally is obtained in policies other than the automobile insurance policy, such as the homeowners policy, including floaters or endorsements thereto. Personal property also may be protected under the theft provisions of business or commercial policies; however, the theft provisions of commercial policies frequently exclude coverage in situations where property is stolen from an unattended vehicle other than by forcible entry into a locked, enclosed body or compartment, as evidenced by physical signs of such forcible entry.

Commercial policies may expressly extend to the transportation of personal property or property in the custody of an employee, such as a salesperson. Often they apply only while the property is actually under the protective custody of the insured’s chauffeur or driver. Some policies apply only to the theft of the entire cargo and do not extend to pilferage.

In some instances the theft provisions of an automobile policy may also extend to the theft of property contained in the insured vehicle. Where the policy does extend to the theft of property contained in a vehicle but is unclear as to whether it applies all theft of personal property or only to theft when the vehicle itself is stolen, ambiguities will be construed in favor of the insured. As a result, coverage will typically apply where personal property is stolen from the vehicle, but the vehicle itself is not stolen.

Frequently, some policies are issued to carriers, indemnifying them from losses of merchandise arising from theft. These policies may extend only to the theft of an entire shipping package. They may exclude pilferage and theft by employees of the carrier. They may also exclude theft from unmanned vehicles, unless the vehicle is enclosed and fully locked, and there is visible evidence of forcible or violent entry.

Although automobile theft coverage customarily does not extend to the theft of personal property contained in an automobile, it often may cover “equipment” of the automobile. “Equipment” in this sense, means something designed for relatively permanent installation in the vehicle, and which cannot readily be utilized without being so installed. However, it is not limited to factory-installed equipment.

Similar to other insurance policies covering loss from crime, there generally can be no recovery under an automobile policy for a loss from a taking of an automobile if there is not proof of the existence of a criminal or felonious intent on the part of the taker. Accordingly, there is no “theft” of an automobile when it is taken by someone incapable of criminal intent, or when it is taken by someone claiming ownership of the vehicle.

Automobile theft insurance policies contain policy provisions expressly excepting particular losses from the coverage provided in the policy. A policy may specifically exempt theft from coverage when the automobile is used in an illegal activity.

Theft of an automobile through acts of a member of the insured’s own household is often expressly excepted from coverage since individuals who live in the insured’s household most often have liberal authority to take possession of and operate motor vehicles of the insured, and they have unlimited opportunity for theft of such vehicles. This exception to coverage has also been designed to prevent fraud and collusion by and between the insured and the persons in his or her household. Various factors are considered in determining whether the taker of the automobile was a member of the insured’s household. The term “household” is
interpreted as pertaining to or belonging to the house or family who resides in the household of the insured. For example, a nephew or an uncle may be a member of the insured’s household even though he may not physically reside in the insured’s home.

Theft policies commonly contain provisions requiring the insured to lock the automobile when unattended or to maintain and use adequate locking devices. The insurer will not be liable for loss that occurs while the vehicle is left unlocked contrary to the policy provision. A stipulation to have and maintain a certain locking device and to “use all diligence and care in maintaining the efficiency of the locking device in locking the automobile when leaving it unattended” does not mean that the car can never be left unlocked. It does, however, require the exercise of due diligence and care that someone of ordinary prudence would exercise under the circumstances.

Leaving a car unlocked and unattended in the street for at least five minutes would breach a warranty to use all due diligence by locking it when leaving it unattended. Similarly, the requirement that an automobile be left locked when unattended is not satisfied when the automobile is locked but the key is left in the automobile. Also, leaving an automobile unlocked after dark on a city street with the motor running and the door open, although only for a few minutes, breaches the covenant to use all diligence and care in keeping the car locked when unattended. As a final example, the duty of due diligence and care would be breached if the insured fails to have a locking device repaired for an extended period of time after the device becomes broken.

**Property Insurance**

A person who derives a benefit from the existence of particular property, or who would suffer from loss of that property, is said to hold an insurable interest in the property. A party may only obtain a benefit from a property insurance policy if that party holds an insurable interest in the insured property.

Generally, there are two classifications of property insurance. “Direct loss insurance” offers coverage to the insured in the event of loss from damages, destruction or theft to his property. “Liability insurance” protects the insured against damages for which the insured is legally liable.

In addition to perils of fire, casualty, disaster and theft, property insurance policies, or extended coverage provisions thereof, commonly insure against “vandalism” or “malicious mischief.” In ordinary usage, the word “vandalism” has been broadened in its meaning to include the destruction of property. Generally the ransacking and destruction of an insured’s personal property has been held sufficient to warrant recovery under a property insurance policy for damages resulting from “vandalism.”

The term “malicious mischief” has been defined as an act done willfully and intentionally. In applying this term to particular acts, “malicious mischief,” as used in property insurance policies, has been held to cover the systematic breaking of windows, doors and fixtures.

Generally, it is unnecessary to distinguish between vandalism and malicious mischief for purposes of determining coverage under property insurance policies. Some examples that have been held as constituting vandalism and malicious mischief under property insurance policies, are:

- Damaging of washing machines in a coin-operated laundry.
- Damaging of a roof by children throwing rocks.
- Removal of air-conditioning units from apartments.
• Placement of poison near feeding cattle.
• Shooting of a dog.
• Flooding of a building by trespassers.

Watchmen and Guards

A property insurance policy may commonly require the presence of watchmen or armed guards. The insurer may require employment of guards to protect the insured building against burglary, robbery, theft or vandalism. Some insurance policies require constant watch, while others only require guards during specific times.

Often, there are questions involving who the watchmen are, and also there are questions regarding the degree of compliance with such provisions. There are questions of what constitutes a “continuous watch” or a “night watch.”

The primary and controlling issue is determining whether a person is a watchman and whether he is employed and acts as such, as required by the terms of the contract of insurance. The compensation he is paid and whether or not he is called a “watchman” are not material.

The purpose of a watchman provision in a policy of insurance is to protect the insurer from fraud and to protect the property from the peril against which it is insured, such as burglary, robbery, theft or fire.

To be considered a watchman, it is necessary that the person have the duty of watching. The mere physical presence of a person on the premises, even though continuously, does not automatically constitute that person as a watchman if he has no duty to watch. For this reason, one who sleeps on the premises is not a watchman even though stationed at a property at night.

In some policies, the obligation to maintain a watchman arises only when a plant located at the property is shut down or idle. Premises on which a large number of people are employed, but are not “open for business,” eliminate the necessity of a watchman.

A temporary absence of a watchman is sometimes held immaterial on the theory that it occurred without the knowledge or consent of the insured and that the insured had otherwise fully complied with the agreement to keep a watchman on the premises whose competency and fidelity he had no reason to distrust.

The fact that the watchman is negligent in the performance of his duty does not breach the obligation of the insured to maintain a watchman, at least where the insured has no reason to expect that the watchman would not perform his duties properly. Accordingly, a warranty that a watchman is kept on duty at night is not broken when, without the employer’s knowledge, the watchman goes to sleep during the time he should be on duty.

On the other hand, a breach of the insured’s obligation to maintain continuous watch would exist if the insured makes arrangements only for a casual or intermittent watch of the insured property.

In some instances, the policy provision requires the presence of an employee of the insured, or a “custodian,” in addition to the presence of a watchman.

A watchman is not required to have only duties as a watchman, nor is it required that only one person be the watchman. Therefore, the insured complies with the requirement of maintaining a watchman where the duty of watching is placed successively on the various members of a hired crew. Even though a watchman is not required to be exclusively a
watchman, the duty of watching must be a significant part of his duties. The watchman must exercise such care and skill in the performance of his duty as are usually exercised by “reasonable, prudent and careful persons in watching similar premises.”

A watchman clause frequently may be eliminated by the payment of an additional premium sufficient to cover the risk.

**Business Interruption Insurance**

Business interruption insurance, sometimes called use and occupancy insurance, has become increasingly popular over the years. As the name implies, this type of insurance is designed to protect the insured from losses arising from the interruption of his or her business. If losses arise as a result of criminal activity, this type of coverage may benefit the insured.

Business interruption insurance does not have a fixed or single meaning and cannot be defined with precision. However, it may generally be described as a form of insurance designed to indemnify the insured against losses arising from the inability to continue the normal operation and functions of the business, industry or other commercial establishment. The insurer is liable, within the policy limits, for the insured’s fixed charges and expenses necessarily continuing during the period of total or partial suspension of such business due to the loss, or loss of use of, or damage to all or part of the building, plant, machinery, equipment, or other physical assets thereof, as the result of a peril or hazard insured against. However, the insurer is liable only to the extent that these expenses would have been incurred if the contingency causing the suspension had not occurred.

Particular matters or items which have been allowed as fixed charges or continuing expenses are:

- Taxes.
- Licenses.
- Rent.
- Insurance.
- Telephone.
- Lights.
- Heat.
- Power.
- Payroll taxes.
- Social security.
- Payments to employees who would have been retained.
- Association and club dues which the insured customarily paid for certain officers.
- The expense of maintaining a branch in another city.

The following items or matters have been excluded from business interruption coverage as they have been held not to constitute fixed charges or continuing expenses:

- Depreciation on the destroyed property.
• Partners’ drawing accounts where the insured was awarded a recovery for lost profits and such withdrawals were included in the net profit figure.

• Labor costs which were paid as a part of the property loss under another insurance policy.

Business interruption insurance policies commonly provide that in the event of loss, the insurer would be liable for (in addition to lost profits, fixed charges and continuing expenses) expenses necessarily incurred to reduce the loss. It has sometimes been stipulated that the expenses are payable only if incurred at the written direction of the insurer. Such policies have usually provided that the insured is required to use due diligence in attempting to resume business operations.

Courts reviewing cases involving business interruption insurance have determined that the purpose of the policy is to protect the prospective earnings of the insured business. In determining the nature and extent of the business covered by the policy, the intention is to insure against loss from the interruption of the insured’s business as a whole. The recoverable losses are not confined to a particular property described in the policy or to the exact operation or business in which the insured is engaged at the time the policy is written.

Recovery has been allowed for lost profits from business activities which were commenced after the issuance of the policy and even for profits which would have been earned by a new plant structure which was not yet built, but would have been built during the suspension period. Recoveries have also been allowed where the business interruption resulted from the destruction of buildings not described in the policy but which were a part of the entire plant. Not surprisingly, business interruption insurance is also often termed “earnings insurance.”

A business interruption insurance policy is generally in the form of a rider or endorsement on a policy insuring against loss or damage to physical assets as the direct result of the perils specified: often burglary, robbery, theft or fire. Policy provisions, terms and conditions, with respect to the perils insured against and notice and proofs of loss are usually those contained in the policy to which the rider or endorsement is attached.

In the construction and interpretation of business interruption insurance, the rules applicable to all insurance policies generally apply. The interpretation must be reasonable, and the contract should be interpreted to give practical effect to the intentions of the parties. In addition, the language must be given the meaning which a person of ordinary intelligence would attribute to it. It should also be construed in favor of the insured if it is susceptible to ambiguous meanings. The loss should be determined in a practical way, having regard for the nature of the business and the methods employed in its operation.

The extent and computation of any loss which may be recovered by the insured are handled like many other types of property insurance. The insured’s accounting practices and system are not controlling in determining the recoverable loss under business interruption insurance, but they are not irrelevant and should be given such weight as practical judgment dictates.

Business interruption policies may be “valued.” In this type of arrangement the value of the loss is agreed upon in advance, and the amount to be paid by the insurer is fixed in the language of the policy. The determination of the amount of liability is a matter of mathematical computation. Where the property is valued and the parties have agreed upon the value of the insured’s loss in advance, the amount fixed by the policy is ordinarily controlling.

In some states, laws called “valued policy statutes” provide that the amount of insurance written is to be taken as the true value of the insured property in the event of a total loss. In
the case of “open policies,” the agreement of the insurer is to indemnify the insured for actual loss, up to the policy limit. The amount of any loss sustained is not agreed upon in advance. The coverage is determined by competent evidence showing the actual amount of loss. The question is one of fact, and the burden of proof of the actual loss sustained is left to the insured.

Open policies have commonly provided for the recovery of the insured's actual loss during the time of the business suspension. Coverage includes:

- Net profits that are not earned as a result of the loss.
- Fixed charges and expenses that continue during the suspension period, up to the amount that they would have been incurred under normal business circumstances.
- Expenses incurred to reduce the amount of the loss.

Profits and business expenses covered by this type of insurance should be determined in a practical way, with due regard for the nature of the business and the methods employed in its operation. In such a determination, the insured’s books and accounting systems are used to help establish the amount of regular ongoing expenses. Other evidence can also be used to help determine the amount of expenses.

Also in the determination of the loss, due consideration is given to the experience of the business of the insured before the event insured against and the probable experience thereafter. The indemnity has commonly been fixed on a daily basis of not exceeding 1/300 of the face amount of the policy or 1/365 in the case of a business which operates on Sundays and holidays.

It is frequently provided that the insurer’s liability for a partial business suspension is limited to a proportion of the liability that would have been incurred by a total suspension of business. The insurer’s liability during a time of partial suspension of business should be limited to the actual loss sustained, not exceeding that proportion of the per diem liability that would have been incurred by a total suspension of business which the actual per diem loss sustained.

There is no prescribed or accepted formula for the determination of the actual loss of net profits and business expenses covered by business interruption insurance, except the test of past experience and the probabilities of the future. All agree that the insured should not be deprived of indemnity merely because it is difficult to determine the loss with absolute precision.

Business interruption insurance policies have frequently contained coinsurance clauses, and these have been held enforceable in the absence of statutory prohibition. These, however, are subject to strict construction and the requirement of strict proof.

