Legal Responsibilities of the Insurance Agent

107 pages • 8 Lessons 1 Online Final
Legal Responsibilities of the Insurance Agent
Published by Pohs Institute
Westbury, New York

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This course will address the following topics:

• Insurance Principles and Legal Responsibilities
• Legal Responsibilities in the Agency
• Legal Responsibilities with the Insured
• Legal Responsibilities in the Insurance Contract
• Legal Responsibilities in Liability
• Legal Responsibilities in Consumer Protection
• Legal Responsibilities and HIPAA
• Legal Issues in Insurance Fraud

This course includes:
• 8 Lessons
• 1 Online Final Exam
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Insurance Principles and Legal Responsibilities of the Agent

**Principles of Insurance**

Insurance is a financial arrangement that redistributes the costs of unexpected losses by transferring potential losses to an insurance pool. The pool combines all of the potential losses and then transfers the cost of the predicted losses by redistributing losses among the members of the pool.

An insurance system redistributes the cost of losses by collecting a premium payment from every participant in the system. In exchange for the premium payment, the insurer promises to pay the insured’s claims in the event of a covered loss. Usually, only a small percentage of insureds suffer losses. So an insurance system redistributes the cost of losses from the unfortunate few members experiencing them to all the members of the insurance system who pay premiums.

**Principles of Loss**

A typical insurable loss is an undesired, unplanned, reduction of economic value arising from chance. Insurable losses are categorized as direct or indirect losses.

- direct losses are the immediate result of an insured peril.
- indirect losses are a secondary result of an insured peril.

If a hurricane destroys a home, the loss of the home is the direct loss. The expense of living in a hotel while the home is being rebuilt is an example of an indirect loss.

A *peril* is the cause of the loss. Insurance policies provide financial protection against losses caused by perils. Fires, tornadoes, heart attacks, and criminal acts are perils. Insurers call policies that specifically identify a list of covered perils *specified-perils contracts.*
Hazards are conditions that increase either the frequency or the severity of losses. Poor lighting in a crime-prone area is a hazard because theft losses may be more frequent than would be the case if better lighting were available. Storing large amounts of gasoline in a garage is a hazard. The gasoline will make fire losses that otherwise occur more severe.

The proximate cause of a loss is the first peril in a chain of events resulting in a loss. If lightning causes a fire in a house, which in turn causes a fire truck to be sent to the fire, and if in responding to the call the fire truck collides with a car, one might assert that the proximate cause of the collision between the fire truck and the car was the lightning that struck the house five miles from the collision. Generally, the proximate cause must be a covered peril. If the proximate cause is excluded from coverage, the insurer generally will not pay for the loss.

**Principles of Risk**

The strict insurance definition of risk means the uncertainty regarding financial loss. For example, if an individual decides to burn down his own home and sprays gasoline on the house and applies a torch the loss is certain. The event is purposeful in nature and there is no uncertainty. In insurance terms there is no risk of loss by fire. When a house fire is started by faulty electrical circuitry or a lightning strike, the even is sudden and unexpected. The owner of the house and the financial institution that holds the loan on the house both suffer a financial loss. The loss is uncertain and accidental. Risk is uncertainty regarding financial loss.

Pure risk refers to possibilities that can result in only loss or no change. Nothing good can come from an exposure to pure risk. A factory’s exposure to loss by fire is an example of a pure risk. A factory either burns or it does not burn. There is no gain potential from this possibility. Pure risks often are insured.

Speculative risk involves the chance of both loss and profit. Investing in the stock market is an example of speculative risk. Speculative risks are not insurable. Pure risk involves only the chance of loss; there is never a possibility of gain or profit. The risk associated with the chance of being robbed is an example of pure risk. There is no opportunity for gain if the even does not occur – only an opportunity for loss if the robbery does occur.

Only pure risks are insurable. The purpose of insurance is to protect the insured against losses caused by pure risk.
Risk Management

Risk management is the logical process used by business firms and individuals to deal with their exposures to loss. It is a strategy of pre-loss planning for post-loss resources. Risk management describes an ongoing process for dealing with the possibility of loss.

- some risks, or loss exposures, may be transferred to another person or entity.
- a risk may be retained. The individual or business may choose to retain all (self-insured) or part (deductible) of that risk. Retention may be passive (the company or person is not aware that the risk exists, does not insure it and must pay if a loss occurs) or it may be active (the company or person is aware of the risk and accepts it).
- the most obvious method of risk treatment is simply to avoid as many risks as possible.

Insurance is a financial device for transferring or shifting risk from an individual or entity to a large group with the same risk. Losses can be reduced or prevented by training, by installing safety devices, and/or by lowering the frequency and/or severity of loss.

- Loss control is managing the risk.

Principles of Coverage

Probability

The mathematical principle of probability is called the law of large numbers. In insurance a prediction must be made from actuarial experience or statistical analysis of the number of losses to be expected within a group of exposures. The law of large numbers tells us that actual losses will be more accurate as the number of units of exposure increases.

Limit of Liability

The limit of liability is the maximum amount that an insurance company will pay in case of a loss. Sometimes it is referred to as the policy’s face amount. This amount is set forth on the declarations page in the policy. Despite a maximum amount payable for a loss, a policy may have inside or internal limits or special limits of insurance, regardless of larger limits of insurance on the home and personal property.
Coinsurance

The term coinsurance has two distinct applications in insurance. When applied to health insurance, a **coinsurance provision** obligates the insured to absorb a specified percentage of medical expenses that otherwise would have been paid by the insurance company. The coinsurance clause in health insurance is very different from the coinsurance clause in real property insurance.

When applied to real property insurance, a **coinsurance clause** requires policyholders to carry insurance equal to a specified percentage of the total value of the property that is being insured.

Deductibles

In most cases, a deductible clause is also included in a policy. This clause requires the insured to pay a small portion of the loss, with the insurance company paying the remainder of the loss. Companies include deductibles for two reasons:

- to place a certain amount of responsibility on the insured to minimize losses and avoid hazards.
- to avoid paying small claims that are disproportionately expensive to handle.

When a loss occurs, any deductible is deducted after the loss payment is estimated.

Cancellation

Cancellation is the termination of a contract before its normal expiration by act of the insurance company or the insured. Termination is effected in accordance with provisions in the contract, by mutual agreement, and/or statute, and must comply with various limits and notifications set by state law. The refund of a premium after cancellation may be on a short rate or pro rata basis depending on which party canceled the policy.

Renewal and Non-Renewal

**Renewal** is the continuation in full force and effect of a policy by the same company that is about to expire. This may be accomplished by issuance of a new policy, a renewal receipt, or a certificate, to take effect upon expiration of the old policy. Though a new policy number may be issued the coverage will be considered continuous and thus a renewal. **Non-renewal** means that the insurance company is not willing to renew or continue the policy beyond the expiration date.
Characteristics of Legal Responsibilities

The study of insurance is surrounded by ongoing legislation, lengthy court decisions, litigation, and administrative actions. The study of insurance law is an ongoing and evolutionary one. Judicial decisions involving insurance contribute to the continuous development of fundamental legal doctrines. This evolution of legal doctrines results from the resolution of insurance disputes.

Insurance law is a system of rules of conduct and rights, which are formally recognized by our society or prescribed by federal or state authority. Insurance law distinguishes between what is permitted and what is prohibited. The modern development of insurance law has been taking place for more than three hundred years. It began first in England and later progressed to the United States.

Legal responsibilities are fundamental. An insurance agent walks a difficult line with legal responsibilities to both an insurance company and a client. When the agent does not live up to these responsibilities, there is the threat of being sued. Periodically, every agent should review the legal responsibilities of an agent in modern society.

There are three primary characteristics of legal responsibilities every agent should remember.

**Mandatory**

An insurance agent’s social, ethical and professional responsibilities may be optional; but legal responsibilities are not. Legal responsibilities are the minimum amount that is required of every agent. If he does not live up to his legal responsibilities, he will end up out of business and maybe even behind bars.

**Non-Negotiable**

Many agents have mastered the art of negotiation. They negotiate rates with the underwriter and settlements with the claims adjuster. They can negotiate a lease on the office and a pay raise with their employees. There are times when a penalty or sanction may be negotiable, but legal liability is not negotiable.
Constantly Changing

Because legal responsibilities are determined by common law, statute, and case law, they are evolving. The definition of an agent’s legal responsibility changes over a period of time as states pass new legislation and courts adjust their interpretations. An agent must remain current, making adjustments for trends and refinements.

No one wants to be faced with a lawsuit. It can be expensive, time consuming and very stressful. One of the ways that an agent can avoid being sued is to have a clear perception of the legal responsibilities that are a part of his work. It is an excellent loss-control mechanism.

Illegal Acts of an Insurance Agent

An agent who is aware which actions constitute criminal behavior will have a better chance of avoiding those actions. The following are examples of the illegal activities that are sometimes committed by agents. Each can result in criminal sanctions.

Misrepresentation

Misrepresentation is defined as an inaccurate statement of fact or the omission of a material fact. Misrepresentation is the leading cause of error and omission claims for the life and health agent. There are two types of misrepresentation:

- unintentional misrepresentation can result in both administrative action (taken by the office of the insurance commissioner) and civil penalties. One of the three areas where E&O claims are rising faster than any other is unintentional misrepresentation.
- intentional misrepresentation is a different matter. It is prosecutable administratively or criminally as fraud. Fraud is not covered under the E&O policy.
Windowing

Windowing is the practice used to describe forging someone else's signature. It is derived from the illegal practice of holding an authentic signature up to a window and tracing over it on another form. It is a criminally prosecutable action.

Altering Applications

Applications may be altered for a number of fraudulent reasons. Sometimes the purpose is to change underwriting information in order to obtain a more favorable premium rate. In the case of life insurance an application may be altered to switch the type of coverage being applied for, in order to earn a larger commission on the sale.

Improper Handling of Monies

When an agent does not properly handle the money received from a client there can be criminal implications. It may be a matter of premium theft, where the agent never submits the premium to the insurance company.

Another illegal activity is the commingling of premiums in a personal account, when an agent is not required to send premiums in to the company immediately. State laws generally require a special business account, with adequate records regarding the source of all deposits and the disposition of all outflows.

Non-Compliance with Licensing Requirements

Each state regulates the licensing of agents and the practice of selling insurance. When these licensing laws are not obeyed, the agent can face criminal actions. Laws in most states impact such things as:

- non-residency work and countersignature requirements.
- excess & Surplus lines control.
- consulting or fee regulation.
- replacement of life insurance.
**Rebating**

Rebating is the act of giving or offering a benefit not specified in the policy (such as a portion of the commission) as an inducement to buy insurance. Rebating is illegal, and in most states; it is a criminal offense.
Ethics in the Insurance Agency

Studies show that the insurance agency is trusted more than the insurance industry as a whole. Most consumers feel that their agent is doing a good job in looking out for their best interests. The success of the industry depends on individuals who are both knowledgeable and ethical. High ethical standards are important in the agency of today, and most insurance agencies meet the challenge. Although it is becoming increasingly difficult, insurance agencies have been successful at attracting and retaining significant numbers of quality educated individuals who are committed to making the insurance products work for their clients.

Both the insurance industry and the client continually challenge the ethics of the individual insurance agent.

Agent-Client Communication

Written Communication

Documentation is written confirmation on all verbal instructions. It is also a written record of all that has been done, and what needs to be done in the future. Lawyers are always instructing their clients to document. Insurance agents should document all instructions and transactions. They should be sure and obtain the client’s signature whenever necessary, even if it has to be on a piece of scratch paper. The note should be specific with details, date, and time, and then signed by both the insured and the agent.

Normally standardized forms are the preferred method of documentation. These should all have a section for remarks and the insured’s signature. Letters are another way of written communication with the client. The letter reinforces or acknowledges what has already been discussed verbally. Many times this can alert either the agent or the client to an error or misunderstanding in their communication.
A signed release from the insured should be used for special requests or rejections of coverage. If an insurer refuses to provide coverage, the agent should communicate that information in writing so that the client does not assume that he has coverage when he does not. If a client rejects coverage by the insurer, that rejection should be confirmed in writing from the insurance agency.

Coverage limits, especially for bodily injury or property damage limits should be in writing on a sign-off form. These forms are communication devices to indicate to the client that higher limits are available. They should be signed at every renewal for every level of coverage. A signed application is no longer sufficient proof that the limits are the insured’s intent.

The agent should discuss the limitations of the coverage in writing. A quote is an estimate of the price for coverage the insured needs or wants. It is a statement of options available and the decisions made by the insured. It describes in detail the offer of coverage by a particular insurer. It is not evidence that coverage is in effect or a substitute for a signed application. A quote, known also as a proposal, will communicate what the insurer is recommending, and what the cost of the coverage will be.

The quote or proposal should be in standard format and language. It should communicate specifically to the client what he should do to effect coverage. All options and limitations should be listed clearly. There should be a disclaimer regarding the purpose of the quote included.

*Faxed Communication*

Another method of written communication is the fax. Both the agent and the client should communicate about the confidentiality level of the information being faxed. Both should approve the sending of the material and be notified ahead of time that confidential material is being faxed. The faxes should be delivered immediately to the appropriate person, and should have an immediate response.

All faxed forms should have an original signature. Faxed signatures may be accepted temporarily in an emergency, but should be replaced by an original signature as soon as possible. Fax confirmation of date and time can be critical, so they should always be stapled to the document or the document should be stamped with the date. The sender should be notified if a fax does not come through properly.

A *faxed* request for coverage that is received in the agent’s office after hours does not confirm coverage. Even though the fax may communicate an offer of a risk, the insurer
has not accepted that offer. Because of this potential in miscommunication, it is wise to leave the fax machine on even when the insurance agency is closed.

**Verbal Communication**

Verbal communication is critical to effective agent-client relationships. Many claims can be avoided if the agent will take the time to confirm all parties’ understanding in each transaction. In order to do this the agent should always repeat his understanding to the client when handling an instruction or request. The agent should never assume any detail about the insured property. When he is recommending certain coverage, he must thoroughly explain the options and the consequences of each decision. He must be sure that the client understands his current coverage.

Speaking over the telephone has become so common that it is easy to forget that it can be the cause of serious errors in communication. One of the ways to avoid misunderstanding is to document telephone conversations. Activity records of all telephone conversations can be an effective tool in defending an agency against lawsuits. The agent should never depend solely upon answering machines or voice mail for records of communication. There is too much room for error. Pocket recorders are the most reliable means of verbal records.

Documentation is especially critical in conversations requiring action. No action should be taken based merely on a telephone conversation. If a change in coverage has been discussed, no action should be taken until a signed and dated confirmation is received from the insured.

Another danger in telephone communication is incomplete information. The agent should have a standard form that he follows in leaving telephone messages which includes all the necessary information such as date, time, name of caller and company, purpose of the call, request for return call, and a return phone number.
Staffing and Customer Service

A high ethical standard is critical for efficient customer service. As we have already discussed verbal and written communication is a big part of customer relations. Technology is constantly giving us new means of communication that sometimes can threaten the humanness of the agent/client relationship. Automated phone systems cannot take the place of communicating with one’s agent. Advertising on the Internet can seem impersonal to one who is looking for a live person to explain his product.

Nothing can take the place of understanding and communication between the insurance agent and his clients.

Ethical Accounting

The opportunity of more efficient and effective billing and collections, in order to increase investment income, is overlooked by many insurance companies. Accelerating the collection of premiums and non-premium revenue, such as service fees and loss-sensitive rating plan reimbursements makes funds available more quickly for investment. This generates additional investment income. The ability to increase earnings through better billing and collections can increase the profits of an insurance company as much as if they wrote several million dollars in profitable new business premiums.

The average amount of premiums that flows through an insurance company is several billion dollars annually. If insurance companies would be as aggressive as banks are in their billing and collection procedures, they could increase their profits greatly. Surveys show that banks have consistent, well-managed collection procedures. Insurance companies use a variety of practices, which leads to different results.

Surveys have revealed that insurance companies could reduce problems with billing was to convert as many accounts as possible to direct billing. Most insurance carriers offer commercial-lines direct-bill services, but they have not been as aggressive with the commercial accounts as with personal-lines. This is not going to change unless companies move from their traditional billing processes. Increased direct bill usage would increase the productivity of any company in a very significant way. Experts feel that the benefits far outweigh the costs and challenges involved.

Top-performing organizations have recognized the connection between collection performance and product standardization. They offer fewer options both in payment plans as well as products. Fewer options lead to more efficiency in customer service.
and less confusion on the part of the client. As companies have studied how to better identify customer needs and improve customer service, there has been a rise in creating programs designed to meet the specialized needs of each segment. High-performing insurance companies align their bill-payment options with agency status to improve customer service for their key agents. They tier payment options by segment. This results in the company’s resources being allocated to their most profitable segments. This also simplifies and reduces processing costs and lowers risk for the smaller segments of the company.