The period of time for which an insured can recover under a business interruption policy is primarily controlled and determined by the terms and conditions of the policy. While definite periods of time have sometimes been fixed during which the liability of the insurer would continue, the period for which an insured can recover under business interruption insurance is generally limited to the time required to rebuild, repair or replace the destroyed or damaged property with the exercise of due diligence and dispatch.

Where the policy limits the liability to actual loss resulting from a business suspension due to a specified risk, the insurer is not liable unless it is shown that the risk insured against directly produced the loss for which a recovery is sought.
It is well established that the loss of (or damage to) physical property is not covered by business interruption insurance policies. The insured must obtain that type of coverage separately under a commercial property policy. In addition, the insurer is not liable under business interruption insurance for interruption losses other than those directly caused by an insured risk. For example, an insurer is not liable for losses actually attributable to lack of demand for the insured’s product, increased production costs, unfavorable business conditions or similar business factors.

**Theft Coverages**

The language and provisions of insurance policies covering theft, robbery, larceny and burglary must be interpreted in a fair and reasonable manner in order to properly cover risk in the manner intended by the parties purchasing these policies. We will now examine some of these specific terms and provisions.

**Theft**

The term “theft” is intended to be interpreted as broadly and as liberally as possible to protect the insured. Theft is defined to mean the taking of the property of another without authority. Theft includes any wrongful deprivation of property of another, including embezzlement or swindling. However, theft coverage under a homeowners policy is almost always limited to the property located on the insured premises. On the other hand, the policy may be expressly endorsed to include property which is away from the insured premises.

Theft coverage for a dwelling may often exclude coverage unless the insured is residing therein. Theft policies frequently contain clauses excepting liability under other circumstances as well. For example, coverage for the loss of goods due to the dishonesty of employees of the insured generally is exempted from coverage and the insurer is relieved of liability for such acts.

**Robbery**

“Robbery” is a greater crime than theft. It is the unlawful taking of property, of any value, by means of force or violence or by putting a person in fear.

Robbery policies frequently insure against loss by theft or larceny as well and may also cover losses from false pretenses. Robbery policies frequently contain provisions requiring the insured to take certain specified precautions to avoid or discourage the commission of robberies.

Such conditions are particularly common in bank robbery policies. Prominent among such provisions are those extending coverage to robbery from safes or vaults while they are locked or if a certain number of custodians, employees or guards are present.

**Larceny**

“Larceny” is the wrongful or fraudulent taking and carrying away by any person of the personal property of another, from any place, with a fraudulent intent to deprive the owner of his property.

**Burglary**

“Burglary” at common law is the breaking and entering of the dwelling house of another, with the intent to commit felony therein. Burglary policies cover loss and damage to property occasioned by burglary or attempted burglary.

There are provisions which are designed to either extend or to limit the coverage under policies covering burglary. These provisions may include the following:
• The policies may expressly restrict coverage to particular times or places, such as times when the property is in the actual care or custody of the insured, in transit, in a specified building, in a safe or vault, or in the mail.

• A burglary policy may require that the insured exercise due diligence in maintaining an alarm system. Failure to keep the insured property within a designated area or place for safekeeping also may preclude recovery.

• Burglary policies commonly extend to losses sustained by the insured, members of the insured’s family and members of the insured’s household. Some insurance policies may restrict the benefit of the coverage to permanent members of the insured’s household.

• In some burglary policies, exception is made for loss caused by riots or civil commotions.

• Burglary policies often contain provisions restricting the insurance company’s liability to cases where there are some “visible marks” or “visible evidence” of the use of force or violence affecting a felonious entry. These provisions are inserted for the protection of the insurer to help avoid false claims.

• Policies covering burglary from safes also commonly require visible marks upon the insured's safe for payment of a claim. In some instances, the requirement of visible marks or visible evidence has also been imposed in policies pertaining to the theft of property from an insured's automobile. In order to satisfy the policy requirement, the determination of what constitutes visible marks or visible evidence, and where the marks or evidence must be located is largely dependent upon the particular facts at hand. For example, a burglary policy requires that there must be visible marks of force or violence “at the place of entry” onto the premises. This requirement has been held to have been complied with if the visible marks are on one of the outer doors of the insured's premises. However, if the only visible marks are those on the inside doors, recovery has been denied. The term, “visible marks at the place of entry,” means that there must be marks from which it can be properly inferred that there exists intent to commit a felonious act.

• Some insurers have added a force or violence provision to their policies. This provision adds a further requirement that the forcible entry must be evidenced by “physical damage to the premises.” A burglary policy may require an entry with force and violence greater than that employed in any breaking in order “to effect entry.” The fact that a thief obtains property through intimidation satisfies the criminal law requirement of a taking by force.

• Many policies specifically exclude loss of property by “mysterious disappearance.” Such a position would relieve the insurer of liability where the property was misplaced or lost by the insured and not the result of the felonious act of another.

• Generally, there are provisions requiring the insured to deliver any recovered or damaged property to the insurer. If the insurer has paid the insured the indemnity provided in the policy, and the property later is recovered, the insurer may be entitled to possession of the recovered property.

• Coverage specifically exists if the insured is forced at gunpoint to cash checks or withdraw money for payment to a thief.
A policy may cover the theft of “securities” and may define what is meant by that term. Blank checks, “all negotiable or nonnegotiable instruments, or contracts representing either money or property” are considered securities.

The word “merchandise” is used in policies insuring proprietors against interior robbery of “money, merchandise and securities.” Merchandise is defined as being customarily sold within the proprietorship. In addition, these policies indemnify the insured for all damages, within the policy limits, for loss of money by robbery from messengers, loss of money when a custodian is kidnapped, loss of money by safe burglary (provided the safe doors are locked), and loss of money by burglary from within any night depository in a bank.

**Safes**

Bank robbery policies commonly provide that coverage is only extended to robbery from safes or vaults while they are locked. Similarly, a commercial burglary insurance policy may limit coverage to property within a safe, vault or other designated container or place of security.

A policy of burglary insurance covering the burglary of the contents of a safe while it is duly closed and locked does not cover a loss where only a compartment was feloniously broken into while the outer door of the safe was unlocked and open.

The loss of money from an open safe is not covered by a burglary insurance policy covering loss from a locked safe opened by force or forcible entry. However, the taking of money by robbers from a safe which has been unlocked in preparation for the transferring of money is an insured risk.

**Disappearance Coverage**

Early burglary and theft insurance policies occasionally contained provisions which stated that the disappearance of an insured object would not be considered as evidence of a theft or burglary. The insurance companies varied widely in their requirements for proof of theft.

Generally, these provisions were interpreted in favor of the insured, allowing the proof of loss by the use of circumstantial evidence. A mysterious disappearance of an object was an event from which theft might be deduced. Courts readily accepted that the proof of the disappearance of insured property under mysterious circumstances was adequate to support recovery under a policy in which the insurer agreed to pay for the loss by theft.

In order to bring about a greater uniformity in adjusting practice and also to eliminate a source of policyholder dissatisfaction, the “mysterious disappearance” contingency clause was later introduced into the standard form theft policy.

Today many policies actually include the term “mysterious disappearance” within the definition of theft. Others simply provide affirmative coverage for loss by theft, attempted theft or by mysterious disappearance. The general rule is that the proof of mysterious disappearance alone suffices to enable the insured to recover, even without showing the probability of theft.

Mysterious disappearance embraces any disappearance or loss under any unknown, puzzling or baffling circumstances. Recovery is typically allowed when the article disappears from the place the insured left it. Generally, proof of the disappearance alone establishes the insured’s right to recover without showing a probability of theft.

Recovery is ordinarily disallowed where the insured has no recollection of when he or she last had possession of the article. Policies may allow for a presumption of theft; however, it is
still necessary for a loss to be established. Thus, the words “mysterious disappearance” do not transform the policy into an “all loss” policy, or one which covers lost or mislaid articles.

**Extortion**

Extortion is defined as the act or practice of obtaining money from a person by force or by illegal power. Extortion is a type of criminal activity which falls within general theft insurance coverage, even where the policy does not specifically mention extortion. Consequently, insurers find it worthwhile to draft theft insurance policies to expressly exclude coverage of extortion payments or to attempt to obtain increases in insurance premiums for the coverage of extortion payments.

Generally, in cases involving kidnapping and the taking of hostages in a plane hijacking, the insured may recover against the insurer under a theft policy for ransom paid in response to such extortion activities. There is no obstacle to the insured’s recovery where the policy states that the losses must occur while the property is on the premises of the insured. As long as the policy covers the sort of risk posed by threats of extortion, the insured cannot be denied coverage on the grounds that the ransom payoff occurred off the premises of the insured.

**Forgery**

“Forgery,” under an insurance policy, is roughly equivalent to an act which the criminal law would consider to be a crime of forgery. This crime is defined as the act of falsely or fraudulently making or altering a document. However, some policies contain their own definitions of that term. In these cases, the policy definition prevails over the criminal law definition.

Recovery is allowed under the policy where the evidence establishes a loss occasioned by forgery. Recovery is denied where the loss does not involve a forgery, such as where the false instruments actually are executed by the parties purporting to have made them. Like other forms of insurance contracts, any ambiguities are resolved in favor of the insured.

There is a fund given appropriations from the United States Treasury that makes money available to the Treasurer of the United States for making settlement with the payees of certain checks drawn on the Treasury of the United States which have been lost or stolen, and negotiated and paid by the treasurer on forged endorsements.

To receive a replacement check, the claimant must show that:

- The check was stolen or lost without fault on the part of the claimant.
- The check was thereafter negotiated and paid on a forged endorsement of the claimant’s.
- The claimant did not participate either directly or indirectly in the proceeds of such negotiations.
- Reclamation from the forger subsequent to the forgery has been or may be unsuccessful.

**Dishonesty and Fraud Insurance**

Insurance against fraud is often found in the coverage of fidelity insurance, or a fidelity bond. The party issuing the bond is called the “insurer” or “surety,” and these terms are often used synonymously. This type of insurance covers losses caused by “fraud or dishonesty” to an employer through acts of an employee. The bond covering these losses is ordinarily held to extend beyond acts which are criminal.
The terms “fraud” and “dishonesty” are generally words which are given a broad meaning, and they are always construed most strongly against the insurer. These terms include any act showing a want of integrity or breach of trust, or an abstraction of funds, together with deceit or concealment. “Abstraction of funds” and “wrongful abstraction” are terms defined as the unauthorized and illegal taking or withdrawing of funds or property from the possession and control of the employer, and the appropriation of such funds or property to the benefit of the taker, or to the benefit of another, without the employer’s knowledge and consent.

“Willful misapplication” means a willful, unauthorized, and illegal application of funds or property of the employer to the use and benefit of the bonded employee, or to the use and benefit of another with the employee’s knowledge and consent with intent to injure or defraud the employer. “Funds” do not necessarily mean actual cash. Funds is a much more comprehensive term and may include other assets or property.

Mere negligence, a mistake or an error in judgment does not constitute fraud or dishonesty. However, by their express terms, some fidelity bonds cover losses resulting from the negligence of the bonded person. A fraudulent or dishonest act is often defined as one of “wrongful purpose and connotes immoral inclination.”

To constitute fraud or dishonesty, it is not necessary that the bonded person intend to benefit personally from his wrongful act or conduct. The breach of trust can be performed for the profit of, or in connection with, another person.

A breach of the bond occurs when an employee fails to account for money which he is engaged in collecting and receiving for his employer, or where he fraudulently misappropriates, or assists in misappropriating, funds or property belonging to his employer. On the other hand, there is no breach of the terms of the bond if an employee becomes indebted to his employer through a mistake or carelessness with no intent to defraud, even though his act results in a loss to his employer.

The following section characterizes the more detailed aspects of fidelity bonds.

**Fidelity Bonds**

A fidelity bond, or fidelity insurance, is a contract whereby, for a consideration, one agrees to indemnify another against a loss arising from the want of honesty, integrity or fidelity of an employee or other person holding a position of trust. While the contract may resemble suretyship, it is generally held that guaranteeing the fidelity of employees or other persons holding positions of trust is, in effect, a form of insurance. Such a contract is subject to the rules applicable to insurance contracts generally.

The party that insures the fidelity of another is called the “insurer” or “surety.” For any party that insures the fidelity of an employee, that party’s liability is primary and direct.

A fidelity bond must be issued for a lawful purpose; a contract guaranteeing the fidelity of one’s employees in an illegal pursuit is unenforceable. A fidelity bond issued to a foreign corporation which has no right to do business in a state is, likewise, invalid.

Fidelity bonds take the nature of insurance contracts and are generally subject to the same rules of construction applicable to insurance policies. For example, ambiguities shall favor the insured. The parties to a fidelity bond or policy have the right to write their own contract under whatever terms they require. Further, a fidelity bond is not binding on the insurer when not signed by the employee.

A surety on a fidelity bond is liable for losses only when they are caused by the derelictions occurring within the period of time covered by the bond. The bond may validly limit the liability of the surety to losses occurring within a specified term or period of time. This
practice thereby excludes liability for acts occurring prior to the effective date of the bond and acts occurring after the expiration of the bond.

Often fidelity bonds are issued to insure the integrity and honesty of officers and employees who are reelected or reappointed to their offices or employments. Where the officer or employee holds a continuous office subject to the pleasure of his superiors, it is held that the continuity of the office has not changed by an annual reappointment, so the party is covered by the bond during the entire time that the party holds the office.

A different rule is applied where the contract of the parties evidences that the fidelity bond is limited to a particular term or time during which the bonded person holds the covered position. The period covered by a fidelity bond and the renewals thereof depends upon the intention of the parties ascertained from the terms. The renewal of a fidelity bond constitutes a separate and distinct contract for the period of time covered.

Some fidelity bonds contain provisions specifying the grounds for the termination of the bond. A clause may authorize the surety or the employer to terminate the bond by giving the other party a notice within a specified advance time. A clause may provide that the bond shall terminate upon the discovery by the employer of any act of infidelity or default on the part of the employee. However, even the strongest suspicion does not amount to knowledge or discovery of dishonesty and nothing short of the discovery of dishonesty, fraud or the positive breach of the imperative conditions will terminate the bond.

A fidelity bond insuring an employer against the dishonesty and/or fraud of a particular employee terminates upon the death of the employer, even though the employer's business is continued by his executors.

In order to hold a surety or insurer liable under a fidelity bond, the loss insured against must be caused by the person whose fidelity is insured and while that person is acting in the particular capacity or position for which his or her fidelity is insured.

Fidelity bonds frequently insure an employer against losses caused by the wrongful acts or conduct of “employees.” The existence of an employer-employee relationship has been sustained where the insured has control over the activities of the alleged employee. If a person performs the duties of an employee, that person is held to be an employee within the terms of a fidelity bond regardless of whether that person is called an employee, agent, broker, salesman, etc. Whether the parties have properly used the generic term “employee” is immaterial.

Ordinarily, the term “employees” applies only to those persons who are regularly and permanently employed by the insured employer. It does not cover an employee of another company, for example, who at its direction merely reported to the insured temporarily for work, and then reported back to his or her own employer.

Generally, where a person occupies a dual position as employee of two or more entities, it is necessary to determine in which capacity he acted when he caused the loss by his misconduct or infidelity. If the loss occurs through acts performed under both employments, the sureties on the fidelity bonds to the different employers are jointly liable.

A corporate director is not an employee under a fidelity bond defining the term “employees” as “officers, clerks and other persons in the insured’s direct employ.” However, the director is not necessarily excluded from the class of “employees” and can be covered by special wording of the policy.

In order for a surety or insurer to be liable under a fidelity bond, the loss suffered by the insured employer must have been caused by acts or defaults contemplated by the bond. The
particular type of misconduct covered by the fidelity bond must be expressly specified, and the bond does not provide coverage for other kinds of misconduct that are not specified.

Ordinarily, a fidelity bond does not cover acts or defaults committed outside the scope of employment. Also, there is no coverage where an employee causes the employer loss in connection with a business other than the one which is designated in the fidelity bond. However, the fact that the wrongful act was committed by the employee after working hours does not preclude coverage for the resulting loss.

Some fidelity bonds limit their coverage to acts or defaults committed at a particular place or location. However, the fact that an employee works at a place other than that described in the terms of the bond does not preclude recovery where the contract permits “interchanges or substitutions among any of the employees.”

Often fidelity bonds are conditioned upon a faithful discharge of duties covering losses resulting from negligence of the bonded employee. Even though a fidelity bond does not use the term “negligence,” but does insure the faithful discharge of an employee’s duties, it is held that if the employee, knowing the risk involved, fails to use such diligence in protecting the property entrusted to his care as should be used by an ordinarily prudent person, the surety may be held liable from the resulting loss. However, fidelity bonds conditioned upon a faithful discharge of duties do not provide coverage where the loss results from the incompetence of the employee.

Fidelity bonds cover losses caused by purposeful acts or conduct on the part of the bonded person amounting to fraud, dishonesty, larceny, embezzlement, wrongful abstraction, misappropriation and the like. However, there is no recovery for these or similar acts when there is only a mistake, carelessness, or error of judgment on the part of the bonded person.

The general principles of concealment, representations and warranties which apply to insurance contracts generally are applicable to fidelity bonds. For example, it would be fraudulent for an employer, without making full disclosure, to apply for and accept a fidelity bond upon an employee whom he knows or believes to be untrustworthy or guilty of conduct which makes him unfit for a position of trust. Further, as a general rule, a surety or insurer on a fidelity bond is released from liability where the employer, in obtaining the bond, knowingly misstated facts or deliberately concealed them.

A fidelity bond may validly impose upon the insured employer the requirement of taking steps to bring about the prosecution and conviction of the defaulting employee and may make performance of such obligation a condition to recovery. Such a provision, however, requires only that the employer make reasonable efforts to bring about the prosecution and conviction of the defaulting employee. If he has made such reasonable efforts he is entitled to recover on the bond, although no indictment is actually returned against the employee.

An insured employer under a fidelity bond cannot recover from the surety if he releases the defaulting employee from liability. For example, if upon discovery of default, the employer and employee, without the consent of the surety, enter into a new contract having resolved their differences, the surety is released from liability.

Even in the absence of an express provision in the fidelity bond, an employer who retains in his employment an employee who has been guilty of conduct that breaches the bond and conceals this fact from the surety cannot hold the surety liable for subsequent defaults of the employee.

Unless specifically stated otherwise within the terms of the bond, a material change in the nature of the duties of the person whose fidelity is guaranteed acts to release the surety from
liability for acts committed after the change in the person’s duties. However, this is
distinguished from the mere addition of further duties to the person’s usual tasks. If a crime is
committed after the termination of a bonded person’s employment, the surety is not liable,
even if the conspiracy was formulated during his or her employment.

Unless otherwise stated under the terms of the fidelity bond, the employer is required to
provide notice of loss when he has actual knowledge of the loss or dishonest act. This is
distinguished from the time the employer may merely suspect wrongdoing. The employer is
required to be diligent in making discovery or obtaining knowledge regarding suspected
wrongdoing. The liability of the surety is generally reduced in the event the insured employer
recovers any part of the loss.

**Rules of Bailment**

A “bailment” is defined as the delivery of personal property by one person to another for a
specific purpose with a contract, expressed or implied, that this trust shall be faithfully
executed. The property is returned or duly accounted for by the bailee when the special
purpose of the bailment is answered or is kept until the bailor reclaims it.

The word “bailment” is derived from the French “bailer,” meaning “to deliver.” “Bailee” is the
term applied to the person who receives possession or custody of the property, thereby
constituting bailment. “Bailor” is the term given to the person from whom the property is
received.

The only property that can be the subject of a bailment is personal property, including money
and personal belongings.

Some examples of particular classifications for transactions to which the law of bailments
applies follow:

- “Depositum” is a deposit of goods to be kept for the bailor by a person usually called a
depository. Custody, as opposed to service, is the chief purpose here. The depositary
only holds the goods for safekeeping without any personal benefit.
- “Mandatum” is a delivery of goods to someone who is to carry or do something to
them, without compensation.
- “Commodatum” is a lending or hiring of personal property to another with the property
to be used by the bailee for his own pleasure or in his own business.
- “Pignori acceptum” or “vadium” is the pawn or delivery of goods as security for a debt,
where the title actually passes until the bailor reclaims it.
- “Locatum” is the delivery of goods, always with reward, such as the bailee who gains
temporary use of the goods.

The Consumer Leasing Act regulates contracts in the form of leases or bailments for the use
of personal property for periods exceeding four months. Here a consumer lease is defined as
a contract in the form of bailment for a period exceeding four months and not exceeding
$25,000, primarily for personal, family or household purposes. Bailments for agricultural,
business, commercial or governmental purposes are specifically excluded.

Each lessor is required to give the lessee, before consummation of the lease, a dated written
statement with all pertinent information concerning the terms, including such things as the
identification of the property, amount of money to be paid or to become payable, express
warranties and guaranties, insurance requirements, security interests, and liabilities on the
expiration of such. Penalties or other charges for delinquency, default or early termination may be specified in the lease.

**Redlining**

Case law has defined “redlining” as discrimination based on the characteristics of the neighborhood surrounding the dwelling. It is the denial of home mortgage loans or insurance coverage in these areas based on geography rather than risk. Redlining evolved when financial institutions and insurance companies literally drew red lines around entire neighborhoods, usually poor and minority communities, deemed off-limits for loans and homeowners insurance. Redlining is now illegal.

Crime is often higher in urban areas, making them riskier to insure. Insurance carriers often cite loss costs being demonstrably higher for these areas, accounting for more stringent underwriting rules and higher premiums.

Over the years, civil rights groups have filed complaints accusing major insurance carriers of redlining, stating that the concept of “risk” is often used as an excuse for prejudice. Lobbyists for the poor have long claimed that this practice denies their clients fair access to the financial system.

One solution to the problem of redlining was introduced when the Federal Crime Insurance Program was established by Congress in 1970 and began operation in August 1971. The Federal Crime Insurance program is a national insurance program administered by the Federal Insurance Administrator. The program’s purpose is to make available crime insurance policies in high crime areas where an availability problem exists. These policies provide coverage for individual and business losses due to burglary and robbery and are made available when private insurance is not.

**Preventive Measures**

Most insurance companies offer reductions in premiums to those who take preventative measures in keeping their homes, businesses, automobiles and personal property secure. Keeping property secure causes a likeliness of avoidance of crime. It is well documented that education and preventative efforts can contribute toward substantial decreases in crime.

To commit a crime, a criminal needs two things: an opportunity and a victim. Some efforts for which insurance companies reward prevention with decreased premiums are keeping the home secure with deadbolt locks, window locking devices, special outdoor lighting and monitored alarms. Automobile theft can be discouraged with the use of car alarms or supplemental security devices. Insurance companies often offer premium reductions for these devices. With regard to businesses or commercial properties, efforts such as security gates, deadbolt locks, and guards or guard services are often given premium reductions.

Neighborhood watch programs have proven to be effective crime deterrents. They offer a constructive way to channel anger over crime. Police departments and citizens’ organizations suggest that promoting social interaction and fighting isolation may be the most effective weapon against crime.

**Conclusion**

Some producers may be reluctant to discuss crime with customers because it may seem like they are trying to scare people into purchasing insurance products. Although insurance producers should not unduly frighten prospects, it is important that the industry make customers aware of the dangers of crime that exist and the coverage available to protect against losses from these dangers.
Chapter Four / Workers’ Compensation And Unemployment Insurance

CHAPTER 4 – WORKERS’ COMPENSATION AND UNEMPLOYMENT INSURANCE

Introduction

Workers’ compensation laws provide cash benefits, medical care, and rehabilitation services to workers who are disabled from work-related accidents or occupational disease, and death benefits to the survivors of workers killed on the job. Workers’ compensation laws exist in all states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands. Two federal workers’ compensation laws also are in operation. The various workers’ compensation laws differ widely with respect to coverage, adequacy of benefits, rehabilitation services, administration, and other provisions.

In this text, we analyze the various state workers’ compensation laws, considering in particular the following areas:

- Development of state workers’ compensation laws.
- Objectives and theory underlying the laws.
- Provisions and concepts in workers’ compensation laws.

Development of State Workers’ Compensation Laws

Workers’ compensation was the first form of social insurance to develop in the United States. Its development can be conveniently analyzed in three stages:

- The common law of industrial accidents.
- The enactment of employer liability laws.
- The emergence of workers’ compensation legislation.

These concepts are discussed below.

Common Law of Industrial Accidents

The common law of industrial accidents was the first stage in the development of workers’ compensation in the United States; its application dates back to 1837. Under the common law, workers injured on the job had to sue their employers and prove negligence before they could collect damages. The employer was permitted to use three common law defenses to block the worker’s suit:

- Under the contributory negligence defense, injured workers could not collect damages if they contributed in any way to their injuries.
- Under the fellow servant defense, an injured worker could not collect if the injury resulted from the negligence of a fellow worker.
- Under the assumption of risk defense, the injured worker could not collect if he or she had advance knowledge of the dangers inherent in a particular occupation.

As a result of these harsh defenses, relatively few disabled workers collected damages for their injuries. Lawsuits were expensive, and the damage awards were small. Furthermore, legal fees had to be paid out of these small awards, and there was considerable uncertainty regarding the outcome of the lawsuit.

The disabled worker had two major problems to solve: the loss of income from the disabling accident and the payment of medical expenses. Under the common law, these problems
were largely unsolved, resulting in great economic insecurity and financial hardship to the disabled workers.

**The Enactment of Employer Liability Laws**

Because of the deficiencies in the common law, most states enacted employer liability laws between 1885 and 1910. These laws lessened the severity of the common law defenses and improved the legal position of the injured workers. For example:

- Three states substituted the less severe doctrine of comparative negligence for contributory negligence.
- The fellow servant rule and assumption of negative risk doctrine were modified.
- Employers and employees were denied the right to sign contracts that would relieve employers of legal liability for industrial accidents.
- Surviving dependents were allowed to sue in death cases.

Despite some improvements, however, the fundamental problems experienced by disabled workers still remained. The injured employee still had to sue the employer and prove negligence, and there were still long delays in securing court action. Lawsuits remained costly and the legal outcome was uncertain. Also, the worker still had problems of maintenance of income during disability and payment of medical expenses.

**Emergence of Workers’ Compensation Legislation**

The Industrial Revolution, which changed the United States from an agricultural to an industrial economy, caused a great increase in the number of workers who were killed or disabled in job-related accidents. Because of limitations on both the common law and the employer liability statutes, the states began to consider workers’ compensation legislation as a solution to the growing problem of work-related accidents.

Workers’ compensation was slower to develop in the United States than it was abroad. Workers’ compensation laws existed in parts of Europe in the 1880s, and by 1903, most European countries had enacted some type of workers’ compensation legislation. In 1902, Maryland passed a law, but it was limited in application and was subsequently declared unconstitutional. The stimulus for enactment of state workers’ compensation laws started in 1908, when the federal government passed a law covering certain federal employees, and by 1911, ten states had passed workers’ compensation laws. By 1920, all but six states had enacted such laws. Workers’ compensation programs exist in all states today.