Surveys also have proved that there are significant benefits to having a centralized location for billing and collection procedures. This is consistent with the principle of standardization. Not only does it enhance the efficiency of customer service, but also attracts clients. Teamwork is vital to productivity. A centralized structure with aligned billing and collection service teams can increase effective communication throughout the organization.

One of the most important factors in efficient and effective billing and collection procedures is the timeliness of the collection follow-up activities on past-due balances. To stress importance of billing and collections, but fail to reinforce the rules can be devastating to the effectiveness of the process. Past-due notices should be sent consistently. Agents should be required to collect partial payments for disputed bills. This reinforces the understanding of clients that billing is being closely monitored.

**Efficient Staffing**

Efficient staffing is imperative if the above strategies are going to be put into practice. One reason that small accounts don’t grow is because of inefficient customer service. Effective hiring and training of competent employees is of utmost importance. Personality, as well as skills, needs to be considered in choosing persons for this extremely important part of marketing insurance.

Creating a team of workers moves all of the responsibility from one or two people to a group who are working together. This is a way of using a variety of skills and yet not sacrificing quality. Accountability will also increase the initiative of employees. This is accomplished by monitoring their performance with payment results. Proper compensation will also promote positive productivity. History has proved again and again that one gets what he pays for. If insurance companies want to provide top-quality customer service, they will have to be willing to invest time and money in hiring and building a competent staff force.
Ethics in Disclosure and Confidentiality

One of the most important compliance issues for the insurance industry is privacy. Consumers are demanding a choice in how information is used. The National Association of Insurance Commissioners believes that consumers are concerned about all types of marketing activities. They are concerned about activities related to their financial or health information.

When individuals provide information to a doctor, a merchant, or a bank, they expect that those professionals/companies will base the information collected on the service and use it for the sole purpose of providing the service requested. The doctor will use it to tend to their health, the merchant will use it to process the bill and ship the product, and the bank will use it to manage their account.

Unfortunately, current practices, both offline and online, foil this expectation of privacy. Whether it is medical information, or a record of a book purchased at the bookstore, information generated in the course of a business transaction is routinely used for a variety of other purposes without the individual's knowledge or consent. Some entities go so far as to declare the information individuals provide them as company property.

Legal Responsibilities with Client Privacy

Confidentiality and Security of the Client

The insurance industry has worked with personal information for a long time. One of its top priorities has been to protect the confidentiality of that information. The insurance agent understands that the consumer demand for new and affordable financial and insurance products is met efficiently when the consumer is willing to share information. He also knows that consumers desire to protect their privacy. The agent faces the challenge of reconciling these two demands:

- convenient, speedy service of new and affordable financial and insurance products.
- protection of the consumer's privacy.

An insurer should establish and maintain policies and practices to protect the confidentiality and security of financial information. He should also provide customers with a notice of his company's privacy policies at the beginning of the business relationship and continue to do so at least once a year. Customers should be given the opportunity to direct that financial information not be shared for marketing purposes,
unless the products and services being marketed are being offered through an affiliated institution.

Clients should be given access and correction rights to their financial information. The insurance company should have a provision that affirms its right to share financial information when it is necessary to issue contracts and to service its business.

The life insurance industry believes that medical information should be subject to far greater restrictions than financial information. Life insurers have a long history of dealing with highly sensitive personal information. They have always protected consumers' medical information, and they will not depart from that tradition. They recognize consumers have special concerns regarding medical information. That is why the life insurance industry has adopted a broad and definitive statement of principles regarding the confidentiality of policyholders' medical records.

Nonpublic personal information is personally identifiable information that a consumer gives to an agent or broker. It can also be information that an agent or broker obtains from a transaction with the consumer or any service performed for the consumer. It can include a list, description or other grouping of consumers. GLBA requires that insurance agents and brokers respect the privacy of consumers and customers by protecting the security and confidentiality of the nonpublic personal information.

**Compliance with Privacy Laws**

Insurance companies should seek to find a commonsense approach to implementing the new privacy laws in a way that assures consumers adequate notice of privacy policies by insurers without requiring members to duplicate their companies' privacy notices. This approach will save agencies thousands of dollars each year in postage and other mailing costs as well as thousands of hours of agency staff members' time.

The privacy rules apply to any person or entity that is licensed or otherwise authorized to conduct business by their State Department of Insurance. However, an agent that discloses protected financial information only to the insurance company on whose behalf the information was collected does not have to comply with the notice and opt out requirements so long as the company itself complies with the notice requirements.

If the agent shares the information with anyone other than an insurance company, the agent must provide separate notices and opt out opportunities as required by the rules. In addition, if an agent, for a fee, provides any other services to an individual, such as financial, investment, or economic advisory services relating to an insurance product, that individual becomes the agent's customer and must be provided with all required
notices about the agent's privacy policy and, if the agent plans to share information with any third party, the opportunity to opt out.

It will be up to the company and the agent to determine who will provide the notice on behalf of the company. The initial notice required by the rules must be given as soon as a person becomes a customer. Some companies may require the agent to provide the initial notice. In that case, it will be the company's responsibility to provide the agent with the notice form to be used. However, after that, it is expected that most companies will probably maintain responsibility to provide follow up and annual notices required by the rule.

The privacy rules apply to agents. However, the rule provides that an independent agent sharing information with multiple insurance companies in order to obtain the best price quote for a client does not need to provide notices to the client. It is the responsibility of each insurance company to comply with the notice requirements as to that client. Under the rules, the client will be considered a consumer of each company to whom the client's information is provided, and, if the client purchases coverage from one of the companies, the client becomes the customer of that company. However, if the agent discloses or plans to disclose that information to anyone other than the companies, the agent must send that client all required notices and provide the client with the opportunity to opt out.

Because each agency's operations are different, and because the law is designed to reflect all of the different types of information sharing in the marketplace, there is no one single privacy notice agencies can use to comply with the federal law. Each agency will need to develop its own internal privacy policy and consumer privacy notice.

A Privacy Policy

The most important step an insurance agent can take toward complying with privacy rules is to develop a detailed policy for handling nonpublic personal information. In developing a privacy policy, an agency should remember that the disclosure of the policy might be treated as a contract between the agency and its clients. In addition, an agency should consider taking the following steps when developing its privacy policy.

The agent should consider including an alternative dispute resolution provision that could help to reduce the costs of defending against future challenges. He should also consider consolidating multiple privacy policies into a single disclosure form in order to avoid confusion and conflicting obligations.

The insurance company should organize quality assurance programs to ensure that each customer is given the requisite notice and that all other elements of its policies are
maintained and followed at all times. The privacy policy may create new liabilities for the company. The agent needs to be sure that his company’s errors and omissions insurance is adequate to address these issues.

E-Commerce and Privacy Violations

The Internet presents a series of new challenges for achieving public policy goals. As more and more consumers are doing business online, the issue of privacy has become critical. With the wealth of personal data stored on the web, privacy violations associated with e-commerce activities have created a minefield of fraud, ethics, and legal issues for insureds and insurers alike.

Often the level of privacy the consumer can expect from an online activity will be clear from the nature of that activity. However, an activity that appears to be private may not be. There are virtually no online activities or services that guarantee an absolute right of privacy.

The Gramm-Leach-Bliley Act (GLBA)

The Gramm-Leach-Bliley Act (GLBA) is a comprehensive law regulating the use of customer information by financial institutions. These provisions apply to insurance agents, brokers and companies. The HIPAA and Gramm-Leach-Bliley Act are both statutes dealing with the financial privacy statue. The legislation applies to all financial institutions. These include all that are involved in:

- traditional banking activities such as lending
- investment-oriented activities such as providing investment advice or underwriting securities offerings,
- insuring, guaranteeing, or indemnifying against loss, harm, damage, illness, disability or death
- providing and issuing annuities
- acting as principal, agent, or broker for these activities

The Gramm-Leach-Bliley Act (GLBA) has issued privacy regulations for all insurers. The Federal Trade Commission has given examples of businesses that could be covered with these privacy regulations. These include retailers who issue their own credit cards, real estate and personal property appraisers, tax preparers, automobile dealerships who lease automobiles, developers of financial software, career counselors providing advice for employees in the financial services industry and business that print and sell checks for consumers. Most insurers will be included within these provisions. These regulations and provisions not only apply to health insurance, but any other line of
insurance. For non-health lines of business, the GLBA may contain the only federal privacy restrictions on medical information.

**Agent Exception**

The rules of the GLBA apply to any person or entity that is authorized to conduct business under state insurance codes. The GLBA establishes a federal standard of privacy of protection. Individual states may provide greater consumer privacy protection. An insurance producer that is licensed by a State’s department of insurance does not have to comply with GLBA privacy notice requirements if

- he is an employee, agent or other representative of another licensed agent
- if his affiliates provide the required notices
- he does not disclose any non-public information to any person other than his employer or those affiliated with him

This agent exception relieves any agency from compliance with GLBA notification burdens if the agency limits its information sharing to insurance companies for which they are acting as agent. If the agent shares the information with anyone other than an insurance company, the agent must provide separate notices and opt out opportunities as required by the rules. If an agent, for a fee, provides any other services to any institution such as financial, investment or economic advisory services relating to an insurance product, that individual becomes the agent's customer and must be provided with all required notices about the agent's privacy policy.

The rule provides that an independent agent sharing information with multiple insurance companies in order to obtain the best price quote for a client does not need to provide notices to the client. It is the responsibility of each insurance company to comply with the notice requirements as to that client. The client will be considered a consumer of each company to whom the client's information is provided, and if the client purchases coverage from one of the companies, the client becomes the customer of that company.

However, if the agent discloses or plans to disclose that information to anyone other than the companies, the agent must send that client all required notices and provide the client with the opportunity to opt out. Each agency's operations are different, and because the law is designed to reflect all of the different types of information-sharing in the marketplace, there is no one single privacy notice agencies can use to comply with the federal law. Each agency will need to develop its own internal privacy policy and consumer privacy notice.
The agent exception benefits agencies that have exclusive agency relationships with an insurer, such as life insurance agents. It may be better for the agencies to be covered by that company’s GLBA privacy policy. The agent exception also benefits agents that are involved in the more traditional types of agency activities. This would include those who do not share protected information with third parties after a sale is complete. If an agent submits an individual’s application to a number of different insurance companies, that individual is not a customer until an application is accepted and the individual becomes a policyholder of the insurance company.

Any agent wanting to take advantage of this exception should be sure that its appointment contracts require the insurer to be in compliance with its GLBA obligations.

Patients are not guaranteed the right to restrict access to their records. Health care providers may refuse to treat a patient if he will not give consent to share his medical records. Any doctor can use those records to treat other patients without one’s consent. Patients will be given limited information about when and to whom their medical records were disclosed for most health care activities.

There is no penalty for disclosing information in one’s medical record. Consequently, patients have no rights for any kind of action even if they believe that their medical privacy has been violated. Identifiable health information such as banking of blood, sperm or body tissue is not protected by the privacy rule, because it is not considered to be health care under this rule. These items include genetic information, and lack of privacy protection in these areas could have far-reaching effects.

**The Privacy Notice**

Under the new law, each financial institution must have a privacy policy and disclose it to its customers at the time the customer relationship is established and at least once a year thereafter. Institutions must provide, at least on an annual basis, clear and conspicuous notice of their policies and procedures for protecting the consumer’s nonpublic personal information.

Institutions also must give customers an opportunity to "opt-out" before disclosing nonpublic information to an unaffiliated third party. According to the legislation, the financial institutions may share nearly any information with companies with whom they are affiliated. The GLBA is considered a notice statute rather than a restriction statute. It tells institutions that they must give notice to their clients that they may be sharing information.

The GBLA requires that a financial institution give the consumer notice of three things:
• **Privacy Policy:** The financial institution must tell an individual the kinds of information it collects about him and how it uses that information.

• **Right to Opt-Out:** The financial institution must explain the individual’s ability to prevent the sale of his customer data to third parties.

• **Safeguards:** Financial institutions are required to develop policies to prevent fraudulent access to confidential financial information. These policies must be disclosed to the consumer.

Each consumer should receive an annual privacy notice from every financial institution where he has an ongoing customer relationship. If a consumer has more than one account with any company, he will probably not receive a notice for each account. He may receive notices from companies where he was not even aware that he had an existing relationship.

Consumers will receive a written notice in the mail (or by electronic mail, if the consumer normally does business online). The notice, whether received in the mail or online, must be clear and conspicuous. In order for it to be effective, the consumer must agree to receive the notice by electronic means and must acknowledge having received it. Verbal notice alone is not enough, nor is it enough for a company to post a notice at its office.

The law does not require that the consumer receive a separate notice of the privacy policy, his right to opt-out, or the policy regarding safeguarding confidential information. There is no standard form, so the notice may come in a variety of ways. The exact format is left to the discretion of the company. The law requires only that the notice be "clear and conspicuous" and "designed to call attention to the nature and significance of the information contained" in the notice.

Notices may be mailed along with the consumer’s account statements. If the consumer does not want his financial institution to share or sell his confidential information, the burden is on him to recognize the notice and follow the opt-out instructions.
The PATRIOT ACT

On October 26, 2001, President Bush signed the USA PATRIOT ACT (USAPA) into law. With this law Congress gave sweeping new powers to both domestic law enforcement and international intelligence agencies and eliminated the checks and balances that previously gave courts the opportunity to ensure that these powers were not abused.

Purposes of the Act

The purposes of Title III of the PATRIOT ACT are to increase the strength of United States measures to prevent, detect, and prosecute international money laundering and the financing of terrorism. It is also to ensure that banking transactions and financial relationships and the conduct of such transactions and relationships, do not contravene the purposes of the United States Code, or the Federal Deposit Insurance Act. It is important that the purposes of such provisions of law continue to be fulfilled, and that such provisions of law are effectively and efficiently administered.

Cooperation Among Financial Institutions

Two or more financial institutions and any association of financial institutions may share information with one another regarding individuals, entities, organizations, and countries suspected of possible terrorist or money laundering activities.

Compliance with the provisions of the PATRIOT ACT requiring or allowing financial institutions and any association of financial institutions to disclose or share information regarding individuals, entities, and organizations engaged in or suspected of engaging in terrorist acts or money laundering activities will not constitute a violation of the provisions of title V of the Gramm-Leach-Bliley Act.

Insurance companies are included in the Bank Secrecy Act's (BSA's) definition of financial institution, and should be prepared to comply with the new law and the regulations promulgated there under. The insurance industry is adopting new policies and guidelines to safeguard against money laundering as a result of the PATRIOT ACT, which is designed to cut off funding to terrorist cells.
Protecting Client Privacy

Following the money trail is a critical method of identifying terrorists, but it is important to must make sure that the privacy of U.S. citizens does not suffer in the process.

Many have concerns about the U.S. Patriot Act and its impact on financial privacy. The law will require any business that deals with large amounts of cash to file reports when it receives certain amounts and when it detects suspicious activities.

Financial institutions and lawmakers will be continually challenged to strike a careful balance between their efforts to unveil the financial activities of potential terrorists and respect for the financial privacy of U.S. citizens.
III

Legal Responsibilities with the Insured

Definition of the Insured

There are many methods and techniques that are used by insurers in order to define, designate, and distinguish those who are covered by a policy contract. There are just as many ways to define and limit the interests covered by the policy. These methods and provisions vary with the type of coverage purchased. Insurance contracts also generally include provisions that concern the nature of the risks being transferred to the insurer.

Therefore, an insured event, which causes a loss, is the cause for the insurer to pay the benefits to the insured that sustained the loss. However, sometimes the insured that actually sustains a loss arranges for the benefits to be paid to someone else.

The status of a claimant who is someone other than the named insured can be a significant issue. The rights under the coverage may differ, depending on whether the person designated to receive the insurance proceeds is covered as an additional insured. If the transaction does not include a commitment from the insurer to treat the designated recipient of the proceeds as an additional insured, a defense available against the named insured is also a defense against designated assignee.

Property Insurance

Designation of the Insured

There are many approaches used to designate exactly who is an insured in property insurance policies. Most insurance contracts specifically identify the persons or entities, which are the insureds. Usually, this is found on a schedule and is frequently referred to as a declaration. This declaration is typically set forth on a page separate from the standard policy form.
Another frequently used approach to designating the insured is to write the name of the person or entity that is insured in a blank space on the first page of the policy.

Property insurance contracts can identify more than one person or entity as the insured. This may include persons or entities that hold different interests in an insured building such as:

- the owner.
- the first mortgagee.
- a second mortgagee.
- a tenant.
- the holder of a remainder interest.

All of these may be insured on a single given policy. It is appropriate, although not necessary, to state in the property insurance policy the nature of the individual interest of each of the insureds. This is especially appropriate when a person who does not have an ownership interest in the insured property secures the insurance.