Workers’ compensation is based on the fundamental principle of liability without fault. The employer is held absolutely liable for the occupational injuries suffered by the workers, regardless of who is at fault. The injured worker is compensated for his or her injuries according to a schedule of benefits established by law and does not have to sue the employer to collect benefits. The laws provide for the prompt payment of benefits to injured workers, regardless of fault, with a minimum of legal formality.

**Objectives of Workers’ Compensation Laws**

There are five basic objectives in workers’ compensation laws:

- Broad coverage of employees for occupational injury and disease.
- Substantial protection against loss of income.
- Sufficient medical care and rehabilitation services.
- Encouragement of safety.
• An effective delivery system for benefits and services.

We now discuss each of these objectives.

**Broad Coverage**

Broad coverage means that the laws should cover most employees for all work-related injuries and occupational diseases. Reasons why certain groups should be excluded have been presented, but the arguments have not withstood careful analysis. Arguments have been presented citing that some firms should be excluded because they are small, have poor safety records, or are reluctant to bear the cost of workers’ compensation benefits.

States have extended their workers’ compensation laws to cover most firms without undue financial distress. If the cost of covering certain excluded groups is high, then the disabled workers and society in general are bearing the costs of occupational injuries to these groups in the form of poverty or welfare programs. For these reasons the states have concluded costs should be charged to the firms and not to society. Broad coverage through workers’ compensation benefits society as a whole by preventing workers from becoming dependents of the states.

**Substantial Protection Against Loss of Income**

The second basic objective of workers’ compensation laws is that the benefits should replace a substantial proportion of the disabled worker’s lost earnings. The measure of a worker’s economic loss is the lifetime reduction in remuneration because of occupational injury or disease. Gross remuneration consists of basic wages and salaries, irregular wage payments, pay for leave time, and employer contributions for fringe benefits and Social Security benefits. The measure of loss is the difference in net remuneration before and after the work-related disability. This net remuneration reflects taxes, job-related expenses, fringe benefits that lapse and uncompensated expenses that result from the disability.

The view that workers’ compensation should restore a large proportion of the disabled worker’s lost remuneration can be justified by two major considerations.

• First, workers’ compensation is social insurance, not public assistance. Public assistance programs provide benefits based on a person’s demonstrated need. Workers’ compensation benefits, however, should be closely related to the worker’s loss of present and future income and so should be considerably higher than a subsistence level of income.

• Second, in exchange for the workers’ compensation benefits, disabled workers renounce their right to seek redress for economic damages and pain and suffering under the common law. Other social insurance programs, including Social Security and unemployment insurance, do not require the surrender of a valuable legal right in exchange for benefits.

Under workers’ compensation, both minimum and maximum weekly cash payments must be established. A minimum benefit is one necessary to keep the disabled worker off welfare. A maximum amount is set because highly paid workers are in a position to provide for their own disability income insurance if the workers’ compensation benefits are inadequate and is also necessary so as not to encourage abuse by creating an incentive not to work.

**Sufficient Medical Care and Rehabilitation Services**

Workers’ compensation also has the objective of providing sufficient medical care and rehabilitation services to injured workers. The laws require the employer to pay medical, hospital and surgical expenses, and other medical bills relating to the disability.
Vocational counseling, guidance, retraining and other rehabilitation services are also provided to restore the injured worker to gainful employment. Disabled workers who can be returned to productive jobs can experience a feeling of well-being and worth as a result, and adequate and prompt rehabilitation services can reduce workers’ compensation costs.

**Encouragement of Safety**

Workers’ compensation programs also encourage safety and the development of sound safety programs. Experience rating is used to encourage firms to be safety-conscious and to make a determined effort to reduce industrial accidents, since firms with superior accident records pay relatively lower workers’ compensation premiums. For safety-conscious firms, the end result is often an improvement in the competitive position. For instance, firms and industries with superior safety records generally are not penalized for others’ lack of safety standards and initiatives. The laws allocate the costs of industrial accidents and occupational disease among those firms and industries responsible for them, so a firm or industry with a poor safety record may have to increase its prices, thereby losing some customers to other firms with lower rates of injury and disease. An individual firm with a poor safety record will generally have higher costs and lower profits, which weaken its competitive position.

**An Effective Delivery System for Benefits and Services**

Finally, the workers’ compensation programs have the objective of providing an effective delivery system, by which the benefits and services are provided comprehensively and efficiently.

Comprehensive performance means that workers’ compensation personnel should exist in sufficient numbers and quality to carry out the objectives of the program. High-quality performance is expected of employers, physicians, state courts and workers’ compensation insurers and agencies.

Efficient performance means that the services necessary to restore an injured worker are provided promptly, simply and economically.

**Disability Insurance Programs**

Workers’ compensation statutes ordinarily provide four classifications of disability. These classifications are determined by the severity or extent of the disability, with the disability characterized as either partial or total. Additionally, disabilities are affected by their duration and are characterized as either permanent or temporary. The four common disability classifications are:

- Temporary partial.
- Temporary total.
- Permanent partial.
- Permanent total.

These classifications, in conjunction with the employee’s average wages and appropriate statutory formulas, provide the basis for disability benefit computation.

**Temporary Partial Disability**

A temporary partial disability is present when an employee who has been injured on the job is no longer able to perform that job, but for the period of disability is able to engage in some kind of gainful employment. Temporary partial disability compensation is designed to pay an injured worker for lost wages. This classification promotes the prompt return of an injured
employee to the work force. Examples of this type of injury include sprains, minor fractures, contusions, and lacerations.

The critical factor in determining the temporary partial classification may be the impairment of the employee’s earning capacity.

**Temporary Total Disability**
The condition of temporary total disability exists when an employee is unable to work at all for a temporary, but undetermined, amount of time. One may be totally disabled, even though not completely helpless or wholly disabled. Examples of injuries that can result in temporary total disability are serious illnesses, heat exhaustion, and disabling back injuries. Temporary total disability is designed to provide compensation to an injured worker for the economic losses incurred during a recuperative period.

**Permanent Partial Disability**
A permanent partial disability may be found when a permanent and irreparable injury has occurred to an employee; in other words, one that probably will continue for an indefinite period with no present indication of recovery. For example, one who loses a foot on the job will experience a period of temporary total disability during hospitalization and recuperation. At the point in time when maximum medical improvement has been attained, the disability should be classified as permanent partial. The employee is now able to perform some gainful work. The purpose of permanent partial disability is to provide compensation for the employee’s reduced earning capacity.

There are two types of permanent partial disabilities: Scheduled and nonscheduled.

- **Scheduled Injuries** – are listed in the law and include the loss of an eye, arm, leg, hand, finger or other member of the body. In most states, the amount paid for a scheduled injury is determined by multiplying a certain number of weeks (based on the bodily member involved) by the weekly disability income benefit. In most states, the amount paid for a scheduled injury is in addition to the benefits paid during the healing period or while the worker is totally disabled. In most states, if a scheduled injury produces additional disability to other parts of the body, the employee will be able to recover an amount in excess of that provided in the schedule; for example, the loss of a foot could produce traumatic neurosis.

- **Nonscheduled Injuries** – are disabilities of a more general nature and involve the loss of earning power to the body as a whole, such as a back or head injury that makes working difficult. The benefit paid for a nonscheduled injury is generally based on a wage-loss replacement percentage. The percentage is applied to the difference in earnings before and after the injury, multiplied by a certain number of weeks. In some states, nonscheduled permanent partial disability benefits are based on a percentage of a total disability case.

**Permanent Total Disability**
The condition of permanent total disability exists when an employment-related injury renders an employee permanently and indefinitely unable to perform any gainful work. An employee need not be entirely helpless or completely incapacitated in a medical sense. The so-called “odd-lot” doctrine permits the finding of a permanent total disability for workers who are not completely incapacitated but are handicapped to such an extent that they cannot become regularly employed in a capacity in which they are skilled; the worker is said to have been left in the position of an “odd-lot” in the labor market.
One may receive a permanent total disability on the basis of a scheduled loss; for example, loss of sight in both eyes can be a scheduled loss that requires compensation as a permanent total disability. It is difficult to generalize about permanent total disabilities, but the following factors are generally relevant to such determinations: age, experience, skills and training, education, nature and extent of injury, employment history, and nature of employment at the time of injury.

**Workers’ Compensation Laws**

The United States Constitution prohibits states from enacting laws that impair contract obligations. As a result of this general prohibition and the parallel provisions sometimes found within state constitutions, some workers’ compensation acts were held at one time to violate these provisions. The general view is that even if a workers’ compensation act impairs an existing contract obligation between an employer and employee, the impairment may nevertheless be valid because a proper exercise of the state’s police power has occurred. The health, safety, and welfare of the people are of overriding importance.

Many of the original workers’ compensation acts were said to be elective in order to avoid the constitutional difficulties imposed by the impairment of contract clause. The majority of states have enacted constitutional amendments that eliminate the constitutional difficulties originally imposed in this area. Virtually all states today have compulsory coverage.

This has generally been accomplished by state constitutional amendments authorizing workers’ compensation statutes. These state amendments grant the necessary legal power for the enactment of workers’ compensation laws. The grants include the power to enact all reasonable and proper provisions necessary to carry out the law and to fulfill the objectives of the constitutional provisions. Needless to say, the legislation cannot exceed whatever limitations exist in the constitutional provision.

Regardless of whether a workers’ compensation act is compulsory or elective, it generally affords the exclusive remedy for employees or dependents against employers for personal injuries, diseases, or deaths arising out of and in the course of employment. The exclusivity provision of workers’ compensation acts is the keystone of all such legislation. The employee or dependents recover without regard to fault, and the employer is spared the possibility of large tort verdicts.

**State Workers’ Compensation Laws**

A limited number of states have elective laws, whereby the employer can either elect or reject the state plan. Under elective plans, if the employer rejects the act and the injured worker sues for damages based on the employer’s negligence, the employer is deprived of the three common law defenses of contributory negligence, fellow servant rule, and assumption of risk.

Although most firms elect workers’ compensation coverage, some do not, so some disabled employees are unable to collect benefits unless they sue for damages. Elective laws also permit firms’ employees to reject coverage, but they seldom do. Under most elective laws, it is presumed that both the employer and the employees elect coverage, unless a specific notice of rejection is filed prior to a loss.

Employers can comply with the law in one of three ways:

- Purchasing a private workers’ compensation policy.
- Most firms purchase a workers’ compensation policy from a private insurer. The policy guarantees payment of the benefits that the employer is legally obligated to pay to the disabled workers.
• Obtaining protection from a monopoly or competitive state fund.

In some jurisdictions, employers generally must insure in a monopoly state fund. Monopoly state funds have been established for the following reasons:

• Workers’ compensation is social insurance, and private companies should not profit from the business.
• Monopoly state funds should have reduced expenses because of economies of scale and no sales effort.
• Monopoly state funds are intended to have greater concern for the welfare of injured workers.

Other states permit employers to purchase insurance from either private insurers or competitive state funds. Competitive state funds are established for the following reasons:

• The fund provides a useful standard for measuring the performance of private insurers.
• The states want to make certain that all employers can obtain the necessary protection.
• A competitive fund operates more efficiently if it faces competition from private insurers.

Employers who do not meet the insurance requirements are subject to fines, imprisonment or both. Also, some states prohibit the employer from doing business in the state until the insurance requirements are fulfilled.

• Self-insuring.

Self-insurance programs are common and permitted in most states. Employers who meet certain requirements may pay their workers’ compensation liabilities directly, rather than by purchasing insurance. As insurance premiums rise, this has become an attractive option for employers with the size and expertise to administer such a program. Self-insurance programs exist in all but a very limited number of jurisdictions.

Temporary Disability Laws

A number of states have laws providing temporary disability benefits. These laws provide benefits for workers who are temporarily disabled by injuries or illness not related to their employment. Benefits may be paid by a state fund, a private insurance company or directly by a self-insured employer.

Temporary disability benefits cover persons who are unable to work because of illness or injury, but who do not qualify for benefits under workers’ compensation or unemployment compensation laws. Workers’ compensation laws cover only injuries or illnesses that are work-related; unemployment laws require that beneficiaries be able and available to work.

While temporary disability laws often share definitions and exclusions with the state unemployment law, temporary disability benefits are often specifically extended to workers not covered under the unemployment laws.

Employers who operate in states having these laws are required to perform certain duties in connection with the laws. Temporary disability benefits may be financed by employee contributions withheld by the employers, employer contributions or a combination. Even in the states where the plans are financed solely by employee contributions, employers are responsible for withholding the contributions, paying them to the state government, and filing
reports in connection with the withholding. Employers who fail to comply with these requirements are subject to penalties.

The state disability benefits laws vary considerably, but most permit employers to substitute an approved plan for the state plan.

As stated earlier in the discussion of the development of worker’s compensation, the common law remedies and the statutory actions provided by the various employers’ liability acts form the underlying layer of law upon which a remedy can be based when the applicable workers’ compensation act fails to provide coverage. Thus, common law and statutory actions remain important. These laws and actions are also extremely important when there is third-party involvement and recovery is sought against them. Third parties are not covered by the act and are not allowed to limit their liability in the same manner as an employer.

Workers’ Compensation – State Requirements and Concepts

Workers’ compensation is a system of state laws, rather than an umbrella federal law. Therefore, requirements vary widely from state to state. It is necessary to know the following terms to be able to discuss application of policy.