For example, this might be someone who is acting in a fiduciary capacity. Stipulating relationships in the contract may reduce the possibility of subsequent disputes over such issues as whether the insurable interest requirement was satisfied. Sometimes the insureds are simply listed as insureds, without indications of their interests. The indication of interest is not required, although it is suggested.

When several persons are identified as insureds in a property insurance policy, the clause “as their interests may appear” is typically used. This provision means that in the event of a loss, the insurance proceeds are paid to the identified persons in proportion to the damage to their respective interests.

**Additional Insureds**

Sometimes the original insured may want to arrange to have the property insurance coverage extended to additional persons or entities. Under these circumstances, those to whom the coverage is extended are characterized as additional insureds.

This type of arrangement is often used when there is a contract for the sale of an insured structure, and the purchaser asks to be designated as an additional insured under the seller’s insurance policy until the sales transaction is completed. Adding an endorsement to the policy may designate more than one additional insureds. If coverage is provided for additional insureds, there should be provisions elsewhere in the policy, or as an endorsement, stating the interests that are insured.
**Multi-Party Arrangements**

Those who have interests in an insured property may be designated, either by name or by a description of their status, as insureds under a single insurance policy. This type of arrangement is known as designation of insureds or as coverage for a named insured and additional insureds. When the clause “as their interests may appear” is used, in the event of an insured loss, this provision provides that the insureds are indemnified in proportion to the harms to their respective interests.

The clauses which are used when the additional insured is a mortgagee generally provide that the insurance “shall be payable to the mortgagee, as interest may appear under all present or future mortgage.” Using this type of arrangement, each of the insureds is entitled to receive part of the insurance proceeds, in the event that his interest in the property is damaged.

An insured may arrange with an insurer that in the event of a loss, all or part of the proceeds will be paid to someone who does not have any interest in the insured property. This type of arrangement is usually employed when one person is designated as the insured, and another person is to be paid the insurance proceeds.

Sometimes a property insurance policy is pledged as collateral for an otherwise unsecured debt, and the creditor has no lien on the property. This arrangement is also used when a creditor has a secured interest in the insured property. This means that the creditor is a mortgagee of the insured property. This type of loss payable arrangement is commonly referred to as an open loss payable clause. It identifies the mortgagee without specifically identifying him as an insured or an additional insured.

When an insurance policy specifically provides insurance for one identified as a creditor and the policy includes the clause extending coverage “as his interest may appear,” this generally means that the insurance proceeds are payable to the creditor only up to the amount of the debt. In this way, the named creditor usually receives the insurance proceeds, even when there is no security interest in the insured property. Therefore, the creditor has no greater interest in the insured property than that of any other unsecured creditor of a debtor.

This language is commonly known as a loss payable clause. A party who is designated in this way is essentially a beneficiary of the insurance proceeds and is not intended or entitled to be treated as an additional insured.
An insurer's obligation to pay the insurance proceeds is generally not affected by the type of transaction that an insured employs to establish an arrangement for more than one person to receive some portion of the insurance proceeds or to transfer a right to receive insurance proceeds.

With respect to most insurance claims, these various arrangements do not affect the insurer’s obligation to provide coverage, nor do they affect the amount of the claim payment which is due in the event of a loss. Further, the choice of a particular arrangement typically does not affect the distribution of the insurance proceeds.

**The Insured’s Interest**

*Mortgaged Property*

Insurance for a property that is subject to a mortgage may be acquired by the mortgagor or by the mortgagee. This insurance may be acquired individually or jointly. When a mortgagor or a mortgagee acquires the insurance, it may be arranged as protection for this person’s individual interest or for the joint interests of the two. When the insurance is not acquired jointly, the individually purchased policy may only identify the purchaser as the insured.

When the mortgagor arranges an insurance policy, the mortgagor’s name is usually on the contract in a statement that the insurer “does insure the insured and legal representatives.” Or he is listed as a named insured on the declarations page. If the mortgagee is also insured, the mortgagee’s name is in another space within a statement, sometimes referred to as a loss payable clause.

When the mortgagor and mortgagee are both identified as insureds, the policy contains a standard mortgage clause referred to as a union mortgage clause. This clause has several important elements, including provisions which specify that the insurance shall be payable to the mortgagee as its interest may appear.

It specifies that insurance for the interest of the mortgagee will not be invalidated by any act or neglect of the mortgagor, and that whenever the insurer pays the mortgagee and establishes that it has no liability to the mortgagor because of some act of the mortgagor, the insurer shall be subrogated to the rights of the mortgagee on the mortgage debt, subject to the mortgagee’s right to recover the full amount of the mortgagee’s claim.

If the mortgagor fails to pay the insurance premiums, or limits or excludes his right of recovery against the insurer, the mortgagee who has been identified as an insured is

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entitled to receive the insurance proceeds. In this situation, the mortgagor is not treated as an insured. Therefore, the insurer may assert a right of subrogation.

Allowing the insurer to enforce subrogation rights does not violate the rule against allowing an insurer to subrogate against its own insured, since the mortgagor ceases to be an insured as a consequence of the act.

**Personal Property**

When personal property is entrusted to a warehouse, either for storage on consignment for sale, distinct types of insurance issues are encountered. Insurance policies for warehouse businesses typically include a provision referred to as an in trust or on commission clause. This is also known as an on consignment clause. This clause extends coverage for damage to property held, but not owned, by an insured.

These clauses have been interpreted to provide quite extensive coverage to the insured. This is likely a result of the rule of resolving disputes in favor of the insured.

The coinsurance provisions included in commercial property insurance contracts apply the coinsurance principle, if the amount of insurance is less than a stated percentage of the actual cash value of the property immediately before the loss.

When a policy contains both a coinsurance clause and an “in trust or on commission” clause, is the property which is held in trust included or excluded when calculating the actual cash value of the property?

Sometimes, the courts have avoided this question by narrowly construing the “in trust or on commission” clause. In contrast, there has been expansive construction accorded to these clauses in order to increase the insurer’s liability. Here an expansive construction of this clause would reduce the insurer’s liability because of the coinsurance provisions.

It might be said that the “property” refers only to the insured’s property and not to the added property. Or, it might be said that the amount included in calculating the actual cash value, because of property covered by the “in trust or on commission” clause, would be limited to the valuation of the insured’s interest in the property, rather than its total value. It is likely that the first assertion will prevail, mainly because unclear or ambiguous terms are always decided in favor of the insured.

However, the answers to these and similar questions are in doubt. A bailee, one who has temporary possession of property belonging to another, should be certain his coverage is adequate to avoid the application of the coinsurance clause, even if the property held in trust is included in the actual cash value calculation. He also should be
certain that his coverage provides an explicit agreement that the property belonging to others is not to be taken into account in determining the applicability of the coinsurance clause.

**Automobile Insurance**

Automobile insurance, much like homeowners insurance is not really one policy at all. It is comprised of many different policies combined to make sure that the policyholder is fully covered for any conceivable accident. The automobile policy is generally divided into six sections, but this will differ from state to state. Depending on where one lives, law may require some of these policies. The driver cannot drive in that state if their auto is not fully insured in the manner that the automobile insurance laws of that state dictate.

The parts of the automobile policy that are not required by law become optional to the automobile insurance buyer. That parts of the automobile insurance policy one buys is dependent on one's personal needs to insure their auto or autos. For example, a car being driven by a teenager will need different coverage than a van that is being driven for taxi purposes.

The various legislative acts that states have adopted to improve the expectance of indemnity have had a major influence on the development of coverage, as well as on the acquisition of automobile insurance. The statutes and the basic public interest, which are represented by this legislation, have affected the judicial treatment of disputes involving provisions of various types of coverages.

The identity of the principal insured for all of the coverages in the typical automobile insurance policy is determined by the policy. The person who purchases the coverage is specifically identified as a named insured. Often, the purchaser expressly designates other persons who are to be insured to the same extent as himself.

The liability coverage in automobile insurance policies typically provides that the insureds are covered for the ownership, maintenance, or use of any auto. Each of these persons is insured as an operator of the vehicle designated in the insurance policy. Additionally, under certain specified circumstances when driving other automobiles, these insureds are also covered.

Most automobile insurance policies provide coverage for specific vehicles identified in the insurance policy. Those who use these vehicles with the owner's permission are also insureds. So, in order to determine whether a liability insurance policy provides coverage, it is necessary to consider the alleged wrongdoer's relationship not only to the person who obtained the policy, but also to the vehicle that was involved in the accident.
Automobile liability insurance generally provides coverage for particular vehicles that are identified in the declarations. Permitted users of those vehicles are insured. When an insured vehicle is being used with the permission of the owner, the policy terms extend coverage for the operation of that vehicle, under the circumstances specified. Typically, these include the expected uses of the vehicle.

**Exclusions**

Automobile liability insurance policies often include clauses that are designed to exclude coverage for specific persons or for classes of persons. Policies commonly state that the liability insurance does not apply to bodily injury to any insured or any member of the family of an insured residing in the same household as the insured.

Sometimes, an exclusion may be included which specifically applies to the named insureds. The clause may state that coverage does not apply to bodily injury to or the death of any person who is a named insured. In the absence of any contradictory statutory provisions, the courts usually uphold these provisions, restrictive though they may be. Legislation, which requires specific coverage to be provided, would be considered a contradictory statutory provision.

Coverage terms are designed to exclude liability for insurers when tort claims are asserted against other named insureds or against additional insureds by a named insured or by any family member in the same household. These provisions sometimes exclude friends, as well.

**Uninsured Motorist**

Uninsured motorist insurance is now included in almost all automobile insurance policies. It is a first-party accident insurance. The insurance company pays insurance benefits to the persons who are identified as insureds in the policy terms.

It is also a fault-based insurance, since the coverage for these insureds only applies when they are legally entitled to recover damages from an uninsured motorist or from a hit and run driver.

Uninsured motorist insurance provides coverage for three classes of insureds:

- the named insured and members of his household.
- persons who are injured while occupying an insured vehicle.
• persons who sustain damages as a result of personal injuries sustained by
  persons who are class (1) or class (2) insureds.

Uninsured motorist coverage has generated an inordinate amount of litigation. The
provision that spouses, relatives, or family members are covered only if they are
residents of the same household as named insureds has been created countless court
cases. The phrase “residents of the same household” really has no precise meaning.

When residency is used in a provision that limits the scope of coverage, that is, when it
is an exclusion, the courts generally interpret the phrase so narrowly that it restricts the
scope of the coverage reduction. The courts interpret the term “resident” in favor of
coverage and typically rule to provide indemnification to injured persons.

**Underinsured Motorist**

Uninsured motorist insurance originally was only available with limits of liability
corresponding to the minimum amounts of coverage required by the applicable state
financial responsibility laws. There were many instances in which serious injuries
occurred as a consequence of the negligence of motorists who were financially
irresponsible, under the applicable state financial responsibility laws.

Consequently, there was need for first-party coverage which would provide insureds
with the right to higher levels of indemnification for accidents involving uninsured
motorists, as well as for accidents involving insured motorists with liability coverages
that were not sufficient. A coverage was needed which would provide first-party
insurance benefits whenever a wrongdoer was uninsured or underinsured.

Today, insurance companies in most states are required to offer insurance for the risk
that the damages sustained by insureds are not adequately indemnified by the liability
coverage carried by a negligent insured motorist.

**No Fault Insurance**

Insurance policies typically provide for the payment of benefits upon the occurrence of
described events, regardless of whether those events are caused by the insured or by
another person. So, most coverages are aptly characterized as no fault insurance.
Many of the coverages typically included in automobile insurance policies provide no
fault protection.

• *Collision coverage* is for damage to the insured vehicle as a result of a collision
  with another object.
• **Comprehensive coverage** is for damage to an insured vehicle caused by falling objects, fire, theft, explosions, earthquakes, and other risks.

• **Medical payment coverage** is for medical treatment from physicians, hospitals, and other health care providers that is required as a result of a collision.

These coverages are viewed as a first-party, no fault insurance because the insurance benefits are paid to the insured regardless of any determination of fault. The interests who are protected by first-party motor vehicle insurance coverages are those of the named insured, persons who are closely associated with named insured, such as family members who live in the named insured’s household, and persons who are authorized to drive or to be passengers in an insured vehicle.

**Health and Life Insurance**

**Advance Directives**

An Advance Directive is a document in which an individual can declare specific healthcare requests and name another person to make healthcare decisions and give necessary medical consent when he is unable to do so. The two major forms of advance directives used in most states are the medical power of attorney and living will.

**Medical Power of Attorney**

In a medical power of attorney, the insured names another person, called his agent, to make medical decisions and give medical consent when and if the insured is unable to do so. In this document, he can specify his desire and limitations on medical treatment. Generally speaking, his agent should carry out his wishes when making his medical decisions together with his healthcare providers.

Having a medical power of attorney is a good idea for any person of any legal age. In most states a spouse can make medical decisions and give medical consent while the individual is unable. But if he does not have a spouse or medical power of attorney, healthcare providers may require a guardianship proceeding if he is not mentally or physically able to make an informed medical decision or give consent.

**Living Will**

A living will gives advance written notice to the insured’s physician, family and friends and instructs them about his wishes if he becomes unable to give directions. It says that
he does not want any life-sustaining procedures, including mechanical ways to restore a bodily function, which would only artificially delay the moment of death. An example of a life-sustaining machine is a respirator. Pain medications, food and water ARE NOT considered life-sustaining substances. A living will usually requests that family and physicians honor the individual's wishes.
One of the basic characteristics of any insurance system is the use of contracts. These contracts are in the form of an agreement for the transfer of a loss by obligating the insurer to bestow an offsetting benefit to the insured. The terms transfer of loss and offsetting benefit are both commonly used to indicate that the amount of insurance benefits paid when a loss is sustained must not exceed the economic measure of the loss.

**The Principles of Indemnity**

Indemnity is a collateral contract or assurance by which one person secures another against an anticipated loss. Indemnity signifies compensation has been given to an insured in order to make him whole again and relieve him from his loss.

Most types of insurance are designed to provide no more than reimbursement for an insured. It is a fundamental principle of insurance that opportunities for net gain to an insured, through the receipt of insurance proceeds exceeding his loss, should be considered adverse to the public interest.

Insurance arrangements are structured to provide funds to offset a loss, either wholly or partly. The payments made by the insurer are generally limited to an amount not greater than what is required to restore the insured to a condition “relatively equivalent” to what existed before the loss.

- **The principle of indemnity** is based on the concept that insurance contracts should confer no benefit greater in value than the loss suffered.

However, the principle of indemnity does not imply that the amount of an insurance payment must be equal to the loss. When insurance provides only partial reimbursement, the principle of indemnity is not compromised. In fact, in many situations, purchasers acquire insurance contracts that do not provide complete and total indemnification in the event of a loss.
The principle of indemnity has a great influence on insurance law. However, it is only one of the facts that affect legal disputes involving questions concerning the amount of insurance benefits a claimant may receive.

**The Doctrine of Insurable Interest**

The doctrine of insurable interest requires that there must be some significant relationship between the insured and the person, object or activity that is the subject of the insurance transaction. The specific justification for the doctrine of insurability is “avoiding one or more of the potential evils which might result from allowing insurance contracts which afford opportunities for net gain as a result of the loss”.

The doctrine of insurable interest came about as a result of underwriters in the early eighteenth century agreeing not to demand proof of the insured’s interest in the ship or cargo being insured. Not surprisingly, a great number of ships and their cargoes were soon fraudulently lost and destroyed.

**Objectives of Insurable Interest**

Usually the objectives of the doctrine of insurable interest are accomplished by requiring the *self-interest of the insurer*. In other words, the insurer would ordinarily desire to provide coverage only for the benefit of those who have an interest in the subject of the insurance.

Insurers usually determine whether the required insurable interest exists *before* entering into the insurance contract. In the case of some types of property insurance, they make a careful examination only after a loss occurs. This examination explores whether the required insurable interest exists and the value of the insured’s interest.

The objectives that underlie the doctrine of insurable interest and the principle of indemnity include:

- avoiding inducements to wagering.
- avoiding inducements to the destruction of insured property.
- avoiding net gain to an insured through receipt of insurance proceeds, which exceed the loss suffered.

With respect to property insurance, an insurable interest is required for property insurance at the time of loss *and* at the time of affecting the contract.
With respect to marine insurance, there is still some disagreement concerning when an insurable interest must exist. Most likely, like property insurance, the insurable interest is required at the time of loss and at the time of affecting the contract. Surprisingly, a majority view on this point cannot be determined. However, insurers have chosen not to defend such questionable cases because a successful defense would literally destroy many lucrative types of insurance business.

An insurer may raise questions concerning whether a claimant has the required insurable interest. In fact, judicial decisions have ruled that only the insurer can raise the question of whether a claimant has the required insurable interest. Accordingly, other persons do not have the standing to question whether an insured or a beneficiary as the required insurable interest. A party to an insurance contract has a legitimate interest in questioning the existence or the absence of insurable interest. This rule applies to both property and life insurance.

Once an underwriting decision has been made by an insurer, for business reasons an insurer is not likely to evoke a defense of lacking insurable interest, even if there is an opportunity for net gain under the contract terms. Of course, if there are other valid reasons for denying a claim, the issue is a different one.

If an insurer decides to raise the issue of lack of insurable interest in order to defeat a claim, it is often because there is strong suspicion of fraud, and a defense based on the lack of insurable interest would be less difficult to prove than the existence of fraud.

**Returning Premiums**

Insurers sometimes return premiums when a claim is denied on the basis of lack of an insurable interest. This tender is probably made in the hopes of avoiding a claim by the insured or the beneficiaries or in the hopes of enhancing the insurer’s image and improving the chances of presenting a successful defense to a claim.

There are relatively few judicial decisions on whether an insurer is obligated to return premiums that have been paid by an insured that lacked the required insurable interest. There are not many instances in which courts have addressed the question whether an insurer that successfully avoids paying a claim on the basis of the absence of the required insurable interest is obligated to return the premiums that were paid.

Some courts have been disturbed about the inequity of allowing an insurer to collect premiums and then defend against a claim that seeks the insurance benefits on the basis of the lack of insurable interest. It has been suggested that any unjust consequence as a result of the collection of premiums and the subsequent nonpayment
of the promised benefits could be addressed by ordering a refund of premiums collected, with interest, when an insurance contract is held to be unenforceable. Refunding the paid premiums provides an acceptable degree of remedy.

**Non-Compliant Contracts**

Insurers ordinarily do not make contracts, which are not in compliance with the insurable interest doctrine. However, even legitimate insurers sometimes market insurance contracts, which afford coverage for insureds that do not have an insurable interest. Marine insurance honor policies are examples of this.

In some instances, these insurance transactions may be defended on the basis that they are designed to serve the commercial convenience of those having legitimate interests in the property covered by the insurance, but that these interests are somehow difficult to prove under legal standards.

Insurers may decide to underwrite some risks, even when it is clear that there is no insurable interest, because an insurer’s reputation for declining coverage requests might cause it to lose lucrative business opportunities in the future. Similarly, insurers may also choose to pay claims in order to maintain good public relations or to avoid expensive litigation.

The enforcement of the doctrine of insurable interest depends almost exclusively on the initiative of the insurer. It is sometimes called upon in instances in which the insurer wishes to deny a claim for other reasons, but this defense is an easier one to sustain.

**Property Ownership and the Insurance Contract**

**Property Rights**

Property rights are characterized as ownership interests. They are uniformly recognized as sufficient to satisfy the insurable interest requirement.

**Contract Rights**

In many circumstances, contract rights can be transformed into property rights, that is, a contract establishes rights or interests, which may mature into an ownership interest in a property. For instance, a buyer’s contract for the purchase of real estate is
appropriately treated as a property right because the contract follows the doctrine of equitable conversion.

A lien on a property, which often exists as a result of a contractual relationship such as a construction contract, is also recognized as property interest. These contract rights are given the same status as property rights so that they are always sufficient to satisfy the insurable interest requirement.

**Property Ownership Issues**

**Stolen Vehicles**

Although there is not complete unanimity among the appellate courts that have considered whether a person who purchases a stolen vehicle has an insurable interest, there seems to be a definite trend among recent cases. These decisions reach the conclusion that such a purchaser has an insurable interest in a stolen vehicle.

The justification here is that the insured generally stands to benefit from the continued existence of the vehicle, even though he could not maintain possession against a claim by the true owner of the property.

The decisions that recognize an insurable interest in a stolen vehicle rest on the good faith of the purchaser, with respect to the acquisition of the stolen vehicle. That is, he must not know the vehicle was stolen or have participated in its theft.

However, the existence of good faith on the part of the purchaser of any stolen vehicle seems to be an increasingly difficult status to achieve. This is mainly attributable to the increasing use of computer systems to keep track of motor vehicle title registration and the identity of stolen vehicles throughout the country.

**Property Owned by a Spouse**

Typically, a spouse has some insurable interest in the property of the other spouse. In fact, each spouse has an insurable interest in virtually all of the property of the other spouse. However, even under the rule that requires a legally enforceable insurable interest, often such an interest would also be supportable by homestead rights, by rights of courtesy or dower (provisions for widows, widowers, or common law marriages), or by community property rights.

**Property Owned by a Corporation**
With rare exceptions, American decisions support the view that a stockholder, although not having a legal or equitable title to the property of a corporation, nevertheless, has an insurable interest in property, which is owned by the corporation.

*Property Owned by a Debtor*

Usually, an unsecured creditor has no insurable interest in a living debtor’s property, even though it is generally acknowledged, both in legal doctrine and in practice, that a creditor may insure a debtor’s life. The recognition of a distinction between a creditor’s interest in a debtor’s life and an interest in the debtor’s property is defensible on the ground that, ordinarily, an unsecured creditor depends less on the debtor’s assets than upon his personal reliability and his earning power.

After a debtor’s death, a strong argument can be made for the position that an unsecured creditor should have an insurable interest in a deceased debtor’s property because the creditor can then make a claim against the property in the estate of the deceased debtor.

*Measure of Recovery*

*Marine Losses*

Marine losses are different from other types of losses. An insured event, in marine terminology, is a casualty from which an insured peril makes it impossible for the insured property to reach its destination.

- Such an event is an *actual total loss*.

Another type of total loss is a *constructive total loss*. A constructive total loss occurs when it would be possible for the property to be brought to its intended destination, but the cost of doing so would exceed the value of the property.

The measure of recovery for hull losses and cargo losses is recovery in full for full or partial losses, up to the amount of the insurance.

*Property Insurance*

Property insurance policies typically provide that, subject to certain qualifications, the company insures the property to the extent of the *actual cash value*, also referred to as *cash value*. Insurers who use this type of coverage provision usually have in mind that the loss will be determined by the value of the property when the insured event occurs.
In fact, some coverages explicitly provide that the valuation must be made at that time. However, other coverage terms are sometimes also used. Some property policies provide coverage for the actual value, as determined at the time coverage commences.

There are several approaches that have been used to establish the actual cash value of insured property. These include methods based on:

- determinations of the market value.
- replacement cost.
- repair cost.
- replacement or repair cost, less depreciation.

Sometimes these different valuation methods produce basically the same result, and in other instances they produce distinctively different measures of recovery.

**Market Value**

When the market value of a property that has been damaged can be easily determined, this is the value that is generally regarded as the appropriate measure of actual cash value. For example, the commonly used measure of recovery of insurance on buildings is the diminution in the fair market value of the structure, as determined by an appraisal of the difference between what a willing buyer would pay and willing seller would take before and after the insured event which caused the loss. This approach may also be applied to personal property claims.

There are some situations where indemnification based upon the differential in the market value before and after the insured event is not an appropriate measure of compensation for an insured’s loss. Coverage for the actual cash value of property is not always synonymous with market value.

**Cost of Replacement**

In these instances, recovery under a property insurance policy is determined by reference to the cost of replacement. Or, it is determined by reference to the original purchase price paid by the insured. Replacement cost is also considered to be an appropriate measure of recovery when that cost is shown to be lower than the original cost of the property or lower than the market value of the property just before the occurrence of the insured event.

Another approach to determining actual cash value is to assess the loss in terms of the cost to replace or reproduce the property. Then this amount is reduced by a
depreciation factor. When using this method, the effect of depreciation can be a significant factor in determining the amount of recovery.

No particular approach to valuation is conclusive with respect to recovery. Appraisers and others use many other methods that have been held by the courts to be relevant measures of recovery, when valuation disputes arise. In some instances, insureds have been permitted to recover the costs associated with repairing a structure without actually being required to show proof of the market value or without any reduction for depreciation.

Some courts have adopted an approach known as the broad evidence rule. This approach requires a fact finder whose job it is to consider all of the evidence, which an expert would consider relevant.

Depreciation

The actual condition of the property affects its value. The effects of age and wear and tear on property are often thought of in terms of depreciation. The amount of indemnification may be influenced by allowances for depreciation. Determining the effects of depreciation can be difficult. Further, assessing an insured’s recovery with an allowance for depreciation may leave an insured with significant out-of-pocket losses.

There is some doubt about the extent to which depreciation should be taken into consideration in the settlement of losses. This is especially true with respect to partial losses, which can be repaired and to vehicles covered by motor vehicle insurance. There also seems to be some disagreement about the desirability of making a deduction for depreciation in calculating actual cash value of motor vehicles.

For example, there are many factors, which affect the value of a vehicle when it is damaged as the result of a collision. It might be argued that neither the loss nor the reduction in actual cash value is equal to the cost of making the repairs, since the repaired vehicle is often in better condition than it was in before the collision. Conversely, once a vehicle is seriously damaged and repaired, it is not typically as valuable in the market place as before the collision.

Coinsurance Provisions

Coinsurance clauses provide that an insured must maintain coverage for an insured property that is at least equal to some specified percentage, typically 80%-90% of the full value of the property. If the insured does not maintain this coverage, he must bear a portion of the risk for either a partial or a total destruction of the property.
Property insurance coverage, other than marine insurance, is not treated as coinsurance unless the insurance policy specifically states so. Otherwise, the insurer is liable for the full amount of any insured loss up to the underwritten amount.

There is great importance to applying the coinsurance approach when insurance is being provided for buildings. This results because the rates for property insurance for a particular type of risk have typically been fixed, regardless of the total value of the property or the amount of coverage purchased.

Therefore, because the insurer will more often be required to provide indemnification for partial losses, the cost, as reflected in losses to the insurer of providing the first one thousand dollars of coverage, is considerably more than the cost of providing the highest one thousand dollars of the coverage.

These factors, the premium rate, and the higher incidence of partial destruction of property cause some insurance purchasers to take a chance by acquiring some amount of insurance that is less than the full value of the property. This is especially true in the absence of a coinsurance feature.

**Indemnity Principles**

The measure of recovery does not necessarily conform exactly to the principle of indemnity. Neither actual cash value nor the reproduction cost less depreciation brings about a measure of recovery, which accomplishes *exact* indemnity of an insured’s loss. Either method might produce more than indemnity for an insured that, for example, was about to accept an offer to sell his home at a price less than the insurance benefit, if a fire occurs.

In some insurance policies, coverage is provided for the cost of replacement or reproduction, and no reduction is made for depreciation. This adaptation protects the insured against the risk of having to pay beyond the amount of the insurance proceeds, if a deduction were made for depreciation. The proceeds paid under this type of coverage are likely to provide an insured with more than indemnity.

However, as long as the insurance benefits are used to make the repairs or replacement, generally, there is only a minimal deviation from the indemnity principle. In practice, this is probably the most, which can be accomplished.
**The Doctrine of Subrogation**

**Subrogation** developed as an equitable doctrine. To subrogate means “to substitute”. Subrogation substitutes one person for another, with respect to a claim or right that the second person has against a third party.

When an insurer indemnifies an insured that is entitled to recover compensation for a loss from another source, the insurer may be subrogated to the insured’s rights. This means that the insurer is substituted for the insured with respect to all or some portion of the rights that the insured has to receive compensation from the other source.

**Conventional Subrogation**

An insurer who asserts a subrogation right is generally considered to be standing in the place of the insured, so that the insurer’s rights are equal to, but no greater than, those of the insured. An insurer’s subrogation right may be provided for by a clause included in the policy or in a settlement agreement with an insured. This type of subrogation right is often referred to as conventional subrogation. Sometimes, the right of subrogation for insurers is specifically conferred by statute.

**Legal Subrogation**

When there is no policy provision or legislative act that expressly confers the right of subrogation, an insurer may be entitled to seek subrogation on the basis of a judicially created right. A judicially created right is a right of subrogation that exists as a consequence of some judicial determination by the courts. This type of subrogation is known legal subrogation.

When the court considers whether or not a subrogation right should exist in the absence of a provision in the policy contract or in the absence of a legislative provision, the concern is usually over whether the insured will receive compensation which provides more than full indemnification, as a result of recoveries from the insurer and from other sources. The courts tend to favor subrogation if it appears that a third party is likely to escape his financial responsibility, if the insurer were not accorded a subrogation right.

Subrogation is an important technique for serving justice by placing the economic responsibility for injuries upon the person whose fault caused the loss, without also allowing a recovery by the injured person from both the insurer and the wrongdoer. This type of an action would clearly violate the principle of indemnity.

Generally, an insurer is not entitled to subrogation rights that may exist as a consequence of a liability claim against its own insured. There is no right of subrogation
for an insurer against a person who is the named insured or against any party who is covered as an additional insured. The insurer’s subrogation interest is typically limited to the rights an insured may have against third persons, that is, against those who are not parties to or beneficiaries of the insurance relationship.

**Subrogation and Insurance**

**Property Insurance**

A property insurer is almost always entitled to assert a subrogation right with respect to any claims its insured may have against another person. The reason for subrogation in this context is that it prevents violations of the principle of indemnity.

Property insurance policies often include a subrogation clause. Property insurers often require a formal assignment to the insurer of an insured’s claims against others with respect to payment of insurance benefits.

**Liability Insurance**

Liability insurance policies also typically include subrogation provisions. There are judicial precedents that support the recognition of a broad subrogation right in connection with liability insurance. In fact, this broad subrogation right may even go beyond the rights provided for by the subrogation terms of the policy.

For example, suppose an attorney’s malpractice insurer reached a settlement with claimants who had purchased a property and were injured as a result of the attorney’s negligent title examination. The insurer would be permitted to assert a subrogation claim against the sellers of the property for breach of the warranty provision contained in the real estate conveyance. The subrogation right exists because justice places the burden of bearing the loss where it ought to be, that is, on the sellers who breached the warranty and who were unjustly enriched.

The uninsured motorist insurance policy provisions often include the section, “Trust Agreement”, as a form of subrogation. This provision provides that in the event a payment is made to any person under the policy, the company is entitled “to the extent of such payment to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of such person against any person or organization legally responsible for the bodily injury because of which such payment is made”.

This provision entitles the insurer to the reimbursement of any sum that the insured may secure from anyone who is legally responsible for the accident. It also entitles the insurer to be reimbursed for any recovery from a third party until the company has been
fully repaid. This includes payment for all costs incurred in connection with securing the recovery.

Casualty Insurance

Casualty insurers are often given subrogation rights by the courts, in the absence of express contract provisions. However, the recognition of these rights is not necessarily a universal practice for all forms of casualty insurance. Subrogation is often limited, and may depend upon some of the following issues:

- the nature of the third party. This issue concerns whether or not the third party is the original wrongdoer, such as the forger. Perhaps the third party is an innocent intermediary, such as the bank upon which the forged check was drawn.
- the specific type of insurance under which the loss is covered.
- the allocation of loss rules of negotiable instruments law. If the insured is the bank upon which the forged check was drawn and has coverage under a forgery bond, the insurer is generally subrogated to the bank’s claim against the innocent party who cashed the check for the forger.

Legislation and Health Insurance Contracts

Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act (ERISA) governs almost three million health benefit plans sponsored by private sector employers nationwide. These plans provide a wide range of medical, surgical, hospital and other health care benefits to almost 125 million Americans. Under ERISA, workers and their families are entitled to receive a summary plan description describing the benefits offered by the plan, how they qualify for benefits, and procedures for filing benefit claims. This plan document also explains the process under which individuals appeal denials of benefits.

Group health plans have up to 90 days to respond to original claims for benefits from workers and their beneficiaries. Individuals then have at least 60 days to appeal denied claims. Plans must consider and respond to appeals of denied claims within 60 days and provide a written explanation of the reason for the denial. Dramatic changes have occurred in recent years in the nature and delivery of health benefits. Claims procedures are particularly important to persons covered by private-sector employment-based health plans because benefit disputes can affect the delivery of health care services.
The Employee Retirement Income Security Act (ERISA) creates statutory requirements for employee benefits plans to ensure that employees will not suffer in the event of company bankruptcy, fraud, or other adverse situations. Although the Act does not require employers to provide benefits, it does establish rules pertaining to employee participation, funding, fiduciary obligations, and more.

The Employee Retirement Income Security Act (ERISA) applies a revised and restated version of the prudent man rule to pension and profit sharing portfolios. ERISA requires that a fiduciary manage a portfolio with the care, skill, prudence, and diligence, under the circumstances then prevailing, that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

This statement differs from the classic prudent man rule in that familiarity with such matters suggests a higher standard than simple prudence—hence the name, prudent expert rule. Other provisions of the law and United States Department of Labor regulations suggest a portfolio approach under which a position imprudent in isolation may be acceptable in a portfolio context.