- **Employee coverage and exemptions.**
  Coverage by the workers’ compensation law is determined by the number of employees. Special rules apply regarding which employees are counted, and there are special rules applying to specific occupations, such as construction.

- **Minors.**
  Minors are covered by the law in every state. Minors employed illegally, however, may be entitled to double or even triple compensation. Because benefit amounts are set based on the employee’s average weekly wage, and minors are generally low-paid, the illegally employed minor’s potential future earnings (what the worker might have earned as an adult, if not injured) may be considered in setting benefits in some states.

- **Exempt employees.**
  These are employees who are specifically exempt from the law. In some cases, there may be limits on the hours worked or wages paid in order for the exemption to be effective.

- **Exempt injuries.**
  Exempt injuries include only those incurred in activities or through actions on the workers’ part for which no compensation is payable. Many states provide for reduced benefits in certain circumstances, as when the employee is injured as a result of intoxication or failure to obey safety rules.

- **Employer coverage.**
  Generally, any employer in the state, regardless of safety history, can secure insurance from the state fund.

- **State funds.**
  State funds are essentially state-run insurers. Some state-fund states prohibit private insurance.

- **Private insurance.**
  Most states permit private insurance. However, some state-fund states prohibit it.
• Self insurance.
As stated earlier, self insurance is also permitted in most states.

• Insurance options.
Insurance options are gaining in popularity. Included under this heading are programs ranging from those permitting employers to use PPOs or other managed care programs to provide medical benefits while controlling costs, and to programs allowing employers to replace their traditional workers’ compensation insurance with some combination of life, disability, accident, health or other insurance.

• Deductibles.
Deductibles have become an increasingly popular cost-savings option.

• Waiting period.
This is the period of time after an accident, during which benefits, other than medical treatment, will not be paid. Generally, the waiting period will be excused after the injury has lasted a certain amount of time. For example, benefits may not be paid for the first three days of disability unless the disability lasts 14 days or more.

• Stress or mental disability.
Injuries of this type are usually mentioned in some state laws. Many of these laws provide fairly stringent limits on benefits for such injuries.

• First choice of physician.
The first choice of physician may be given to the employee or to the employer. A number of states allow a second choice, if the employee or employer is dissatisfied with the first choice.

• Fee limits.
A number of states are imposing fee limits. These may take the form of actual schedules of approved fees for specified procedures or may be more general, limiting fees to “prevailing rates in the community” or to “usual and customary costs.”

• Benefit amounts.
Under the workers’ compensation laws of the various states, benefit amounts set the wage replacement/indemnity benefits payable to injured workers and dependents of deceased workers.

• Total disability.
These are the total benefits payable to workers unable to work as the result of an occupational injury or, in most states, disease. Permanent total disabilities are those which render the employee unable to engage in remunerative employment. In some states, certain injuries (loss of eye(s) or limb(s)) are considered permanently, totally disabling even if the worker is able to perform some services after recovery. Temporary total disability benefits are paid during a period of recuperation, where the employee has expectations of regaining sufficient health to return to work.

• Partial disability.
These benefits are paid to workers whose ability to earn has been impaired by an injury. However, some injuries are considered inherently disabling, and permanent
Partial disability benefits may be paid, regardless of earnings loss. Often, these benefits are expressed in terms of benefits to be paid for a specific number of weeks for a specific injury. For example, loss of a thumb may be compensated for 300 weeks, loss of one phalange of a finger compensated at the same rate for 100 weeks, etc. Injuries not specified in the law may be compensated in terms of the entire benefit for a part of the maximum number of weeks proportional to the degree of disability.

Temporary partial disability is the least clearly-defined of the injury categories. Often, however, it is used as a stop-gap, being paid to individuals between the time of the injury and the time of maximum medical improvement, when, if the worker remains unable to perform the pre-injury job, wage loss or permanent partial disability benefits begin.

- **Survivor’s benefits.**
  
  When an employee is killed on the job or dies as a result of an occupational injury or disease, persons dependent on that employee are entitled to compensation. A surviving spouse and minor children are compensated automatically in virtually all states. Most states also have provisions for other persons who may have been dependent on the worker, such as parents, grandparents, siblings, etc. Burial expenses are also payable in all states.

- **Payment of claims.**
  
  Medical coverage is usually provided in full, without any dollar or limits on the amount paid. Medical costs now account for 40 percent of workers’ compensation benefits.

  Disability income benefits are payable after the disabled worker satisfies a waiting period that usually ranges from three to seven days. If the worker is still disabled after a certain number of days or weeks, most states pay benefits retroactively to the date of the injury.

  The weekly benefit amount is based on a percentage of the worker’s average weekly wage and the degree of disability. Most states have minimum and maximum dollar limits on the weekly benefits. In addition, in most jurisdictions, the maximum weekly benefit is automatically adjusted each year based on changes in the state’s average weekly wage. In 40 states, the maximum weekly cash benefit for temporary total disability cases now equals or exceeds 66 2/3 percent of the statewide average weekly wages; of these states, 29 now pay a maximum weekly benefit of 100 percent or more of the statewide weekly wage.

- **Death benefits.**
  
  Death benefits are also payable if the worker is killed on the job. Two types of benefits are paid. First, a burial allowance is paid. Second, cash income payments can be paid to eligible surviving dependents. A weekly benefit based on a proportion of the deceased worker’s wages (typically 66 2/3 percent) is usually paid to a surviving spouse for life or until he or she remarries. Upon remarriage, the widower/widow usually receives a lump-sum benefit, such as one or two years of payments. Benefits also can be paid to the children until age 16, 18, or later if the children are incapacitated. Many states, however, have amount or time limits on the maximum that can be paid.
• Rehabilitation services.

Rehabilitation services are also available in all states to disabled workers to restore them to productive employment. In addition to weekly disability benefits, workers who are being rehabilitated are compensated for board, lodging, travel, books and equipment. Training allowances are also paid in some states.

• Second injury funds.

All states have second injury funds. The purpose is to encourage employers to hire handicapped workers. If a second-injury fund did not exist, employers would be reluctant to hire handicapped workers because of the higher benefits that might have to be paid if a second injury occurs.

For instance, assume that a worker with a pre-existing injury is injured in a work-related accident. The second injury, when combined with the first injury, produces a disability greater than that caused by the second injury alone. Thus, the amount of workers’ compensation benefits that must be paid is higher than if only the second injury had occurred. The employer pays only for the disability caused by the second injury, and the second-injury fund pays for the remainder of the benefit award.

Workers’ Compensation Financing

Workers’ compensation benefits are financed by employer premiums or self-insurance payments, based on the theory that the costs of job-related accidents or disease are part of the cost of production. However, a few states also have provisions for nominal contributions by covered employees for hospital and medical benefits.

The actual workers’ compensation premium paid by employers is based on numerous factors, including the size of payroll, industry, occupation of covered employees and industrial operations performed. Smaller firms are class-rated. Class rating means all employers in the same class pay the same workers’ compensation rate. Larger firms, whose annual workers’ compensation premiums are at least $750, are subject to experience rating. Experience rating means the class-rated premium is adjusted upward or downward depending on the employers’ loss of experience and the statistical reliability of that experience.

The purpose of experience rating is to encourage loss prevention by providing employers with a financial incentive to reduce job-related accidents or disease.

Finally, the costs incurred by the states in administering the workers’ compensation laws and supervising insurance carriers, self-insurers and the state funds are financed by legislative appropriations or by special assessments on insurance carriers and self-insurers.

Workers’ Compensation Claims Administration

Most states use a workers’ compensation board or commission to administer workers’ compensation claims. The law is administered either by an independent workers’ compensation agency or by the same agency that administers the state’s labor law. A few states use the courts to administer the claims. The court must either approve the settlement or, if the parties disagree, resolve the dispute.

To receive workers’ compensation benefits, the injured worker must file a claim for benefits with the appropriate workers’ compensation agency and give proper notice to the employer or insurer.
Three principal methods are used to settle non-contested claims:

- **Agreement.** Most states use the agreement method, by which the injured worker and employer or insurer agree upon a settlement before the claim is paid.

- **Direct settlement.** Some states use the direct-settlement system, by which the employer or insurer pays benefits immediately to the injured worker upon notice of disability.

- **Hearing.** Under the hearing method, an industrial commission or board hears the case and must approve it before the claim is paid.

### Workers’ Compensation Pricing

Most states base their workers’ compensation benefits on their statewide average weekly wage, which most commonly is calculated annually. However, states vary in the way they set benefits. Some states set maximum benefits by statute, and those benefits remain in effect until changed by the legislature. In most states at the present time, workers’ compensation insurers use the rates developed by the National Council on Compensation Insurance.

### Prior Approval Rating

Prior approval rating means that workers’ compensation rates are determined for the various occupations and classes by the National Council on Compensation Insurance. These rates must be approved by state regulatory officials, and workers’ compensation insurers must use these rates, subject to any rate deviations allowed under state law. It is argued that approved rating has worked well over time since rates are established for numerous occupations and trades that are ranked according to their risk or hazard level. The rates are based on a broad range of national loss data.

### Competitive Rating

In contrast, competitive rating or open competition means that workers’ compensation insurers are free to develop their own rates based on the competitive market system. A company would be free to establish and charge a particular rate without first obtaining approval of state regulatory officials.

Supporters of the present system of approved rating argue that adoption of a competitive rating will result in several adverse effects. They include the following:

- **Safety may be undermined.** Emphasis on low workers’ compensation rates may force insurance companies to drop the additional expense of providing loss-control services and rehabilitation programs to firms. Since safety services may decrease, future workers’ compensation claims could increase.

- **Small policy owners will be adversely affected.** Critics also argue that under competitive rating, workers’ compensation insurers would rate small firms on the basis of individual loss experience. Thus, smaller firms with a high loss potential would pay much higher premiums for their workers’ compensation coverage than they are now paying.

- **Small insurers would be adversely affected.** Under competitive rating, individual insurance companies must have their own staff of experts to estimate the costs of any benefit changes in the state. Many insurers would have to hire additional persons with the necessary actuarial and underwriting expertise. Many smaller insurers would be confronted with a substantial increase in expenses and may lack the financial resources to develop their own rates. It is argued that, ultimately, many smaller companies would not be able to compete and would withdraw from the workers’
compensation market. This would leave only a small number of large companies to write the coverage.

On the other hand, supporters of competitive rating point out certain advantages that will result from a competitive rating system. They include the following:

- **Price competition will lower rates.** It is argued that under approved rating there is little incentive to reduce rates, even when loss experience is favorable. However, under competitive pricing, it is argued that there would be greater price competition, which would tend to lower rates.

- **Government involvement would be reduced.** Since rates would not have to be approved by state regulatory officials, government involvement in the insurance industry would be reduced. This is consistent with the present national trend of reducing the role of government in the economy.

- **Product innovation would increase.** Eliminating the present system of administered pricing would stimulate the development of new programs and products in workers’ compensation insurance. Thus, policy owners would have a greater opportunity to select their own combination of product, price, and service. In addition, insurers would be able to respond quickly to changing loss and loss experience.

These competing arguments will determine future trends toward price approval or competitive rating.

**Impact of Workers’ Compensation**

It is important to be aware of how social insurance programs like workers’ compensation supplement the private insurance coverage provided by the insurance industry. Unemployment insurance is another form of social insurance that an informed agent should understand as a result of its impact on the client’s overall risk management program.

**Unemployment Insurance**

In 1935, an unemployment insurance system was established in order to provide economic security for workers during periods of temporary unemployment. The original system was created by Title IX of the Social Security Act of 1935. In 1939, the tax provisions of Title IX became the Federal Unemployment Tax Act, under the Internal Revenue Code. Today, the Social Security Act, the Federal Unemployment Tax Act, and numerous amendments to these acts provide the statutory basis for federal unemployment compensation programs in the United States.

The unemployment insurance program relies on cooperative federal and state programs. Federal laws provide general guidelines, standards, and requirements, with administration left to the states under their particular unemployment legislation. The unemployment compensation system is generally funded by unemployment insurance taxes or contributions imposed upon employers. The federal taxes are generally applied to the costs of administration, while the state taxes provide trust funds for the payment of benefits. Federal taxes are paid into a Federal Unemployment Trust Fund, from which administrative costs and the federal share of extended benefits are paid.

The fund is also used to establish a Federal Unemployment Account from which the states can borrow if their state trust funds become depleted. Unemployment taxes should not be confused with the separate Social Security taxes imposed by the federal government, or with the separate disability benefits taxes imposed by some states. Unemployment benefits are taxable as ordinary income.
Federal Unemployment Insurance Programs
The principal vehicle for providing weekly unemployment benefits is referred to as the regular state program. Subject to federal guidelines, the states determine all of the following:

- Qualifying requirements.
- Amounts of benefits.
- Duration.
- Grounds for disqualification.

State unemployment laws vary, and qualification requires a demonstration of employment by an employer subject to the unemployment tax of a particular jurisdiction, and employment during a base period, usually a recent 12 month period. Generally, one must have been employed in more than one quarter.

Payments usually take the form of weekly benefits calculated on the basis of a particular jurisdictions formula. Commonly, an employee’s average weekly wage provides the basis for the weekly benefit amount, and this average amount is determined by dividing one’s high quarter wages by the 13 weeks in a quarter; one-half of the result is the weekly benefit amount paid to the worker. There is usually a one week waiting period prior to the initial payment of benefits.

The duration of unemployment varies with the particular jurisdiction. The vast majority of jurisdictions determine duration on the basis of the length of employment or the amount earned. Usually, the longer the length or the greater the amount, the more weeks of benefits one can receive.