**Mental Health Parity Act**

The Mental Health Parity Act (MHPA) requires that annual or lifetime limits on mental health benefits be no lower than that of the dollar limits for medical and surgical benefits offered by a group health plan. The law:

- generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan;
- provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity).

The law also contains the following two exemptions:

**Small Employer Exemption** ~ MHPA does not apply to any plan or coverage of any employer who employed an average of between two and 50 employees on business days during the preceding calendar year, and who employs at least two employees on the first day of the plan year.
Increased Cost Exemption ~ MHPA does not apply to a group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least 1%.

The law, however, does not apply to benefits for substance abuse or chemical dependency.

**Women & Job Based Health Benefits**

Working women are likely to be the primary decision maker for the family as well as the caregiver when a family member falls ill. Therefore, women need adequate knowledge and tools to satisfy their multiple roles as decision makers and consumers of health care.

Data show that women are the primary seekers of information about their legal rights under private employment-provided health insurance, making 66% of the calls to the Department of Labor. Concurrent with the growth in women’s employment has been an increase in the number of women with health insurance through their jobs.

**Newborns’ and Mothers’ Health Protection Act**

The Newborns’ Act and its regulations provide that health plans and insurance issuers may not restrict mothers’ or newborns’ benefits for a hospital length of stay that is in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider who is a person such as the mother’s physician or nurse midwife may, in consultation with the mother, discharge earlier.

The Newborns’ Act and the new regulations prohibit incentives in any way (positively or negatively) that could encourage less than the minimum protections under the Act as described above. Basically, a mother cannot be encouraged to accept less than the minimum protections and an attending provider cannot be induced to discharge a mother or newborn earlier than the minimum protections provided in the Newborns’ Act. The type of coverage and the state law will determine whether the Newborns Act applies to a mother’s or newborn’s coverage. For coverage that is self-insured, the Newborns’ Act provisions always apply. Many states have passed laws containing protections similar to the Newborns Act. Thus, in cases where health benefits are provided through insurance, the state laws would apply.
Women's Health and Cancer Rights Act

The Women’s Health and Cancer Rights Act contains protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. In certain cases, plans offering coverage for a mastectomy must also cover reconstructive surgery in connection with a mastectomy. It applies to individual health insurance policies offered, sold, issued, renewed, in effect, or operated on the date of enactment.

The law:

- applies to group health plans, health insurance companies, or HMO’s if the plan or coverage provides medical and surgical benefits with respect to a mastectomy
- requires coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient

Under the Act, reconstructive benefits must include coverage for:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance
- prostheses and physical complications at all stages of mastectomy, including lymph edemas.

Benefits under the act may be subject to annual deductibles and co-insurance consistent with those established for other benefits under the plan or coverage.

The law also contains prohibitions---

- Plans and issuers may not deny patients eligibility or continued eligibility to avoid the requirements of the Women’s Health Act;
- Plans and issuers may not provide incentives to, or penalize, physicians to induce them to provide care in a manner inconsistent with the Act.

Group health plans, health insurance companies, and HMO’s covered by the law must notify individuals of the reconstructive benefit available under the Act. The Labor Department has authority to prescribe regulations clarifying how group health plans can comply with the notification requirement of the Women’s Health Act.
Group Life Insurance Contract

One of the primary features of Group Life insurance is that it is made available to everyone in the group at much more attractive rates than would be available with an individual policy. Insurers are able to offer this advantage because of the law of large numbers. The expectation is that many people of differing ages and health conditions will pass through the group over time. Some members will leave the group before they die, thus terminating their insurance coverage since Group Life is usually term insurance. New, often younger, members will join the group, generating additional life insurance premiums.

Insurability

Usually only members of the very smallest groups are required to prove their individual insurability, while members of larger groups are often covered automatically when they become eligible. This is typical, but there are exceptions, so it is important to know exactly how a particular insurer writes Group Life coverage.

Benefit of Schedules

A Benefit Schedule is a predetermined statement of the formula under which benefits will be provided. These Benefit Schedules generally generate coverage amounts by using five different formulas. These five formulas are:

Duration of Service ~ This will reward long-term employees and may also decrease an employee’s incentive to leave the company. Few employees would stay with a company only because of the group coverage or of its formula or the insurance coverage provided to employees under this method.

Occupational Classifications ~ Uniform amounts of coverage are provided within each classification. The advantage of this type of formula is that it is simple to administer and is somewhat related to the employee’s survivors’ needs, to the employee’s ability to pay in the case of a contributory plan, and to the employer’s assessment of the employee’s worth to the business.

Combination of Factors ~ Perhaps the most common formula will base the amount of insurance on a multiple of the employee’s income -- from one to three times earnings. Most insurers require a minimum of $5,000 on each covered employee or even $10,000 in the case of small groups. Some insurance companies may require a minimum coverage for the entire group. However, most insurance companies will issue up to $500,000 or more on any particular life. Group insurers use medical examinations for
ultra large amounts, sometimes establish special reserves, and reinsure at least a portion of the coverage.

_Earnings_ ~ Proponents of an earnings basis schedule point out that this type of formula benefits survivors by providing an amount equal to full salary for a limited time after death and by tending to increase with inflation since it is tied to salary. The employees who may be more productive and consequently are paid more are rewarded accordingly, and if the plan requires contributions, cost is directly related to the employee’s ability to pay.

_A Flat Benefit_ ~ This formula provides a flat benefit amount for all participants, thus being the easiest formula to administer. Giving everyone the same benefit bears a close relationship to a “needs and abilities to pay” policy. This type is a very good choice for a large multiple-employer group that is providing coverage under collective bargaining agreements.

**Master Contract**

With Group Life insurance, only one policy is issued -- the master contract is held by a master policy-owner, such as the employer. The master contract details the coverage just as any other life insurance policy does, but instead of individual policies, insured employees receive certificates of insurance as proof of coverage. This certificate provides essential information such as:

✓ Who is covered
✓ When the coverage takes effect
✓ How long it lasts
✓ The amount of insurance provided
✓ The claims procedures

Usually these certificates are included in the announcement booklet distributed to the insured at the time a Group Life insurance plan is installed.

Since the employer is considered to be the master policy-owner, he or she is responsible for paying premiums to the insurance company, although the employee may share in the payment of the policy premiums.

When the employer signs the master contract, he or she will be assured that the insurance company cannot refuse to renew the contract as long as the employer wishes to continue coverage and pays the premiums. However, the insurer does have the right to increase the premium rates. The insurance company, according to the master
contract, will also have the right to cancel the contract if the number of employees falls below a specified number.

There are four important clauses in the master contract.

✓ **Grace Period** ~ This period is generally for 31 days after the premium is due.
✓ **Claims Limitation** ~ A death benefit claim must be made within one year of the last premium paid for a deceased employee.
✓ **Adjustment in Premiums Clause** ~ When an employee’s age is overstated, the employer will receive a refund. However, if it is understated, there is no change in the employee’s coverage, but the employer will be required to make up the difference in premiums.
✓ **Incontestable Clause** ~ The policy is incontestable except for fraud.

**Qualifying Factors for Group Life Insurance**

The Employee Retirement Income Security Act (ERISA) has requirements that a Group Life insurance plan must meet to qualify. One of the many requirements is that the plan must be established and maintained in writing. In addition to this, the plan document must provide a procedure of amending the plan should the occasion arise, and plan documents must provide one or more “named fiduciaries” who administer the plan.

The plan documents must specify the basis on which payments are to be made to and from the plan. The claims review procedure of the plan has the following prerequisites for a Group Term Life policy:

- The individual’s employer must provide under a policy carried directly or benefits indirectly.
- The plan’s benefits must be offered to a group of employees as compensation for their services.
- The amount of insurance provided to each employee must be computed under a certain formula.
- The plan must provide a specific death benefit that meets the definition of the life insurance contract.
Legal Responsibilities in Liability

Property Loss Exposures

Categories of Property

Real property has been defined as “land and whatever is growing on it, erected on it, or affixed to it. Common examples are buildings and attachments to buildings, land, and crops or other items growing on the land.

Personal property has been defined as “anything that is subject to ownership other than real property.” Examples are automobiles, money, clothes, radios, furniture, sailboats, jewelry, and tickets to a rock concert, textbooks, paintings, personal computers, airplanes, chemicals, and animals.

Direct or Indirect Loss

When property is damaged, there may be both direct and indirect losses. A direct loss occurs when there is damage to property, as when a fire damages a home. Indirect loss occurs when a direct loss causes expenses to increase or revenues to decline. Because of this dual nature of property losses, many insurance contracts insure both direct and indirect losses in the same contract.

Indirect losses are more difficult to identify than direct property losses. One can see a machine and measure its value, but we cannot see the lost profits if the machine is unavailable for several months. It is difficult to estimate how long a machine or a building will be unavailable after a loss, or whether a loss will occur during a busy season or a slack period. The process begins with a forecast of expected income under normal circumstances. A second estimate of post loss income follows. The difference is the potential income loss following a direct loss.
**Liability Losses**

Liability losses arise from three sources. One of these is an organization responsible for negligently injuring someone must pay legal damages awarded by a court to the injured party. Another is the cost of a legal defense. Loss prevention arising from potential legal liability is the third source.

One of the most serious financial risks covered by insurance is that of loss through legal liability for harm caused to others. Insurance for liability losses is more complex than property insurance, because people other than the insured and the insurer are involved.

**Negligence**

Liability is usually determined by proving negligence, a concept that is difficult for most people to understand. Negligence as a basis for determining liability for industrial accidents and illness has been eliminated by the adoption of workers’ compensation laws.

**Limit of Liability**

The limit of liability is the maximum amount that an insurance company will pay in case of a loss; sometimes it is referred to as the policy’s face amount. This amount is set forth on the declarations page in the policy. Despite a maximum amount payable for a loss, a policy may have inside or internal limits or special limits of insurance, regardless of larger limits of insurance on the home and personal property.

**Liability Damages**

Individuals may be sued for numerous types of liability damages. Insurance contracts are designed to pay only for certain types of losses. In terms of liability, insurance policies are usually restricted to pay for bodily injury, property damage, personal injury, and legal expense.

*Bodily injury liability* includes liability for losses a person may incur because his/her body or mind has been harmed. Such losses include payments for medical bills, loss of income, rehabilitation costs, loss of services (household as well as marital), pain and suffering damages, and punitive damages.
Property damage liability for damage to real and personal property may arise. There may be a loss from actual damage to the property, as well as loss of use of the property. The loss of use exposure may include both loss of income, because the property cannot be used, and payments for extra expenses, because property must be rented to replace the damaged property.

Personal injury liability losses result from libel, slander, and invasion of privacy, false arrest, and the like. Libel involves written, printed, or pictorial material that damages a person’s reputation by defaming or ridiculing the person. Slander involves spoken words that are defamatory and/or injurious to a person’s reputation.

Legal expenses caused by individuals or organizations being sued must be prepared to retain a lawyer for their defense, as the defense process can be very costly. In some types of loss exposures, such as product liability, the cost of defense may be as great or greater than damage awards.

Types of Liability Exposures

There are many types of liability exposures. They arise out of different functions performed and standards of care required of persons or organizations.

Contractual Liability

Under this concept, one’s liability may be imputed to another by contract. A city may require that a street paving contractor hold the city harmless for all negligence arising out of the operations of the contractor. Consequently, suits that might be directed against the city will be directed against the contractor.

Employer-Employee Liability

Workers’ compensation laws do not cover all classes of employees. Farm workers and workers of an employer who hires fewer than a specified number of people are often excluded from coverage. The duties owed by an employer to employees and, which if not covered properly, may give rise to liability are the following:

- The employer must provide a safe place to work.
- The employer must employ individuals reasonably competent to carry out their tasks.
- The employer must warn of danger.
- The employer must furnish appropriate and safe tools.
The employer must set up and enforce proper rules of conduct of employees, as they relate to safe working procedures.

The employer may use the common-law defenses in suits by employees, providing these defenses have not been lost for one reason or another. If a worker brings an action against an employer for some breach of care, the employer may argue either that the worker was partly to blame (contributory negligence defense) or that the worker should have known there were certain risks on the job and cannot complain because one of these risks materialized (assumption of risk).

**Property Owner-Tenant Liability**

In situations that involve the use of real property, the tenant or owner owes a certain degree of care to those who enter the premises. In most states, the degree of care is governed by the status of the person entering. Common law recognizes three classes of individuals who enter premises: invitees, licensees, and trespassers.

**Invitees** are individuals who are invited on the premises for their own benefit as well as for that of the landlord or tenant. It is not enough to warn an invitee of danger; positive steps must also be taken to protect an invitee from a known danger and to discover unknown dangers. Customers in a retail store or guests at a hotel are examples. The collapse of the skywalk at the Kansas City Hyatt Regency resulted in 200 injured persons and 114 people killed. Accidents like this produce liability losses in the millions.

**Licensees** are those who are on the premises for a legitimate purpose with the permission of the occupier. Typical licensees are police officers and fire fighters. The landlord owes the licensee the duty to warn of danger and to refrain from causing deliberate harm, but no other duty.

**Trespassers** include all those other than invitees and licensees who enter on the premises. No care is owed to a trespasser, but an owner cannot set a trap for or deliberately injure a trespasser. If the trespasser is injured by some unknown, hidden hazard, the landlord or tenant is not liable. There is a current trend to abolish the classifications of trespasser, licensee, and invitee and to hold the occupier of the land liable under most circumstances for failure to exercise due care.
**Liability of Tenant**

When an individual leases a building, the question arises as to what extent the landlord is responsible for injuries to tenants. In general when the landlord releases possession of the building, the tenant takes on whatever duty the landlord owes to members of the public.

In some cases, the landlord is liable to a third person because the landlord has retained possession of the area where the third person was injured. In most states it is both common and legal to require, by terms of the lease, that the tenant assumes whatever liability the landlord may have had for injuries to members of the public or to employees of the tenant.

**Attractive Nuisance Doctrine**

Under a doctrine that has become known as the attractive nuisance doctrine, the liability of the occupier of land may be changed so that a trespassing child is considered to be an invitee. In various situations, landlords have been held liable for placing an allurement of some kind known to attract children, who are incapable of recognizing the danger involved. The courts, in utilizing the attractive nuisance doctrine, usually consider the age of the child in rendering judgments.

**Breach of Warranty**

A manufacturer, wholesaler, or retailer is required to exercise reasonable care and to maintain certain standards in the handling and selection of the goods in which it deals. If injury to person or property results from the use of a faulty product, there may be grounds for legal action in the courts. Such actions are generally based on grounds of breach of warranty, strict tort, or negligence.

A warranty may be expressed or implied. A seller may give a written or an express warranty on goods or services sold, and it is the breach of this written contract that may give rise to a court action. Under the Uniform Commercial Code, the seller is held to have made certain unwritten or implied warranties concerning a product. These warranties are:

- The seller warrants that the goods are reasonably fit for their intended purpose.
- The seller warrants that when the goods are bought by description instead of by actual inspection, the goods are salable in the hands of the buyer.
Breach of implied warranty is most often used as the basis for suits for faulty products. The injured consumer may bring cases of liability of a manufacturer for faulty products directly or by a retailer who has paid a judgment as a result of selling a faulty product, particularly in the case of food, medicine, explosives, or weapons.

**Strict Tort**

Under strict tort liability, the manufacturer or distributor of a defective product is liable to a person who is injured by the product, regardless of whether the person injured is a purchasers, consumer, or a third person such as a bystander. It must be shown that there was a defect in the product and that the defect caused harm. The manufacturer cannot claim as a defense that no negligence was committed or that the defect was in a component purchased from another manufacturer.

**Negligence**

A person injured because of the use or condition of a product may be entitled to sue for damages sustained on the theory that the defendant was negligent in the preparation or manufacture of the product or failed to provide adequate instructions or warnings. A manufacturer is held to have the knowledge of an expert with respect to the product involved and must, therefore, take reasonable steps to guard against the dangers or inadequacies apparent to an expert.

**Criminal and Civil Law**

Criminal law is directed toward wrongs against society. Examples of such wrongs would be murder, robbery, rape, and assault with a deadly weapon. A government body or agent, such as a city, county, state, or federal prosecutor, makes charges under criminal law and the guilty party is subject to fine and/or imprisonment.

Civil law is directed toward wrongs against individuals and organizations. A person may be tried for criminal and civil charges for the same action. Someone who has committed a murder will be tried by the state for murder, and possibly sued in civil court for damages.
Law of Negligence

The basic law of negligence has many threads that are sometimes difficult to disentangle. Negligence is the failure to exercise the degree of care required by law. What law requires is understood to be the conduct that a reasonable individual would exercise to prevent harm. A negligent act may be the failure to do something just as much as it is the doing of something. It arises from a breach of legal duty to another. A negligent act is one that is done voluntarily—it is a voluntary act. If an act is done involuntarily, the act is excusable. If such were the case, the plaintiff could not collect damages. Unintentional injury to another may give rise to both criminal and civil action.

The law does not expect perfection to be the standard by which conduct is judged. It is interpreted in the light of the decision that any reasonable person would have made in an emergency when there was no time to consider all the possible alternatives.

Liability for a negligent act may be imputed from another person. One is liable not only for one’s own acts but also for the negligent acts of servants or agents acting in the course of their employment or agency. Employers may be sued because of the negligent acts of their employees. These imputed acts may also create what is called vicarious liability.

Defenses to Negligence Claims

In common law, if both parties are to blame in a given accident, each is guilty of contributory negligence and may not collect against the other if the defendant was 90% to blame and the plaintiff was only 10% to blame. Under certain circumstances, a defendant may raise the defense that the plaintiff has no cause for action because the plaintiff assumed the risk of harm from the conduct of the defendant, the condition of the premises, or the defendant’s product.

An exception to the general trend towards absolute liability in our society has been the passage of what are known as guest-host statutes. These laws relate to the standard of care owed by an automobile driver to a passenger. The general effect of the laws is to reduce the standard of care owed to a guest in a car in such a manner that the guest must prove that the driver was guilty of gross negligence or willful injury, such as might be the case if the driver were intoxicated. Under guest-host laws, ordinary negligence will not be sufficient to sustain a case against the driver. In a number of states, guest-host statutes have been declared unconstitutional.
**Comparative Negligence**

The defense of contributory negligence likewise has been weakened in various ways. In a few states, statues have been enacted that replace this principle with *comparative negligence*. Under this doctrine, the liability of the defendant is reduced by the extent to which the plaintiff was contributively negligent. If the plaintiff was 20% negligent, the defendant is liable for only 80% of the plaintiff’s damages.

Another way in which the defense of contributory negligence has been weakened is in the *last clear chance rule*. Under this rule, a plaintiff who was contributively negligent may still have a cause of action against the defendant if it can be shown that the defendant had a last clear chance before the accident to avoid injuring the plaintiff but failed to do so.

**Vicarious Liability Laws**

The effect of vicarious liability laws is to place liability on the owner of a car for the negligence of the driver, thereby expanding the common-law rule applicable to employers and principals. In the states with this law, under certain circumstances the owner of a car may be held liable simply because in good faith he or she loaned the car to someone and that person negligently caused harm.

**Joint and Several Liability**

When an accident occurs in a large corporation and several different parties are negligent, the plaintiff may sue and collect from one or more of the negligent parties. Under joint and several liabilities, the plaintiff can collect the entire judgment from a large corporation that was barely at fault.
VI

Legal Responsibilities in Consumer Protection

Categories of Consumer Protection

Post-Claim Representation

Consumers have access to post-claim representation by way of the state bar, once they have a claim. There are laws enacted to protect insurance consumers, and there are certain remedies available to them in the event they have been treated unfairly.

Pre-Claim Representation

Consumers have had little or no representation with respect to important issues, which arise prior to the handling of a claim. Such issues are rule-making, ratemaking, and policy formation. Some states have independent state agencies or consumer-based groups, which represent insurance consumer issues and the consumers themselves as a class.

These groups often assess the impact of insurance rates, rules, and policy formation on consumers. They are advocates for insurance consumers. Typically, they hold strong power as lobbyists, and they monitor insurance legislation. Without these organizations, consumers as a group could not adequately be represented in matters, which directly affect them. These organizations have been involved in such areas as:

- requiring insurers to offer installment payment plans for premiums.
- requiring policies to be in easily understood language.
- proposing rule changes which prohibit discrimination against drivers with no prior insurance.
- requiring a toll-free number on policies for consumers to make complaints.
- bilingual policy forms.
Other areas of consumer protection covered by such advocate groups are public education, distributing literature on insurance topics, offering newsletters, which inform consumers and legislators, and public speaking to community groups.

Rule making is critical to consumers in the area of claims. Rules can prohibit unfair claim settlement practices. They can also create other issues, which enhance the ability of the consumer to obtain a fast and fair payment of a claim. Rules can contain definitions and statutory interpretations that remove any doubt concerning claim coverage.

**Policy Formation**

The most important consideration concerning any claim is the policy itself. A claim must be made within the limitations of the insurance policy contract. Consumers need a strong advocate acting on their behalf with respect to insurance policy contracts. Barring this, only the insurance industry would have input concerning which coverages are included in policies. Without this capable representation, there would be a serious disparity of power between the insurance industry and those it serves.

Consumer advocate groups ensure access to representation for consumers who do not have the financial incentive to participate on an individual basis. Since they represent consumers as a class, they can address the comprehensive problems, which cannot be solved when dealing with individual claims.

**Industry Abuses**

Another factor to be considered in discussing the need for insurance consumer protection is that of industry abuses which ultimately harm consumers. Even though, technically, the insurers pay fraudulent and inflated claims, the claimant and other consumers by means of increased insurance rates in reality, pay them.

In order for the insurance system to operate safely and soundly, claims must be made legitimately for the full amount of damages, no more and no less. Insurance consumers themselves have a responsibility to do their part to see that this happens, and consumer advocacy groups address this issue.
Securing Customer Protection

The intent of consumer protection legislation is generally to protect consumers against unfair or deceptive practices and to provide relief to consumers through efficient and economical procedures in order to secure this protection.

In order to secure this relief, liability on the part of the insurer usually must be found. If an insurance consumer maintains an action against an insurer, it must be based upon one of the following theories of recovery.

Theories of Recovery

Breach of contract ~ Breach of contract is a fundamental element of contract law. It is the foundation of most disputes. If the policy provides for coverage, which is not granted, a suit may be brought for breach of contract. The failure to pay policy benefits is firmly established as the insurers’ liability for unfair insurance practices. The rules for interpreting insurance policy contracts always favor the insured.

The main principles for construing a policy contract in favor of the insured are:

- An insurance policy is always construed against the insurance company.
- Ambiguous or unclear clauses are always construed in favor of the insured.
- Ambiguous policies are always interpreted to provide, rather than to deny, coverage.
- An insurance policy is considered “patently ambiguous” when it may be subject to more than one “reasonable” interpretation.
- When a policy provision is capable of more than one reasonable construction, a court must adopt the construction, which favors coverage.
- Once the insured offers a reasonable interpretation of the policy, any contrary interpretation is not permitted and is consequently rejected.
- No limitations or exclusions are implied into any policy contract.

The Breach of the Duty of Good Faith and Fair Dealing ~ There is inherently the duty of good faith and fair dealing concerning all insurance policies. This duty is breached if the insurer denies or delays payment of a claim without a reasonable basis for doing so. The duty of good faith and fair dealing is also breached if the insurer fails to determine whether there is a reasonable basis for the claim. There is a cause of action by an insurance consumer if there is no reasonable basis for denying benefits or delaying payment of a claim.
Negligence ~ The breach of the duty of good faith and fair dealing is often construed as negligence, if the insurer fails to perform its duty.

Fraud ~ Fraud may be used as a theory of recovery. In order for the element of fraud to be present, there must be a material representation that is false, and the maker of the representation must know it to be false. Or, the maker of the representation must make it recklessly, without any knowledge of the truth. The maker of the representation must also make it with the intention that it should be acted on by the other party. The other party must rely upon it, and this party must suffer some resulting injury.

Deceptive Trade Practices ~ Deceptive trade practices are frequently used as a theory of recovery. The grounds for recovery under deceptive trade practices are such things as:

- false, misleading, or deceptive acts or practices.
- the breach of express or implied warranty.
- any unconscionable act.
- any unfair practice or act.

Unfair Insurance Practices ~ The unfair insurance practices theory of recovery is very broad in its scope. Engaging in these practices or acts often falls under the provisions of unfair competition and unfair practices or under the provisions of unfair claim settlement practices.

Untimely Claim Payment or Claim Denial ~ The untimely payment of a claim or the unfair denial of a claim is clearly grounds for recovery. An insurer must comply with certain time limits when paying or denying a claim. If these deadlines are not met and liability is found, the insurer is typically subjected to a penalty and attorneys’ fees, in addition having to pay the amount of the claim.

Types of Remedies

Generally, any remedies provided for by the various states’ legislative actions are in addition to other procedures or remedies that are provided by other laws. If a consumer brings an action under some other statute, this does not preclude him from also using the various insurance consumer protection laws. Any attempts to circumvent these consumer protection acts are usually rendered void.

When a consumer brings an action against an insurer for unfair practices, there are various remedies available to him. Typically, these are:
The amount of actual damages ~ Actual damages are those losses which the consumer can substantiate as being a result of the unfair practice. Many states provide for an additional award of a multiplier, for example, three times the first $500 of actual damages. Actual damages may be such things as cost of repair, diminished value, mental anguish, out-of-pocket expense, loss of bargain, interest or finance charges, and consequential economic loss.

Actual damages may be offset by a countersuit by the defendant. For example, a consumer plaintiff may be awarded $500 in actual damages plus three times the first $500 of actual damages, for a total of $2,000. However, a countersuit by the insurer in the amount of $1,000 may somehow offset his award. His net recovery would be $1,000. Under most consumer protection statutes, even if there is no net recovery as a result of a setoff, the consumer is still entitled to attorneys’ fees.

Incentive damages ~ Most states typically provide for incentive damages. If the violation is committed knowingly, the court may award incentive damages, typically up to three to five times the amount of actual damages. Incentive damages usually apply to amounts in excess of $1,000.

Even if the insurer were found to have knowingly committed the act, the consumer would not be awarded additional incentive damages, since his initial award was only $500. Most states provide for some kind of incentive damages to be paid to the consumer if knowing conduct is involved.

If personal injury or death results as a consequence of the insurer’s unfair practice, the multiplier used to calculate the incentive damages is usually increased. Many statutes provide the incentive damages to be a minimum amount, such as $200,000. So, if the incentive damages multiplier were six on a $20,000 claim because knowing conduct was involved, the consumer would recover the minimum recovery of $200,000, rather than $120,000 (six times his actual damages of $20,000).

Restoring unlawfully acquired real or personal money or property ~ If it is shown that the insurer acquired money as a result of his unfair practices, most states issue orders requiring the insurer to restore (by means of refund or return) the unfairly acquired money or property.

Any other relief the Court deems proper ~ In most states, the Court may appoint a receiver to look after the practices of an insurer. The Court may decide to revoke the license or certificate authorizing business in the state. The Court may also sequester assets. These orders do not come unless a judgment against the insurer has not been satisfied, typically after three months of the final judgment. The cost of this receivership is assessed against the defendant insurer.
Court costs ~ Court costs incurred by the consumer plaintiff may be recovered in most states, if he prevails in his case.

Reasonable and necessary attorneys’ fees ~ Most states provide for the award of attorneys’ fees to the consumer. These fees are expressed by a percentage of the recovery.

Unfair Practices and Acts

The Federal Trade Commission Act

Both the federal law and the law of virtually every state include statutes that prohibit the use of deceptive or unfair trade methods of doing business. One of the first of these laws passed was the Federal Trade Commission Act, enacted in 1914. As originally written, the law forbade only "unfair methods of competition and commerce." The statute was designed to supplement the then recently enacted Sherman and Clayton antitrust acts.

In 1938, the law was amended also to prohibit unfair and defective acts or practices in commerce. This change was designed to make those consumers injured by unfair trade practices protected by the law in the same way that merchants and manufacturers had been protected by the original enactment. The Federal Trade Commission (FTC), the principal federal agency protecting consumer interests, now mostly enforces the law.

Uniform Deceptive Trade Practices Act

In addition, most states have now adopted either the Uniform Deceptive Trade Practices Act or their own similar laws. These laws protect consumers and other businesses in much the same way as the FTC Act. The Uniform Deceptive Trade Practices Act provides that a person or business has engaged in an illegal deceptive trade practice when the business or person does any of the following things:

- passes off goods or services as those of another.
- causes likelihood of confusion or misunderstanding as to the source or approval of goods or services; or an affiliation with or certification by someone else.
- uses deceptive representations or designations of the geographic source of the goods or service.
represents that goods or services have sponsorship, approval, characteristics, ingredients, uses or benefits that they don’t have, or that a person has some sponsorship, approval or connections that he or she does not.
• represents that the goods are original or new when they are not.
• represents that goods or services are of a particular standard, quality or grade, or of a particular style or model, when they are not.
• disparages the goods, services or business of someone else by false or misleading representations.
• advertises goods or services with no intent to sell them as advertised or that supplies needed to meet reasonable demand (unless the advertisement discloses a supply limitation).
• makes false or misleading statements of fact concerning the reasons for or the existence of price reduction.
• engages in any other conduct which similarly creates a likelihood of confusion or of misunderstanding

Legislation and Insurance Companies

The legislation for regulating unfair or deceptive acts or practices is very broad in its scope. The rules apply not only to individuals, but also to corporations, associations, partnerships, insurers, and any other legal entity, which is engaged in the business of insurance. This includes agents, brokers, adjusters, life insurance counselors, etc.

The purpose of the legislation is to create causes of actions for consumers who are aggrieved. In order to avoid a cause of action, agents and insurers should not engage in any unfair method of competition or in any unfair or deceptive act or practice, while conducting the business of insurance.

Penalties for Unfair Conduct

In addition to creating causes of actions for consumers, the statutes also provide for punishment to the insurance companies who engage in this unfair conduct. Typically, the state insurance commissioner may investigate insurers to ensure compliance.

If there is thought to be unfair or deceptive acts or practices by an insurer, in most states, the commissioner must first provide a statement of charges to the insurer, when he has reason to believe the insurer is not in compliance. Next, he gives notice of a hearing. In most states, this is a show cause hearing. In a show cause hearing, the insurer has the burden of showing why the appropriate regulatory agency or board should not order a Cease and Desist Order.
If the insurer fails to meet this burden, the state commissioner will usually issue a formal Cease and Desist Order to the insurer. A Cease and Desist order directs the insurer to cease and desist from engaging further in the method, which served as the basis of the complaint.

Any insurer who violates the terms of the Cease and Desist Order is subject to various civil penalties or administrative penalties. Civil penalties are fines. Administrative penalties are such things as an injunction from conducting further business or the suspension or loss of a license.

Further, most state insurance commissioners may restrain the insurer by means of a temporary restraining order, a temporary injunction, or a permanent injunction.

Most state commissioners have the authority to order the insurer to make restitution, not only to the consumer victim, but also to all policyholders who are similarly situated. The insurer may be required to refund all premiums, minus policy benefits, to its policyholders.

**Unfair Methods in the Insurance Business**

The following practices are considered unfair methods of conducting the business of insurance.

**Misrepresentation and False Advertising of Policy Contract**

Consumers are protected against misstatements and misrepresentation concerning policy contracts. Making an estimate or illustration that portrays the terms of any insurance policy in a false or misleading way is a violation of most insurance laws. Also prohibited is the misrepresentation of the terms of any policy in any way. This may include benefits, advantages, terms, etc.

The misrepresentation of policy dividends may not be made. This includes dividends previously paid on similar policies, as well as misleading statements with respect to policies that are the subject of a sale. There may be no misleading representation concerning the financial condition of any insurer or the legal reserve system upon which the insurer operates.

Also prohibited is using any name or title of a policy (or class of policies) which may distort the true nature of the policy. Insurers are prohibited from inducing any policy holder to lapse, forfeit, or surrender his insurance policy in any way, for example, for the
purpose of cashing in one policy and purchasing another only to benefit the agent’s commission or quota.

The statement of incorrect or misleading comparisons of policy contracts is sometimes called **twisting** in the insurance industry. By twisting, an agent might attempt to convince a policyholder to cancel a policy that he currently holds in order to purchase the policy the agent is selling. Twisting can cause significant losses, especially if the policy canceled is a whole life policy.

**False Information and Advertising**

Although the wording of the statutes may not be the same, states protect insurance consumers by prohibiting false information in advertising. Publishing, disseminating, circulating or placing before the public in any way, directly or indirectly, circulars, pamphlets, newspapers, magazines, or other publications that contain misleading statements is prohibited. This applies also to such things as brochures, letters, posters, etc. Untrue, deceptive, or misleading statements may not be made over any radio or television station.

**Defamation**

Defamation violations occur when false statements, made directly or indirectly, are intended to injure anyone engaged in the business of insurance. “Directly or indirectly” refers not only to statements made as verbal assertions, but also to pamphlets, circulars, articles, literature, etc. No assertions or statements may be made which are false, maliciously critical, or derogatory to the financial condition of the insurer.
Boycott, Coercion, and Intimidation

It is unlawful in most states to enter into any agreement to commit an act of boycott, coercion, or intimidation, which would result in a monopoly or in the unreasonable restraint of the insurance business.

False Financial Statements

These restrictions on insurers are very clear. Insurers are prohibited from misrepresenting the financial condition of any insurer (the insurer itself or another insurer) with the intent to deceive. Filing with any supervisor or public official or making, publishing, disseminating, or circulating a false statement concerning the financial condition with the intent to deceive is prohibited.