Workers can be denied unemployment compensation if certain grounds for disqualification exist. Policy dictates payment only to those employees who have lost their jobs through no fault on their part. In all jurisdictions, an employee is disqualified from benefits if the worker voluntarily quits employment without good cause or is discharged for employment-related misconduct.

Additionally, disqualification can occur at any time if a claimant or benefit recipient refuses to accept suitable employment without good cause. In order for benefits to continue, a claimant must:

- Register for employment with the jurisdiction’s employment service.
- Be able to work.
- Be available for work.
- Seek work on one’s own.

Claims examiners make initial findings of fact that lead to a grant or a denial of unemployment compensation benefits.

The appellate rights of a dissatisfied claimant are generally guaranteed by Title III, Section 303(a) of the Social Security Act, which requires administration by the states in a manner reasonably calculated to insure full payment of unemployment benefits when due and an opportunity for a fair hearing before an impartial tribunal for all individuals whose claims for unemployment are denied.

An employer’s unemployment experience rating affects the amounts that an employer is required to contribute.
Certain amendments have provided extended, supplemental, or special unemployment benefits, thus increasing unemployment compensation for many unemployed persons in the United States.

**Conclusion**

Workers’ compensation and unemployment insurance are both very important to the individual receiving benefits and society; however, there are many instances in which the needs caused by an illness or disability cannot be fully met by these programs. Private sector insurance does have programs to meet these needs in disability and long term care insurance. We will explore these policies in our next section.
Understanding the Importance of Disability Income

Disability income insurance is one of the most undersold and overlooked markets in the insurance business. In the United States we tend to have a very optimistic outlook. Most of your clients probably give little consideration to what they would do if they became disabled and unable to work for more than a month. The fact is that if we look at the reason many individuals and families fall upon extreme hardship we find that inability to work due to prolonged illness or disability is a common factor.

Disability income insurance may seem expensive to your clients, but its importance is significant. If disability insurance can be afforded, it can help protect against a risk that could be devastating to your clients and their families.

Disability Insurance Concepts

Policy Elimination Period

The policy elimination period is the amount of time the insured will wait before the company begins paying benefits after occurrence of a disability. Therefore an important factor to consider when choosing the elimination period is how long the insured would be able to continue his or her present standard of living in the event of a total disability.

Most policies offer a choice of elimination periods ranging from thirty days to a full year. These periods are typically 60, 90, 180, or 365 days.

Obviously the policy elimination period has a great deal to do with the premium the insured will pay. The longer the insured is willing to wait, the less the policy will cost. The shorter the policy elimination period the higher the cost will be.

You need to consider the following factors in helping your client choose the policy elimination period:

- How much liquidity of assets or savings does the client have?
- Does the prospective insured:
  - Have a short-term disability policy at work?
  - Have sick days, accumulated holidays, or bonus days at work that may be used?
  - Have vacation time coming?
  - Have a spouse earning an income that can be depended upon?
  - Have sources of unearned income from rentals, investments, dividends, interest and the like?

Very carefully make a list of the prospect’s fixed expenses and know exactly how long the above factors can provide an income. With this knowledge you can intelligently assist the prospect in determining the proper policy elimination period.

Benefit Period

Another factor that affects the cost of a disability income policy is its benefit period. The benefit period is the period of time that benefits will be paid for total disability. Typical benefit periods are one year, two years, five years, age 65, or the insured’s lifetime.
Insurance company statistics indicate the average disability lasts 9 to 18 months. However, depending on the occupation and the classification of the occupation, the benefit period is a major consideration.

**Renewal**

There are two types of renewal provisions in disability plans.

- **Non-cancelable.**
  
  If premiums are paid on time to a pre-determined date, usually age 65, the company cannot:
  
  - Cancel the policy.
  - Change any provisions.
  - Add any riders that restrict coverage.
  - Add any changes to the policy.
  - Raise the premiums.

  This type is the most favorable to the insured and therefore the applications that underwriters look at most carefully.

- **Guaranteed Renewable.**
  
  Guaranteed renewable policies only provide the first four guarantees listed above for the non-cancelable policy. This means that the company can raise the premium under certain circumstances. An individual insured cannot be singled out for a premium increase. The company must raise the premium for all policies that are either in a particular class or type of policy.

**Total Disability**

The policy’s definition of “total disability” determines whether the insured will receive payment when a claim is filed.

Total disability is defined by two requirements:

- The insured cannot or is unable to work at one or more of the important duties of his or her regular job.
- The insured is under the care of a qualified and licensed physician.

Claims will be paid only if the insured satisfies both of these requirements.

**Occupations**

One of the most important considerations in issuing a disability policy is the insured’s occupation. Obviously, because of the inherent risks factors the more hazardous the job, the higher the premium.

Therefore, when insurance company underwriters determine the risk classification for a specific occupation, the underwriters take a close look at the following issues:

- Does the job require a lot of travel?
- What kinds of materials, machines, or tools are used at the job?
- What types of products or services are offered?
- Is the insured involved directly in the work or is the job managerial?
• Is the job seasonal in nature?
• Is the occupation prone to layoffs or having hours shortened?

Each of these factors helps determine the level of hazards associated with the occupation, and the appropriate occupational classification can be determined for that occupation.

Disability policies typically use either a class grouping or an alphabetical grouping for occupations.

These classifications are usually set as “AAAA” through “B” with “B” carrying the highest risk of loss to the insurance company.

• Class One (or AAAA).
  Occupations commonly found here are the ones with favorable claims experience such as CPAs, lawyers, dentists, and doctors.

• Class Two (or AAA).
  Occupations in this group are typically managerial, technical, professional, and executive types whose duties are generally restricted to the office.

• Class Three (or AA).
  Occupations here are comprised of supervisors of performing employees but not those that participate in the actual operations. Merchants, salespeople, and store managers are a few examples.

• Class Four (or A).
  Here you will find skilled labor types of occupations such as home construction and small construction.

• Class Five (or B).
  These are the most hazardous of the occupational classifications and the most difficult to insure. Motorcycle police officers, bricklayers, or welders are prime examples.
  The premium charged for the disability policy will be the highest for the Class Five (or B) grouping.

**Income Requirement**

This area is one that is very strictly underwritten as insurance companies do not want to permit the insured to earn more income while disabled than he or she would earn while working. Obviously, this situation would cultivate false claims and lingering disabilities. Therefore, companies place a limit on the percentage of monthly benefits to monthly-earned income. Typically, companies will issue a monthly benefit equal to between 40% and 70% of the insured’s earned income. For example, if earned income is $3,000 per month, a company will allow a monthly benefit of between $1,200 (40% of $3,000) and $2,100 (70% of $3,000).

Underwriters look at “earned income,” which is the income an insured earns for work performed. Companies also look at “unearned income” such as rental income, royalties, investments, or dividends. Since this is income that would normally continue even if the insured were disabled it is generally not considered in the percentage formula and in some cases, it may even reduce the amount the company is willing to issue as a benefit.
**Definition of “Disabled”**

Various definitions are used to describe “disabled” as it applies to the payment of benefits under disability insurance policies. The particular definition will be an important factor in the decision regarding to which policy is the best choice for each client.

The common definitions for “disabled” are the inability to work in

- The insured’s regular occupation; or
- Any occupation for which the insured is reasonably suited based on his or her training or experience.

“Insured’s regular occupation” – This definition is the best of the choices for the insured, since it will consider the insured disabled and qualified to receive benefits even if the insured could perform work other than exactly the work he or she has been performing.

“Any occupation for which the insured is reasonably suited” – This is the less favorable definition for the insured, as this type of policy would only pay benefits when the insured could not work in any occupation for which the insured is reasonably suited based on his or her training or experience.

Some policies offer a combination approach to the definition of “disabled.” This approach is the second best choice for the insured, as the insured would not be considered disabled in the same way for the full benefit period. For example if the benefit period were 5 years, the policy may cover 3 of those years under the regular occupation definition and then switch to the reasonably suited definition for the remainder of the benefit period.

Some policies also provide partial disability benefits if the insured has lost a portion of his or her income due to disability.

**Waiver of Premium**

A “waiver of premium” provision is included in most disability contracts. It states that if the insured is disabled more than 6 months (some may state 90 days) the premiums are waived until the insured goes back to work and is no longer disabled, or until the benefit period expires. Some policies also refund the premiums paid during the 6 month (or 90 day) period while waiting for the waiver provision to start.

**Exclusions**

There are three specific exclusions that commonly appear in most disability policies:

- Self inflicted injury.
- Pregnancy.
- War.

**Grace Period**

The grace period is defined as the period of time beyond the due date that the insured may pay the premium without the policy lapsing. The grace period is 31 days in most disability policies. During the grace period, the policy stays in force so long as the insured pays the premium that is due before the end of the 31st day.

**Contestability**

Disability policies contain a period of contestability that is usually two years. It should be noted that some policies exclude periods of disability during the two years. During the period of contestability the insurance company is given time to determine if any misstatements were
made so that it can have the option of either rewriting the policy, or canceling it. After two years, there is nothing that can be done if misstatements are discovered.

**Disability Policy Options**

**Customizing the Policy**

Flexibility is one of disability income’s strong suits in that companies offer a number of options to customize the disability policy.

The following are common options that are available to customize the policy:

- **Cost of living.**
  
  This is an excellent option considering the steady trend of inflation. This option permits the insured to increase the monthly income benefit based upon certain factors. The increase may be tied to the Consumer Price Index or it can be guaranteed up to specific limits, as cost of living provisions contain a cap on the maximum increase. Others have no cap and allow the insured to continue increasing coverage until age 65.

- **Future increase of monthly benefit.**
  
  This option allows the insured to increase the monthly benefit without evidence of insurability on specific future dates. Examples of times in which the insured may increase the monthly benefit include:
  
  - Every fourth policy year anniversary up to a specific number or amount.
  - The birth of a child.
  - Marriage.
  - Purchasing a new home.
  
  Typically, the policy states that when any of the above events take place, the insured may increase the monthly benefit by a specific amount up to a final monthly maximum.

- **Hospital confinement.**
  
  This option permits the insured to purchase a specific daily benefit in addition to the regular monthly disability income benefit. This option requires being admitted to the hospital on an in-patient basis, and during that time, the policy pays a specified daily benefit for each day of hospital confinement.

- **Life extension.**
  
  This option is available when the basic policy has a benefit period limited to age 65. It extends the benefit period for total disability to the lifetime of the insured in one or more of the following ways:
  
  - Lifetime benefits are paid if total disability begins before a specific age; usually age 50, 55, or 60.
  - Lifetime benefits are paid if total disability begins before a specific age, but at a reduced percentage of the policy’s monthly income benefits. For example, if an insured is 60 years of age and becomes totally disabled, the full monthly benefit will be paid until 65, then at age 65, the lifetime extension is reduced to 50%.
  - Lifetime benefits are paid if an accident causes total disability before age 65. This covers accidents but does not include illness, in which case benefits would cease at age 65 with no lifetime extension.
• Lifetime benefits are paid if total disability occurs before age 65 and there are absolutely no other restrictions as to accident or sickness, age of onset of disability prior to age 65, or reduction in benefit. Obviously, this is the best of the four choices and also the most expensive.

• Social Security rider.
Here a benefit is paid if Social Security does not pay benefits. This can be a valuable rider for the additional premium because Social Security disability income can be difficult to obtain.

Basically this rider stipulates that the insured will receive an additional monthly benefit above and beyond the basic monthly benefit if Social Security benefits are denied. If however, Social Security does approve benefits, then the insurance company will not pay this additional monthly benefit. Another way in which this option may work is that the basic monthly benefit will be reduced by any amount Social Security pays the insured.

• Cash back option.
Many people feel that this option is expensive and impractical. One of the major complaints is that money under this option does not earn any interest. An insurance company charges an additional premium, which can be very substantial for the cash back option.

The two most common cash back options are:

• At age 65 the company will return to the insured all premiums paid less any benefits received. In the event benefits received exceed the premiums paid to age 65, there is no return of premium. Some companies will permit the insured to drop the cash back option, and reduce the premium accordingly, should the insured ever reach the point that benefits paid exceed the premiums. However, most companies continue charging the additional premiums for the cash back option even when benefits paid exceed premiums paid.

• The company will review the policy every ten years (rather than waiting to age 65) and return 80% of all premiums paid, less any benefits received.

As mentioned above these options are very expensive and not frequently added to policies.

Policies for Business

Business Overhead Policy
When the insured owns a business, one of the major problems which could hurt the business would be the unavailability of the owner to run the business. Many businesses are uniquely dependent upon the owner’s knowledge, skilled profession, or contacts with customers or suppliers. Obviously, the owner’s absence could pose significant problems in these areas. This is especially true when the owner is the key employee or major factor in the success of the business. A business overhead policy functions as a type of “business disability” policy which can help the business meet necessary expenses until the owner is able to return to work.

The purpose of the policy is to cover essential expenses which must be paid to operate the business:

• Elimination periods.
Common elimination periods for business overhead policies are:

- 30 days.
- 60 days.
- 90 days.

The most commonly purchased policy contains the 30 day elimination period, particularly for businesses in which the owners do not have sufficient funds to cover business expenses for a long period of time.

- Benefit period.

  Common benefit periods for business overhead policies are:
  
  - 12 months.
  - 15 months.
  - 18 months.
  - 24 months.

  Benefit periods generally do not exceed 24 months because if the business owner does not return from a total disability after 24 months, the owner is less likely to return at all.

- Monthly benefit.