These types of misrepresentation include making false entries into any book, report, or statement with the intent to deceive an agent or examiner who has been appointed to examine these affairs. Similarly, purposely omitting such a material fact on any book, report, or statement is also prohibited.

Deceptive Name or Symbol

In most states, insurers are prohibited from the use, display, publication, circulation, or distribution of any name, symbol, slogan, or device which is the same or greatly similar to a name adopted and already in use.

Unfair Discrimination

Again, this issue is a clear one. Unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract by insurers is prohibited. This applies to life insurance, life annuities, dividends, other benefits payable by these contracts and to any terms and conditions of the insurance policy contract. Also, there may be no unfair discrimination between individuals with respect to the amount of premiums, policy fees, and rates charged for accident and health insurance.
Unfair Claims Settlement Practices

There has been a great amount of legislation created to protect insurance consumers with respect to unfair claims settlement practices. No insurer in any state may engage in unfair claims settlement practices. Some acts that are prohibited are:

- the failure to acknowledge, with reasonable promptness, appropriate communications concerning claims.
- knowingly misrepresenting to a claimant pertinent facts or policy provisions which relate to his coverage.
- the failure to adopt and implement effective and efficient standards for the prompt investigation of claims.
- not attempting, in good faith, to make a prompt, fair, and equitable settlement of a claim submitted in which liability is reasonably clear.
- compelling policy holders to initiate lawsuits in order to recover amounts due under policy coverage by offering to settle for an amount substantially less than is ultimately recovered by the claimant.
- the failure to maintain a complete record of all of the complaints received during recent years or since the date of the last examination by the insurance commissioner, whichever is shorter. This record must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, their disposition, and the time to process each complaint.
- committing any other actions, which the state defines as an unfair claim settlement practice.

Insurer Compliance

Each state has its own guidelines with respect to regulatory intervention when an insurer insolvency is possible. Some type of state board of insurance regulates the insurance industry in each of the various states. The Governor typically appoints this board. One member is usually selected to act as the chairman. Often, an insurance commissioner is appointed, as well. The board and the commissioner are responsible for supervising the Department of Insurance and administering the laws that govern the insurance practices of the state.

Typically, the state board of insurance has the power to examine and investigate the affairs of anyone who is engaged in the business of insurance within the state. This board may determine if there has been any unfair method of competition, any unfair or deceptive act, or any unfair claim settlement practice. Additionally, the state board of insurance usually monitors financial practices and ensures compliance with the laws of the state.
When a state board of insurance has reason to believe that an insurer is engaging in some violation of the various insurance consumer protection acts, most states permit the board to file an application in court to serve a statement of charges against the insurer and to give the insurer notice of a hearing to be held. The purpose of the hearing is for the insurer to show cause why a Cease and Desist Order should not be brought requiring the practices complained of to be ceased.

At this hearing, the insurer has the opportunity to be heard. During this hearing, the insurer may be represented by an attorney. In fact, in some states, anyone with something relative to say on the subject is permitted to appear and to be heard. These hearings are typically not formal, and there are no formal rules of pleading or evidence.

In most states, the board has the power to:

- to administer oaths.
- to examine and cross-examine witnesses.
- to receive evidence.
- to subpoena witnesses.
- to require the production of books, papers, records, correspondence, and other documents which are relevant.

If someone refuses to comply with a subpoena or refuses to testify for the board, typically, the state board may make a request to the District Court to have this person comply. The failure to comply with requests at this point is considered to be in contempt of the Court.

If, after the hearing, the state board determines that the insurer has engaged in some unfair insurance practice, a Cease and Desist Order must be issued. A Cease and Desist Order requires the insurer to cease and desist from engaging in the unfair practice.

In most states, if the insurer violates the terms of the Cease and Desist Order, he is then given notice to appear at another hearing and show cause why he should not pay a civil penalty.
Methods of Insurer Compliance

Target Exams

Each state may employ various measures for assuring regulatory compliance by insurers. Target exams are the method most commonly used for assuring regulatory compliance by insurers. They typically take place every two to four years. The insurer, as well as the books and records of its agents, are examined. The company being examined must bear the expenses of the exam. Negative results of a target examination can lead to the revocation or modification the insurer’s certificate of authority.

Federal Legislation

Two pieces of federal legislation are often used as the models for state statutes. These two federal acts are The Uniform Insurers Liquidation Act (UILA) and The Insurers’ Supervision, Rehabilitation, and Liquidation Model Act.

Rehabilitation

Although other regulatory measures may be referred to by different names, they come under the broad headings of rehabilitation or liquidation. Rehabilitation allows for the restructuring of the insurer under the supervision of the state board. Liquidation is a most severe situation where the state board takes title of the insurer’s assets and uses them to pay creditors and policyholders. Typically steps in rehabilitation include:

Administrative Oversight

Administrative oversight is generally an informal process. The insurer must pay the expenses of administrative oversight. This is a procedural tool used for insurers who show troubling financial or policyholder trends. These types of measures are not confidential. So, any consumer can call the state board to inquire whether a particular insurance company is under administrative oversight.

Sanctions

Sanctions are steps taken to order an insurer to cease and desist a specified activity or to suspend or revoke the authority of an insurer to do business in the state. An insurer may even be ordered to pay restitution to those who have been harmed by a violation. Further, monetary penalties may be imposed as sanctions on companies, which are found to be in violation of provisions of the state’s insurance code.
Injunctions

Injunctions are used when the state board requests the state attorney general to bring an action in the name of the state against an insurer in order to restrain the use of unfair practices. This restraint may be in the form of a temporary or a permanent injunction. In addition to requesting the injunction, the state board is typically permitted to request a civil penalty.

Supervision

In most states, the state board has the authority to place a company or its agent in a state of supervision, and the insurer must bear the cost of the supervision. Generally, a supervision order contains a list of prohibited transactions. It also specifies remedial actions, which must be taken by the insurer in order to be released from the supervision. The supervision order sets a hearing date by which the insurer must correct the items in question.

Conservation

Conservation is also known as conservatorship. Generally, if an insurer cannot prove that it has satisfied the actions necessary for release from supervision, the state board may order that the insurer be placed in conservation. Conservation is a very harsh measure. It is used when a company is insolvent, its condition is hazardous to the public or to its policy holders, it has exceeded its powers, or it has failed to comply with the state board’s requirements. A conservator can actually temporarily take over the operation of the company.

Receivership

Receivership is the harshest remedy against a licensed insurer. Using receivership, the state board requests the state attorney general to institute a receivership action. The application for an order-appointing receiver usually contains language alleging the company to be insolvent.

Generally, the state board has the discretion to accept the assurance of voluntary compliance by an insurer. There are conditions impose on voluntary compliance, for example, that the insurer restore to all consumers any money which may have been acquired by its unfair practices.

Any civil penalties, premium refunds, judgments, recoveries, orders, awards, costs, damages, attorneys’ fees, etc. which are awarded to any consumer as a result of the
insurer being found guilty of liability, must be paid only from the capital or surplus funds of the insurance company.
VII

Legal Responsibilities and HIPAA

Pre-Existing Conditions

Traditionally, many employer-sponsored group health plans and health insurance issuers in both the group and individual markets limited or denied coverage of health conditions that an individual had prior to the person's enrollment in the plan. These types of exclusions are known as pre-existing condition exclusions.

Although such exclusions were problematic for those trying to secure health coverage in the past, HIPAA (The Health Insurance Portability Accountability Act) and other recent federal laws bring some relief to this problem in certain situations. To best understand the protections provided by the law, we need to remember the following:

- HIPAA establishes requirements and limits under which a pre-existing condition exclusion can apply.
- If an individual has a pre-existing condition, HIPAA helps minimize the impact of that exclusion on his access to health coverage.
- If an individual is a HIPAA eligible individual in the individual market, no pre-existing condition exclusion can be applied to his coverage.

Limits for Exclusions

Even if an individual’s family member had a medical condition in the past, it is possible that the group health plan cannot use it as the basis for pre-existing condition exclusion. HIPAA limits pre-existing condition exclusions to those medical conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the individual’s enrollment date (his first day of coverage or, if there is a waiting period, the first day of his waiting period). This is typically the date of hire. This six-month period is often called "look-back" period. Some State laws shorten this look-back period if the individual’s group health plan is an insured plan.
The Impact of Exclusions

In many instances, HIPAA can reduce the impact of the pre-existing condition exclusion. HIPAA does this in two principal ways:

- The law limits the time over which an exclusion can keep an individual from getting coverage.
- HIPAA generally allows an individual’s previous health insurance coverage to reduce the amount of time the exclusion can apply, or, in some cases, can totally eliminate such exclusions.

In addition, no pre-existing condition exclusion is permitted for newborn and adopted children who are enrolled within thirty days, or for pregnancy.

The Exclusion Period

The exclusion period must begin on the enrollment date. It can generally last no longer than twelve months. If an individual does not enroll when he is first eligible and does not enroll when he has special enrollment rights, the plan can refuse to cover pre-existing conditions for up to eighteen months after he enters the plan.

Before a pre-existing condition exclusion can be applied to an individual’s coverage, the plan’s consumer materials must tell him if the plan imposes pre-existing condition exclusions. His group health plan must send him a written notice that an exclusion will be imposed on him. The notice should describe the length of the exclusion period. The notice also should describe how he can demonstrate how much creditable coverage he has.

Once he understands that he has a pre-existing condition that is subject to exclusion, it is important to remember that his previous health insurance coverage might reduce or eliminate the length of the pre-existing condition exclusion. Under HIPAA’s group market rules, creditable coverage can be used to reduce or eliminate pre-existing condition exclusions that might be applied to him under a future plan or policy. In general, if he had other health coverage (for example, under another group health plan or under an individual health insurance policy, Medicare, Medicaid, an HMO, or a state high-risk pool) his new plan’s pre-existing condition exclusion period must be reduced by the period of his other coverage. This earned credit for previous coverage that can help him reduce his exclusion period is called creditable coverage.

The exclusion period must be shortened by one day for each day of creditable coverage that he has. If the amount of creditable coverage he has is equal to or longer than the
exclusion period, no exclusion period can be imposed on him. When figuring out how much creditable coverage he has, however, he receives no credit for previous coverage that has been followed by a significant break in coverage - a period of 63 or more full days in a row during which he had no creditable coverage.

**Coverage Issues**

**State Law**

If an individual is in an insured plan, his State law may let him have a longer break in coverage. If so, he may be able to count creditable coverage even if it is followed by a break of 63 days or more in a row. State law also may require a shorter exclusion period, or shorter look-back period. State law requirements for pre-existing condition exclusions do not affect those imposed by self-insured plans.

Group health plans and health insurance issuers are required to furnish an individual with a certificate of creditable coverage. The certificate describes how much creditable coverage he has and the date the coverage ended. Most group health plans and insurance issuers are required to issue certificates automatically shortly after his coverage ends. He also can request a certificate describing particular coverage at any time while the coverage is in effect and within 24 months of the time the coverage ends. Finally, his new health plan can simply call his old plan to inquire about his creditable coverage. If the two plans agree, the plans can exchange the information by telephone.

When he receives a certificate from a former employer, he should make sure the information is accurate. He should contact the plan administrator of his former health plan or the health insurance issuer if any of the information is wrong. If he does not receive a certificate from his previous plan or health insurance issuer, his new health plan must accept other documentation that shows that he had prior creditable coverage.

**Special Enrollment Rights**

Group health plans and health insurance issuers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll. Importantly, individuals will be able to enroll without having to wait until the plan’s next open enrollment period, but in most situations an individual must request a special enrollment within thirty days.

A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or
placement for adoption. Special enrollment is not late enrollment, which can trigger an eighteen-month pre-existing condition exclusion period.

**Health Status and Access to Care**

If an individual is in a group health plan, he cannot be denied coverage based on his health status. A group health plan cannot refuse to enroll him just because of the following:

- his health status
- physical or mental condition
- claims experience
- receipt of health care
- medical history
- genetic information
- evidence of insurability
- disability

But employers can establish limits or restrictions on benefits or coverage for similarly situated individuals under a group health plan, or charge a higher premium or contribution for similarly situated individuals. In addition, employers may change an employee's plan benefits or covered services if they give the employee proper notification.

If an individual is no longer in a group health plan, and he meets the requirements to be a HIPAA eligible individual, he cannot be denied individual health coverage. However, the choices available to him will depend on the approach an individual's state has taken to make health coverage available to him.

If he is not an eligible individual, state law rather than HIPAA will determine whether he can be denied coverage. Depending on his state's laws, insurers and HMO's offering individual health insurance may be able to deny coverage based on his health status. Federal laws, other than HIPAA, and some state laws may ensure that certain people who have lost group coverage are guaranteed access to health coverage, at least temporarily, regardless of their health status.

**HIPAA Protection and COBRA**

Some key HIPAA protections help an individual avoid pre-existing condition exclusions on his access to coverage. One federal law that may help him take advantage of those
and other HIPAA protections is the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage gives employees (and their dependents) that leave an employer’s group health plan the opportunity to purchase and maintain the same group health coverage for a period of time (generally, 18, 29 or 36 months) under certain conditions. Workers in companies with twenty or more employees generally qualify for COBRA.

An individual may have this right if he loses his job or has his working hours reduced. He also may have this right if he is covered under his spouse’s plan and his spouse dies or he gets divorced. Children who are born, adopted, or placed for adoption with the covered employee while he or she is on COBRA also will be entitled to coverage.

Some State laws require issuers to provide similar protections for employers with fewer than twenty employees. If the individual works in a small business, he should check with his state insurance department to see if his state has such a law.

**Changing Jobs**

If an individual is between jobs, COBRA continuation coverage or similar state-mandated continuation coverage can help him avoid a significant break in coverage. That, in turn, may allow him to maximize his creditable coverage that can be used to shorten or eliminate his pre-existing condition exclusion period under a new plan.

If he is going to a new job immediately, his new employer might impose a waiting period before he can start getting benefits under the health plan. While days spent in the waiting period will not be counted as a break in coverage, he still will not have health coverage during the waiting period unless he can obtain it from another source. For many people, COBRA may be that source. Taking COBRA from an individual’s old plan until coverage under his new plan starts can provide him with continued health coverage.

When he loses eligibility for coverage under one group health plan, he also may be able to special enroll into another group health plan, such as a spouse’s plan, under which he originally declined coverage because he already had coverage under his plan. He may want to do this as a temporary measure during a waiting period imposed by an employer plan or as a permanent change. If both COBRA continuation coverage and special enrollment under another plan are available to him, he has two opportunities to request special enrollment:
• when he loses coverage under his old plan.
• if he elects to take COBRA continuation coverage, when he has exhausted his COBRA coverage.

If an individual elects COBRA coverage when he loses group health coverage, he will have to exhaust the COBRA coverage before he will be entitled to special enrollment into the other plan. He may need to carefully evaluate whether it is more to his advantage to special enroll into the other plan immediately or to first take COBRA continuation coverage from his old plan.

**Buying Individual Coverage**

In addition to helping an individual avoid a significant break in coverage when he is between jobs or helping him maintain coverage while he is in a waiting period, COBRA can help him to buy individual health insurance which is not connected to a job. Normally, his decision to buy COBRA coverage is voluntary. However, if he wants to protect his right to coverage in the individual market as a HIPAA eligible individual, he must take and exhaust COBRA or similar state continuation coverage that is offered to him.

**Exhausting COBRA Coverage**

Sometimes there may be a clear advantage to paying insurance premiums for the entire period until COBRA continuation coverage is no longer available to the individual. This is called "exhausting" his COBRA coverage. Continuation coverage is creditable coverage for HIPAA purposes. If someone accepts continuation coverage, it could help him avoid a significant break in coverage. In turn, that could reduce or eliminate a pre-existing condition exclusion if he later has access to another group health plan. If he reaches the end of his COBRA coverage without having access to another group health plan, exhausting COBRA will help him qualify for portability into the individual market as an eligible individual.

There are certain situations in which he may lose COBRA coverage earlier than the end of the usual period:

- His coverage is under a network plan (such as an HMO), he moves out of the plan's service area, and there are no other options for continuing COBRA benefits. In this first example, his COBRA continuation coverage is considered to be exhausted.
His former employer is permitted to terminate continuation coverage in certain situations when he is covered under another group health plan. However, if he has a pre-existing condition, the former employer cannot terminate his COBRA continuation coverage if the new group health plan limits or excludes coverage for his pre-existing condition.

**Conversion Options**

Conversion coverage is individual health coverage that might be offered to an individual when he loses group health plan coverage. Conversion coverage is sometimes offered by a group health plan at the end of COBRA continuation coverage. It also may be offered in place of COBRA or similar state-mandated continuation coverage. Some states require issuers of group health insurance coverage to offer conversion coverage. A few states also have chosen to use conversion policies as their approach to guaranteeing availability of coverage in the individual market to HIPAA eligible individuals.