  Considerations affecting the amount of the monthly benefit to be paid under the business overhead policy include:

  - The type of business.
  - Owner’s occupation.
  - Insured’s portion of the work.
  - Employee’s portion of the work.
  - Amount of loss of income.
  - The company’s current expenses.

- Covered expenses.

  There are many expenses in running a business and not all can be covered with a business overhead expense policy.

  The following are some of the more common of the covered expenses:

  - Rent.
  - Utilities such as water, heat, and electricity.
  - Telephone.
  - Telephone answering service.
  - Employee’s salaries.
  - Employee fringe benefits.
  - Payroll taxes.
• Professional or association dues.
• Accounting fees.
• Premiums for business insurance.
• Postage.
• Stationary and supplies.
• Furniture and equipment depreciation.
• Janitorial service and maintenance.
• Laundry.
• Expenses not covered.

It is very important that the policy owner understands what is not covered so that there are no misunderstandings or disputes at the time of a claim. Common exclusions are:

• Purchases of equipment or furniture.
• Salaries, draws, commissions, fees, or any other monies due the owner. (The owner covers these expenses with a personal disability income plan.)
• Payments made towards debts.

**Disability Insurance for a Key Employee**

Often an employee of a company is a key ingredient to its success. Should he or she become sick or hurt, the financial consequences to the company could be severe. A disability insurance plan for this key employee may provide significant protection against this possibility. The company purchases the disability policy and the company becomes its beneficiary. Should the key employee become disabled, the company is then reimbursed for the expected income loss to the company caused by the employee’s absence. As a general rule, the benefit period runs for 6, 12, or 18 months.

**Tax Effects of Disability Insurance**

Disability insurance policies may offer certain tax benefits to the insured. Here we examine tax treatment for some of the policies which we have discussed.

• Personal disability income plans.

Premiums paid for personal disability income plans are not tax deductible. The good news for the insured is that regardless of how much the insured business owner receives while totally disabled under a personal disability plan; all income is received 100% tax-free. A business owner for example, could insure him or herself under a “tax-favored sick-pay plan” and have it construed to be personally purchased. Here again the benefits are completely tax free because the business owner is not considered an employee and the premiums are not tax deductible.

• Sick-pay plan for key employees.

The premiums are tax deductible for the business owner as a necessary business expense for disability purchased on key employees.

• Taxes on overhead expense policies.

Since the business owns the policy and the premiums are deducted as a business expense, the income from the policy is taxable when paid to a disabled owner.
Disability Underwriting

Many companies place a lot of responsibility on the good judgment of the agent in the field when it comes to insuring a disability risk. As an agent in the field, you have the upper hand in that you are not merely dealing with the information contained on the application, but are in fact, seeing and talking to the potential insured. For this reason the agent is sometimes referred to as the field underwriter.

Underwriters use the following details to determine the risk factors in writing a disability policy:

- Date of birth.
- Occupational rating.
- Address.
- Gender.
- Earned income.
- Net worth.
- Expenses.
- Unearned income.
- Benefits applied for.
- Current coverage.
- Medical history.
- Family history.
- Present physical condition.
- Hobbies.
- Moral character.

Correlating the Data

Underwriters gather all of the evidence concerning an individual and try to determine whether to issue that individual a disability income plan. Disability underwriting and life underwriting have many different concerns. There are many conditions a potential insured can have that are not life threatening but are certainly possible disability income claims. For example, a bad knee or back or shoulder injury, while not life threatening, certainly can become the subject of a future disability claim.

Medical Underwriting

Medical underwriting for the disability policy is accomplished in two ways: First, in the field with the agent and, second, with questions on the application.

The following areas are studied very carefully during the medical underwriting process:

- Parts of the body that have been affected.
- Symptoms.
- Date of onset.
- Severity of symptoms.
• Frequency of symptoms or illness.
• Duration of symptoms or illness.
• Cause of symptoms or illness.
• Time off work.
• Diagnostics.
• Kind of treatments taken.
• Names of all medical practitioners consulted.

**Importance of Medical Examinations**

The companies print and publish what are referred to as “non-medical limits” for examinations. In other words, there are certain thresholds at which a medical exam is required.

The following factors are taken into consideration and the company determines whether or not to require a physical exam or other test.

• Occupational classification.
• Age of applicant.
• Amount of benefit applied for.
• Benefit period applied for.

If the applicant has a non-hazardous occupational class, is over age 60, and requests a long benefit period, he or she will probably exceed the non-medical limit. Conversely, the applicant could have a hazardous occupation with a short benefit period and not be required to take an exam.

**Underwriting Substandard Policies**

Not every applicant can be given a standard policy. There are many factors that cause an applicant to be considered substandard.

Some reasons an applicant may be considered substandard are:

• Current status of health.
• Age.
• Occupational rating.
• Pre-existing conditions.
• Sports or hobbies.

Rather than completely deny coverage, some companies are willing to make adjustments and issue a substandard policy.

This can be done in a number of ways:

• Shorten the benefit period.
• Lengthen the elimination period.
• Issue a rider that excludes or limits coverage in certain areas.
• Charge an extra premium above the standard premium.
• Issue an exclusion rider for a specific condition.

Disability Claims
Any time that an insurance company sells disability income insurance, it recognizes that part of the premium dollars taken in are going to be paid out in claims. Most companies make every effort to pay claims fairly and promptly. However, they also know that it is the company’s obligation to be certain that unjust claims are not paid.

Obviously, the claim form is very important. As an agent, your role is to bring the form to the insured and assist them in completing it. Caution is given here in that you should only assist the insured and you should never complete the form yourself. The claim form will give the company the information necessary to process the claim. The quicker the claim process begins, the quicker the claim can be paid for your client.

Payment of Claims
Some confusion may exist as to when one can apply for claim benefits if the disability income policy contains a 30 day waiting period. The insured is eligible for benefits on the 31st day. However the agent must realize that his client may not see the first check for over 60 days. Companies pay claims only as earned. In other words, they will not accept estimates that a client may be off work for six months and therefore send a check for six months in the future.

As a rule, if an insured is in fact not going to return to work for a period of six or eight months, according to the physician’s estimates, the insured must submit an up to date claim form every 30 days.

One of the primary requirements of the insurance company for continuation of disability benefits is that the insured be currently under the care of a qualified licensed physician.

The company also reserves the right to request periodic physical examinations of the insured to ascertain whether or not the condition that has caused total disability still applies. In most cases, the company pays for the physical examination and in almost all cases, the company, not the insured, picks the doctor to perform that examination.

Long Term Care Insurance
The Producer’s Role
Most clients would rather not think about the possibility of themselves being subject to an injury or illness that would impact them for an extended period of time. This reluctance to think about these possibilities makes it that much more important for you, the insurance producer, to discuss these uncomfortable topics with clients so they can begin to appreciate the protection that can be available through disability and/or long term care insurance.

History
Long term care is not a new concept or idea. Long term care insurance (LTC) first appeared on the scene in the early 1980’s, but was very primitive in nature and had numerous stipulations, requirements, and exclusions that made it undesirable.

Insurance companies were reluctant to enter this market simply because there was not previous claims experience that they could follow. Actuarial science could not be applied because there were no records of who went into long term care facilities, their ages, what caused their need or how long they remained in care. Needless to say, this posed major obstacles in the pricing of the long term care policies.

Over the years long term care insurance has become more popular. This is true because the need is increasing, more people are becoming aware of the need, and the policies have
improved. Baby boomers and their children are seeing their parents and grandparents live longer and require the kind of financial assistance provided by LTC. LTC policies can cover the cost of certain types of care at home as well as care provided in a professional facility.

Long term care policies have also become more standardized. The National Association of Insurance Commissioners (NAIC) has helped move LTC from a fringe product to the mainstream. The NAIC has created model polices that have been adopted by many states. While some states have adopted the model in its entirety, others have made use of its principles or used portions of its language. Once a number of states began to insist on the use of these policies, a standard developed that most insurance companies have applied to all of their LTC policies.

**What Is Long Term Care**

LTC insurance provides coverage for the care that becomes necessary when an individual cannot perform the “activities of daily living” (ADLs) for themselves.

The ADLs include:

- Bathing and personal hygiene.
- Continence.
- Dressing.
- Eating.
- Toileting.
- Transferring or mobility.

**Benefits Provided By LTC**

To provide assistance with the ADLs, the four most common long-term care benefits required and provided by LTC are:

- Skilled nursing care.
  Skilled nursing care is the most expensive type of care. It requires a prescription from a qualified licensed physician. The care must be continuous on a 24 hour a day basis and the insured individual is to be cared for by a Registered Nurse.

- Intermediate care.
  Although a doctor’s prescription is not necessary for this level of care, it does require medical care under the supervision of medical personnel it must be administered by a Registered Nurse, Licensed Practical Nurse, or a Physical Therapist.

- Custodial care.
  Custodial care assists the patient in meeting ADLs shown above. This type of care can be provided by someone without a medical or professional nursing degree.
• Home health care.

Under this care, the patient is not confined to a nursing home and is usually able to care for him or herself. Usually a non-medical type person assists in shopping, meal preparation, and some physical therapy.

Optional Benefits
The more common optional benefits are:

• Hospice.

Hospice provides the terminally ill with comfort in their last days and does not prolong treatment or employ life saving devices. Often a hospital bed is set up in the patient’s home to keep them in familiar surroundings with family members during their last days. Depending on the severity of pain or medical needs, home visits are made by Registered Nurses as well as Social Workers.

• Adult day care.

Adult day care is usually given at a center that caters to those that are mentally or physically impaired. A typical day at the center provides social activity, medical care, meals, and transportation to and from home.

• Inflation protection.

Long term care is not immune to inflation. Inflation protection is an important option available with most LTC policies. Inflation protection provides for automatic increases in the daily benefit provided by the policy. Most times this policy provision offers a 5 percent increase in the daily benefit each year. One of the differences to be aware of is that while some inflation clauses apply through the entire life of the policy, others limit this benefit to the first ten or twenty years of coverage.

• Waiver of premium.

While optional, most companies include waiver of premium as a standard provision. Typically, once the insured has been receiving benefits for more than 90 days, the policy premiums will be paid by the company.

How Long Will Benefits Be Paid?

Insurance companies offer long term care benefit periods from one year to the remainder of the insured’s life. Benefits can also be scheduled to begin at different intervals of time after the care becomes necessary.

The decision regarding an insured’s choice of benefit period can be complex. The cost of LTC must be balanced against the risk after taking a number of factors into consideration. The age and current financial condition of the insured will of course be major considerations. Other insurance that will cover the expense of long term care can considerably change the needs of your prospect. If the prospect has disability coverage that lasts for five years and provides similar care to LTC coverage you would want your client to avoid duplication. The availability of Medicaid should also be a consideration. There may also be income tax considerations since portions of some LTC premiums may be tax deductible.

Pre-Existing Conditions and Other Exclusions

Most policies make provisions for pre-existing conditions. Most pre-existing conditions are measured by excluding any condition for which the insured was treated or given medical
advice. It is common for pre-existing conditions to include the period of six months prior to, and in some instances six months following the effective date of the policy.

An agent must be aware and make prospects aware of the exclusions that long-term care policies contain. The time of a claim is not the time when the insured wants to first learn of these coverage exclusions. In the early long term care policies, companies would exclude Alzheimer’s disease by saying that “the policy excludes diseases of an organic nature,” which was a way of excluding Alzheimer’s disease without mentioning the disease by name. This has since been rectified because Alzheimer’s disease and other organic diseases are now covered in most policies.

There are some of the other common exclusions:

- Care given in a veteran’s hospital.
- Losses that workers’ compensation provides for.
- Mental psychoneurotic, or personality disorders that are not the result of organic or physical disease.
- War.
- Self inflicted injuries that are intentional.

**Long Term Care Provisions in Other Policies**

Some insurance companies now make it possible to purchase a life insurance policy or a disability income policy and add long term care as a rider. The rider is very much like the standard long-term care policy in that it affords the insured the same elimination periods, benefits periods and levels of care.

A living benefit long term care rider permits terminally ill patients to use life insurance proceeds in advance to cover expenses connected with their illness. In some instances this option will make 70% to 80% of the death benefit available to the insured to cover the cost of nursing home care. Another option in this category is agreeing to and receiving a discounted amount of the death benefit that the patients are entitled to because they are terminally ill.

**Underwriting Long Term Care**

**Sources of Information**

The underwriting process employs four important sources of information.

- The application.
  
  The application provides the company with the primary basis upon which they will make the decision to issue a contract. Questions need to be answered in full with honesty and integrity.

- The agent.
  
  Years ago, you were permitted to take applications by mail or phone so long as they were signed by the applicant. Today, however, companies want to know that the agent actually sees the applicant and assists in the field underwriting. You will be able to make observations unavailable to the home office underwriter.

- Verification reports.
  
  The verification reports provide investigative information to verify statements made by the applicant. These reports also sometimes produce additional information or problems that may not have been listed on the application.
Today it has also become common for insurers to check the applicant’s credit report. Many insurers believe an applicant’s credit history can let them know a great deal about the applicant. In fact the major credit bureaus have developed credit scoring models specifically for insurance purposes.

- Medical records and history.

Often companies employ the Medical Information Bureau and obtain information from attending physician’s reports when verifying medical records and history. Obviously, this information is extremely important in the underwriting process.

**Substandard Underwriting**

Not all applications are approved as submitted or issued standard. Often, the applicant is required to pay more than the standard premium in order for the company to absorb certain extraordinary hazards or risks.

Factors that directly affect whether the policy will be issued standard or substandard are:

- Pre-existing conditions.
- Age.
- Occupation (if applicable).
- Moral issues affecting the customer’s record.

**Policy Provisions**

The National Association of Insurance Commissioners developed model standardized provisions to be used by states adopting their Uniform Policy. These provisions are divided among two categories. One group of “required provisions” that must appear in all policies, and another group of “optional provisions” that may be used at the discretion of insurance companies to better customize their policies. One rule that is strictly enforced is that no substitute language may be used in any provision unless the substitute language is in favor of the insured.

**Required Policy Provisions**

- Entire contract.

A policy including all attached papers constitutes the entire contract. Riders, endorsements, and changes must be approved in writing and executed by an officer of the company. The agent does not have permission to change or waive any policy provision.

- Time limit on certain defenses.

This provision is more commonly referred to as the “period of incontestability.” The period of contestability is usually two years in length. Should an application contain any fraudulent statements, the policy’s period of contestability will be extended to the life of the contract. The only exception is a “guaranteed renewable policy.” Under a guaranteed renewable policy, once the period of contestability has expired the policy cannot be contested. This is true even if fraudulent statements were made on the application.
• Reinstatement.
A policy that has lapsed may be reinstated under certain conditions, provided that the
proper procedure is followed. Some companies require an application for
reinstatement, which may or may not be approved.

• Claim forms.
Companies are required to supply the insured with a claim form within 15 days after
receiving a claim. If the company does not meet this requirement, the insured may
submit proof of loss on any form.

• Grace period.
The grace period is the time the company gives the insured to make a delayed
payment without penalty and with the policy remaining in force. Should payment not be
made by the end of the grace period, the policy will lapse and terminate. A grace
period of 31 days is fairly common.

• Notice of claims.
When a loss occurs the insured is required to notify the company within 20 days, or as
soon thereafter as is reasonably possible that a claim will be made.

• Time payment of claims.
This provision stipulates that “the company must pay the claim immediately.” Usually
payment of claim is made within 60 days.

• Proof of loss.
When a claim is made the insured is given 90 days in which to submit proof of loss.
Should the insured be unable to meet this 90 day deadline, the claim will not be
affected if it was not reasonably possible for the insured to meet the deadline.

• Claim payment.
Payment is paid to the insured or the insured’s hospital, physician, or other designated
service provider. For loss of life, benefits are paid to the designated beneficiary. If no
beneficiary has been named, payment will be made to the insured’s estate.

• Autopsy or physical exam.
The company can request, at its own expense, physical exams. So long as law does
not forbid it, the company also has a right to request an autopsy on the body of the
insured.

• Change of beneficiary.
The insured has a right to change the beneficiary at any time unless an irrevocable
beneficiary has been designated.

• Legal Action.
Should the insured have a dispute with the company in regards to a claim, the insured
must wait at least 60 days and no longer than 5 years to take legal action.
Optional Policy Provisions

- **Misstatement of age.**
  
  If an applicant misstates his or her age at the time he or she is applying for coverage, any benefit due to the applicant will be adjusted to reflect what would have been purchased had the correct age been stated in the first place.

- **Unpaid premiums.**
  
  Should a claim become due and payable while a premium remains unpaid, the premium due will be subtracted from the claim amount due and the difference will be sent to the insured or the insured’s beneficiary.

- **Insurance with other insurer.**
  
  In order to avoid over insurance, if the company finds that there was other existing coverage for the same risk, the excess premiums will be refunded to the policy owner.

- **Cancellation.**
  
  The company has the right to cancel the policy with 20 days written notice to the insured and the insured may cancel the policy following the expiration of the policy’s original term.

- **Change of occupation.**
  
  After a policy has been issued, if the insured changes to a more hazardous occupation that would require an increase in premium and the insurance company is not notified and a loss occurs, the benefit paid will be reduced. Should the opposite occur, and a loss occurs, a refund will be made to the insured for the excess premium.

- **Other insurance in this insurer.**
  
  To avoid over insurance and to limit a company’s risk, coverage written on one person is restricted to a maximum amount no matter how many separate policies the insured has. Premiums that have been applied to the excess coverage will be refunded to the insured or to the beneficiary.

- **Conformity with state statutes.**
  
  Should any part of a policy conflict with state statutes in the state where the insured resides, the policy shall automatically amend itself to conform to statutory requirements.

- **Illegal occupation.**
  
  Policy benefits are not payable if the insured has a loss while committing a felony or being connected with a felony or participation in any illegal occupation.

- **Intoxicants and narcotics.**
  
  Should the insured be intoxicated or under the influence of narcotics, unless such drugs were administered on the advice of a physician, the company is not liable for any losses.

**Conclusion**

As we mentioned earlier, disability and long term care insurance may seem expensive when purchased; however, if you ever get the opportunity to speak to someone who has had the
unfortunate experience of needing these benefits you will never again neglect to talk to your clients about this coverage.
Appendix A – Final Examination

Below is the Final Examination for this course. You may enroll in this course and complete an online version of this exam at our website: www.BookmarkEducation.com

Your certificate will be issued immediately upon successful completion of the course.

Insuring Commercial Risks

1. The more hazardous the job, the ______ the premium for disability insurance.
   A. higher
   B. lower
   C. more adjustable
   D. more fixed

2. ______ provides for automatic increases in the daily benefit provided by a long term care policy.
   A. Premium escalation
   B. Lock-in procedures
   C. Premium waiver
   D. Inflation protection

3. Long term care insurance provides coverage for the care that becomes necessary when an individual cannot perform ______ for themselves.
   A. activities of daily living
   B. extraordinary feats
   C. military maneuvers
   D. medical procedures

4. The BOP liability insuring agreement provides comprehensive general liability insurance on a ______ basis.
   A. per capita
   B. per stirpes
   C. per occurrence
   D. biannual

5. General liability coverage covers exposures such as lawsuits occurring because of ______.
   A. slips or falls on the insured premises
   B. on-the-job employee injuries
   C. professional errors and omissions
   D. operation of automobiles

6. The agent’s role is to bring the disability claim form to the insured and ______.
   A. complete it for the insured
   B. assist the insured in completing it
   C. leave the form with the insured
   D. wait 90 days to complete the form
7. Workers’ compensation was the first form of _______ to develop in the United States.
   A. social insurance
   B. federal statutory law
   C. state statutory law
   D. cash reimbursement

8. Insurance companies back up their finances by taking out insurance policies of their own. This is known as _______.
   A. coverage
   B. reinsurance
   C. syndication
   D. overprotection

9. _______ is the income an insured earns for work performed.
   A. Earned income
   B. Unearned income
   C. Discretionary income
   D. Net income

10. _______ means that damaged or destroyed property is covered for the amount that it actually costs to replace or to restore the item to its original condition.
    A. Depreciation
    B. Actual cash value
    C. Replacement cost
    D. Market value

11. There are _______ federal workers’ compensation laws in operation.
    A. 2
    B. 4
    C. 6
    D. 8

12. Theft is defined as the taking of the property of another
    A. without a lease.
    B. with deception.
    C. without authority.
    D. with force.

13. A _______ policy functions as a type of “business disability” policy.
    A. long term care
    B. business overhead
    C. special multi-peril
    D. crime insurance

14. _______ is defined as the act or practice of obtaining money from a person by force or by illegal power.
    A. Forgery
    B. Extortion
    C. Burglary
    D. Auto theft
15. ________ provides retirement income and unemployment insurance for qualifying individuals.
   A. Terrorism insurance
   B. Reinsurance
   C. Social security
   D. Long term care insurance

16. Which of the following businesses qualifies for the SMP program?
   A. Industrial and processing plants.
   B. Boarding houses.
   C. Farming operations.
   D. Automobile service stations.

17. A watchman clause frequently may be eliminated by:
   A. payment of an additional premium.
   B. having had no previous losses.
   C. having a family owned business.
   D. having employee dishonesty insurance.

18. Lawmakers authorized the creation of the ________ as part of the airline assistance package to allow those citizens affected by the September 11 attacks to receive potential reparations.
   A. Pool Re
   B. Victims Compensation Fund (VCF)
   C. General Re
   D. Victims Rights Act (VRA)

19. BOP Premium debits and credits are based on all of the following underwriting factors EXCEPT:
   A. location
   B. building features
   C. employees
   D. marital status of owners

20. Floater policies and endorsements provide coverage for specific goods or classes of property which are ________.
    A. fixed in location
    B. worth more than $1,000,000
    C. easily moveable
    D. worth less than $1,000

21. Today’s SMP policy program consists of ________ different classification groups.
    A. two
    B. four
    C. six
    D. eight

22. TRIA required that the Secretary report to ________ by June 30, 2005 about the program’s effectiveness.
    A. the president
    B. the Joint Inquiry Committee
    C. the Congress
    D. the Treasurer
23. Typically, insurance companies will issue a monthly disability benefit equal to _______ of the insured's earned income.
   A. 100%
   B. between 80% and 90%
   C. between 40% and 70%
   D. between 10% and 20%

24. In order to receive reimbursement for losses through TRIA, the government must first receive a (n) _______ form.
   A. Initial Notice of Insured Loss
   B. proof of replacement
   C. dispute resolution notice
   D. waiver of claims form

25. The special BOP makes coverages available _______, while the standard BOP is a named peril policy.
   A. without charge
   B. with only two exclusions
   C. on an all-risk basis
   D. without underwriting

26. Under TRIA, neither the insurance community nor the government must absorb aggregate losses above _______ in a year.
   A. $1 Million
   B. $100 Million
   C. $1 Billion
   D. $100 Billion

27. Insures have used this form of risk assessment to predict long-term financial outcomes:
   A. short-term data review
   B. freelance
   C. open inquiry
   D. catastrophe models

28. _______ is probably the most important and most attractive feature of the Special Multi-peril Policy (SMP) program.
   A. Increased paperwork
   B. Reduction in cost
   C. Homeowners coverage
   D. Tax deferral

29. Traditionally, insurance companies can exempt themselves from honoring certain policies following:
   A. standard losses
   B. acts of war
   C. national holidays
   D. actual theft
30. There generally can be no recovery under an automobile policy for a loss from a taking of an automobile if there is no:
   A. criminal intent.
   B. floater endorsement.
   C. accompanying homeowners policy.
   D. garage protection.

31. Insurance companies offer long term care benefit periods from one year to ________.
   A. two years
   B. five years
   C. ten years
   D. the remainder of the insured’s life

32. Which of the following types of policies are NOT covered by TRIA?
   A. Products liability
   B. Fire
   C. Workers’ compensation
   D. Financial guaranty

33. The 2002 version of TRIA only provided for ________ to make their coverage available subject to the law’s requirements through 2004.
   A. itself
   B. insurers
   C. respondents
   D. injured parties

34. A ________ promotes investing and often blinds insurers to potential underwriting problems.
   A. good economy
   B. reinsurer
   C. catastrophe model
   D. war-risk exclusion

35. In its comprehensive report to Congress on June 30, 2005, the Treasury Department recommended that lawmakers not renew TRIA:
   A. In its then-current form
   B. with the same punitive damages
   C. without establishing a Pool Re
   D. in favor of the President’s plan

36. Under a disability income insurance policy, the benefit period is the period of time that benefits will be paid for total disability. Which one of the following is a common benefit period?
   A. Three months.
   B. Two years.
   C. Up to age 35.
   D. Up to age 40.

37. TRIA requires mandatory participation from all U.S. ________ insurers.
   A. life
   B. health
   C. property and casualty
   D. disability
38. The all-risk form of property coverage excludes losses caused by:
   A. fire.
   B. lightning.
   C. windstorm.
   D. animals.

39. The cost of Pool Re coverage and the premiums paid by insurers to the mutual company tend to depend upon the ________ of the insured properties.
   A. use
   B. resale
   C. size
   D. location

40. Perhaps the biggest complaint among Pool Re policyholders is that if people want to insure one building, they must purchase coverage for ________.
   A. all other properties in their portfolio
   B. the majority of properties in their portfolio
   C. three other properties
   D. all lien holders

41. The business owners policy plan (BOP) is written in a way that is ________.
   A. difficult to understand
   B. conducive to high premiums
   C. easy to understand
   D. conducive to limited coverage

42. ________ means that the insurance policy specifically names those perils from which the business owner is protected.
   A. Named peril
   B. Defined peril
   C. All risk peril
   D. All inclusive peril

43. The Terrorism Risk Insurance Extension Act of 2005 extended TRIA through:
   A. 2005
   B. 2006
   C. 2007
   D. 2020

44. The two types of renewal provisions in disability plans are non-cancelable and ________.
   A. guaranteed renewable
   B. occupational
   C. income-based
   D. waiver

45. A business overhead policy covers which of the following expenses?
   A. Purchases of equipment.
   B. Salary of the owner.
   C. Payments toward debts.
   D. Rent.
46. Plaintiffs typically sue for ________ when they feel that a defendant’s actions were not only wrong but also committed outside of the lines of human decency.
A. punitive damages
B. injunction
C. liquidated damages
D. specific performance

47. The first real commercial multi-peril packages offering protection for both property and liability did not appear until the early ________.
A. 1700s
B. 1800s
C. 1960s
D. 2000s

48. In Great Britain, ________ consists of several commercial insurers that share a portion of their profits from premiums in order to cover terrorism losses:
A. Pool Re
B. The IRA
C. FIFA
D. TRIA

49. TRIA’s original definition of terrorism clearly did NOT include violent acts committed by ________.
A. Americans
B. terrorists
C. foreign individuals
D. bombers

50. Which of the following businesses might qualify for a BOP?
A. Motorcycle dealership
B. Hobby store
C. Restaurant
D. Amusement park