If an individual accepts conversion coverage at the end of coverage under a group health plan or at the end of COBRA or similar state continuation coverage, he might give up some HIPAA protections. These include the ability to qualify as a HIPAA eligible individual. To retain that guarantee, his most recent coverage must have been group health plan coverage.

For HIPAA purposes, conversion coverage is not group coverage. Therefore, he can lose his rights as a HIPAA eligible individual if he chooses conversion coverage.

**Renewing Group and Individual Coverage**

HIPAA generally gives the individual the right to renew his group and individual health insurance. But that right varies considerably between group and individual plans based on certain events. When the group health plan buys a group insurance policy, coverage generally must be renewed for as long as the employer wants it to be. If the individual’s group health plan buys an individual policy for him, it generally must be renewed so long as he wants to do so.

Group coverage is not guaranteed to be renewable, however, if the group health plan has done any of the following:

- failed to pay premiums for the coverage.
- committed fraud against the issuer providing the coverage.
• violated participation or contribution rules that apply to the coverage
• terminated the coverage
• ended membership in an association (if the coverage is available only to members of the association)

If the coverage is a network plan (such as an HMO), the issuer also may terminate or refuse to renew the coverage if all members of the group move outside of the plan’s service area.

If one has individual health insurance, his coverage is generally renewable regardless of whether he is a HIPAA eligible individual. His coverage may be discontinued or non-renewed by his insurance company, only if he does any of the following:

✓ fails to pay his premiums.
✓ commits fraud against the issuer.
✓ terminates the policy.
✓ moves outside the service area (if in a network plan).
✓ moves outside a state (if in a state high-risk pool).
✓ ends his membership in an association (if the coverage is available only to members of the association).

**Final Rule for Security Standards**

The final rule adopting HIPAA standards for the security of electronic health information was published in the Federal Register on February 20, 2003. This final rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. The standards are delineated into either required or addressable implementation specifications.

The federal government has enacted regulations that will protect private health information. As required by HIPAA, the final regulation covers the following:

- Health plans.
- Health care clearinghouses
- Those health care providers who conduct certain financial and administrative transactions such as electronic billing and electronic fund transfers

All medical records and other individually identifiable health information held or disclosed by a covered entity in any form, whether communicated electronically, on paper, or orally, are covered by the final regulation.
The rule is the result of the Department's careful consideration of every comment and reflects a balance between accommodating practical uses of individually identifiable health information and rendering maximum privacy protection of that information.

**Consumer Control Over Health Information**

Under this final rule, patients have significant new rights to understand and to control how their health information is used.

- **Patient education on privacy protections** ~ Providers and health plans are required to give patients a clear written explanation of how they can use, keep, and disclose their health information.
- **Ensuring patient access to their medical records** ~ Patients must be able to see and get copies of their records and request amendments. In addition, a history of most disclosures must be made accessible to patients.
- **Receiving patient consent before information is released** ~ Patient authorization to disclose information must meet specific requirements. Health care providers who see patients are required to obtain patient consent before sharing their information for treatment, payment, and health care operations purposes. In addition, specific patient consent must be sought and granted for non-routine uses and most non-health care purposes, such as releasing information to financial institutions determining mortgages and other loans or selling mailing lists to interested parties such as life insurers. Patients have the right to request restrictions on the uses and disclosures of their information.
- **Ensuring that consent is not coerced** ~ Providers and health plans generally cannot condition treatment on a patient's agreement to disclose health information for non-routine uses.
- **Providing recourse if privacy protections are violated** ~ People have the right to complain to a covered provider or health plan, or to the Secretary, about violations of the provisions of this rule or the policies and procedures of the covered entity.

**Medical Record Use and Release**

With few exceptions, an individual's health information can be used for health purposes only.

- **Ensuring that health information is not used for non-health purposes** ~ Patient information can be used or disclosed by a health plan, provider or clearinghouse only for purposes of health care treatment, payment, and operations. Health
information cannot be used for purposes not related to health care (such as use by employers to make personnel decisions, or use by financial institutions) without explicit authorization from the individual.

- **Providing the minimum amount of information necessary** ~ Disclosures of information must be limited to the minimum necessary for the purpose of the disclosure. However, this provision does not apply to the transfer of medical records for purposes of treatment, since physicians, specialists, and other providers need access to the full record to provide best quality care.

- **Ensuring informed and voluntary consent** ~ Non-routine disclosures with patient authorization must meet standards that ensure the authorization is truly informed and voluntary.

**Security of Personal Health Information**

The regulation establishes the privacy safeguard standards that covered entities must meet, but it leaves detailed policies and procedures for meeting these standards to the discretion of each covered entity. In this way, implementation of the standards will be flexible and scalable, to account for the nature of each entity’s business, its size, and its resources. Covered entities must:

- **Adopt written privacy procedures** ~ these must include who has access to protected information, how it will be used within the entity, and when the information would or would not be disclosed to others. They must also take steps to ensure that their business associates protect the privacy of health information.

- **Train employees and designate a privacy officer** ~ Covered entities must provide sufficient training so that their employees understand the new privacy protections procedures and designate an individual to be responsible for ensuring the procedures are followed.

- **Establish grievance processes** ~ Covered entities must provide a means for patients to make inquiries or complaints regarding the privacy of their records.

**Accountability for Medical Records Use and Release**

Penalties for covered entities that misuse personal health information are provided in HIPAA.

- **Civil penalties** ~ Health plans, providers, and clearinghouses that violate these standards would be subject to civil liability.

- **Federal criminal penalties** ~ There would be federal criminal penalties for health plans, providers, and clearinghouses that knowingly and improperly disclose

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information or obtain information under false pretenses. Penalties would be higher for actions designed to generate monetary gain.

**Public Responsibility and Privacy Protections**

After balancing privacy and other social values, HHS is establishing rules that would permit certain existing disclosures of health information (without individual authorization) for the following national priority activities (and for activities that allow the health care system to operate more smoothly). All of these disclosures have been permitted under existing laws and regulations.

Within certain guidelines found in the regulation, covered entities may disclose information for the following:

- Oversight of the health care system, including quality assurance activities
- Public health
- Research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board
- Judicial and administrative proceedings
- Limited law enforcement activities
- Emergency circumstances
- Identification of the body of a deceased person, or the cause of death
- Facility patient directories
- Activities related to national defense and security

The rule permits but does not require these types of disclosures. If there is no other law requiring that information be disclosed, physicians and hospitals will still have to make judgments about whether to disclose information in light of their own policies and ethical principles.

**Public and Private Sector Health Plans and Providers**

The provisions of the final rule generally apply equally to private sector and public sector entities. For example, both private hospitals and government agency medical units must comply with the full range of requirements, such as providing notice, access rights, requiring consent before disclosure for routine uses, and establishing contracts with business associates.
Insurance fraud is one of the most costly white-collar crimes in America, ranking second to tax evasion. According to the National Insurance Crime Bureau (NICB), 10% of property and casualty insurance claims are fraudulent. Insurance fraud is a crime and includes:

- submitting false applications for insurance.
- making false or inflated insurance claims.
- paying for referrals of insurance claimants to lawyers and health care providers.

Thousands of individuals know firsthand the financial harm that insurance fraud can inflict. These victims include people whose car insurance premiums were stolen by outlaw agents, employees left with worthless health insurance, businesses that purchased bogus workers' compensation coverage and doctors whose search for lower medical malpractice insurance rates led them to fictitious offshore companies. Many more individuals become victims indirectly when claim fraud drives up their insurance premiums. Dollars paid by insurance companies for fraudulent claims increase the "loss" statistics used in determining future rates.

Fighting insurance fraud is given high priority in most states. The most important job is to detect fraud and stop it with license revocations, cease-and-desist orders and criminal prosecutions of those who commit it. The individual state’s insurance department investigates suspected fraud cases, refers perpetrators to local district attorneys and the U.S. Attorney for prosecution and, when asked, furnishes trained attorneys to assist as special prosecutors.

Conviction can result in imprisonment, fines, and loss of professional licenses. Insurance fraud occurs in virtually all types of insurance, including automobile, worker’s compensation, disability, healthcare, life and homeowner’s. Some people think the victims are the insurance companies. In reality, the victims are all of us who must pay higher insurance premiums and higher costs for goods and health care as a result of fraud.
Insurance fraud is an attempt to obtain money from insurance companies by arranging a loss or accident or falsifying information on applications for insurance claims. When caught, prosecuted and found guilty, most fraud perpetrators are required to make restitution and jail time is also commonly imposed.

**Property Insurance**

**Homeowners’ Insurance Fraud**

Homeowners’ insurance fraud is committed whenever a person knowingly submits a claim under a homeowner’s policy for more than the actual loss sustained. In short, it is lying about an insurance claim. It is a crime. It is also a crime to use false, incomplete or misleading information—such as a receipt, repair estimate, statement of loss, legal deposition, or even a photo—to support such a claim. It is even a crime to help someone else prepare false documentation to support a false claim. And it does not really matter whether the claim is paid or not. It is still a crime.

**Arson Fraud**

Arson fraud is insurance fraud committed by property owners who deliberately destroy or damage their property by fire for the purpose of collecting from their insurance companies. The motive for this act is profit and individuals who find themselves in difficult financial positions, such as high debt, possible foreclosure or bankruptcy, usually commit it.

The typical arson fraud involves an individual or a conspirator setting fire to their home, business or automobile. The intent is to collect insurance money to pay off a loan or mortgage balance, which may be in excess of the value of the property.

Business owners also commit arson fraud for the same reasons as individuals. However, business owners are often more savvy than individuals when it comes to arson fraud and the monetary impact is greater. They sometimes hire professional arsonists to perform the act. In addition, they are more adept at perpetrating more elaborate schemes such as claiming damage to inventory that did not exist or was removed from the building before the fire was set.
**Water Damage Fraud**

Several years ago some individuals were arrested and indicted for scamming insurers out of $5 million by intentionally flooding their homes and filing mold and water damage insurance claims. Investigators said that the individuals involved had purchased homes with full insurance coverage.

Water hoses or damaged existing water lines inside the houses were intentionally used to flood the interiors. The water lines would be repaired before an adjuster arrived. Attempts were made to obtain the full policy limits of the insurance coverage along with additional living expenses.

Those arrested faced charges of money laundering, mail fraud, conspiracy and monetary transactions with criminally derived property, and if found guilty, possible prison terms and substantial fines.

**Burglary & Theft Fraud**

Generally burglary and theft fraud schemes have been staged events, and often, they have centered on padded appraised values of personal property. A property owner falsely reports items stolen or exaggerates the values of items taken in a burglary to collect insurance money.

**Auto Insurance Fraud**

Auto insurance fraud is an enormous problem in the United States -- one that costs some states millions of dollars each and every year. Unfortunately, many people do not realize the severity of this crime. There exists a mistaken perception that this type of fraud is somehow harmless and acceptable. All people are victims of this illegal activity, paying in the form of higher insurance premiums -- hundreds of dollars more than they would otherwise be.

Fraud can come in many different sizes and varieties, all of which are costly to each driver. It can be as simple as misrepresenting facts on insurance applications and inflating insurance claims or as serious as staging accidents and submitting claim forms for injuries or damage that never occurred.

Achieving success depends on public awareness of the problem and willingness to assist our efforts. Under some states' Insurance Law, licensees of the Insurance
Department (such as insurers, agents, and brokers) are required to report any suspected fraudulent acts to the Department’s Insurance Fraud Bureau.

**Types of Schemes**

Here are some commonly used fraud definitions/schemes in accidents that are caused intentionally or they have never happened:

**Cappers and/or Runners** ~ Third-party middlemen who recruit insurance defrauders (such as drivers and passengers) and befriend legitimate accident victims for medical mills.

**Padding** ~ Intentionally inflating or exaggerating a claim.

**Swoop and Squat** ~ Two vehicles work as a team to set up an accident. While driving, one vehicle pulls in front of victim and the other along side, blocking the victim in. The lead car stops short causing the victim to rear-end him. The car that pulled up along side serves as a block to prevent victim from taking evasive action. Lead car alleges that someone cut him off.

**Drive Down** ~ As an unsuspecting driver tries to merge into traffic, the suspect driver yields, waving innocent driver on. As the innocent driver merges, suspect driver intentionally collides with victim and denies giving him the right of way.

**Start and Stop** ~ Stopped in the same lane of traffic, claimant’s vehicle is positioned directly in front of victim’s vehicle. The claimant starts to move forward, as does the victim behind him. For no reason, the claimant vehicle suddenly stops short causing the victim to rear-end him.

**Jump In** ~ A claimant who was not in vehicle at time of loss, but nevertheless, submits a claim for bodily injury.

**False Auto Insurance Claim**

Auto insurance fraud is committed whenever someone intentionally lies to an insurance company about a claim involving their car insurance. In some states, it is a felony to submit a false auto insurance claim. It is a criminal act to use untrue or misleading documentation to support a false claim. This includes faked, falsified or exaggerated receipts, bills, estimates, test results, or any evidence of injury, loss or expense. It is even a crime to assist someone else in submitting or documenting a false claim.
Five of the most common ways of committing auto insurance fraud are:

**False Parts Claims** ~ Auto parts are removed, hidden and then reported stolen. After the insurance is paid, the parts are reinstalled.

**Owner Dumping** ~ A car is falsely reported stolen. The owner then collects a claim payment from the insurance company while the car parts are sold to salvage yards and auto shops.

**Abandoned Vehicles** ~ A car is left on the street or in a parking lot in the hopes it will be stolen or destroyed. The owner then reports the vehicle stolen to the police and collects from the insurance company.

**Salvage Switches** ~ the vehicle identification number tag is taken from a junked car and switched to a similar make and model that an owner has fraudulently reported stolen. With the false number in place, the car is then re-registered in another state and sold.

**Staged Auto Accidents** ~ an auto accident is staged, usually in some kind of conspiracy between the owner of the car, doctors, and lawyers, to falsify a claim and collect from the insurance company. The vast majority of the fraud reports are for staged automobile accidents. "Staged accident" is a catch all term for many types of fraudulent automobile claims perpetrated against insurers. Four most common scenarios are

- caused accidents
- staged accidents
- paper accidents
- multiple policies

**Auto Arson and Auto Theft Fraud**

Auto arson and theft are often part of the same scheme. Arson is a leading cause of vehicle fires. Someone pouring gasoline or kerosene on the seats and carpeting usually starts these fires. The arsonist, who is either the owner of the automobile or has been hired by the owner, then throws a lighted match into the vehicles.

Then the owner reports the fire to his insurance company saying that the vehicle caught on fire for no apparent reason. Facts tell us that accidental fires generally occur in the
wiring, fuel lines, fuel filter, fuel pump, or carburetor. Newer model cars rarely catch fire due to a wiring problem.

Insured have fraudulently reported their vehicle stolen or vandalized in order to collect on insurance. Staged burglaries range from the entire burglary being staged to simple inflation of a claim for a legitimate burglary.

**Workers’ Compensation Insurance**

Businesses without standard workers’ compensation insurance forfeit almost all their defenses against lawsuits and may face unlimited liability if sued by injured employees. However, the field of workers’ compensation insurance has been fertile for insurance fraud perpetrators. Workers’ compensation fraud has primarily involved illegitimate or exaggerated claims and premium fraud where payroll or job classifications have been falsified.

Each state has individually enacted workers’ compensation laws that provide employees the right to collect from their employers for injury, disability or death that arises out of their employment and is sustained in the course of employment.

There are five types of fraud commonly found in the workers’ compensation system:

- injured worker benefit fraud
- insurance carrier fraud
- employer premium fraud
- health care provider fraud
- attorney fraud

Insurance carriers use several clues to identify a potential workers’ compensation fraud case including:

- when the injury occurred
- past history of workers' compensation claims
- frequent change of doctors
- employer classification codes not consistent with the duties normally associated with the employer's type of business
- multiple businesses located at the same address
- duplicate medical billings
- health care providers attempting to bill an injured worker for medical services provided on a workers' compensation claim
- incorrect information on attorney bills or duplicate billing
An estimated 25% of the general population knows someone that has committed workers' compensation fraud:

- someone that has faked an injury or exaggerated symptoms in order to have time off work with pay
- someone that was injured at home, but claimed it was work-related in order to receive benefits
- someone receiving benefits and working a second job without claiming the income
- someone receiving benefits and working a second job without claiming the income
- someone receiving benefits and working a second job without claiming the income
- someone who has employees but not the proper workers' compensation insurance coverage
- an employer misreporting payroll to keep the cost of premiums low

Dramatic increases in workers' compensation premiums throughout the late 1980s and early 1990s fueled unsubstantiated charges that costs were high in part because workers abused the system, fraudulently collecting benefits for faked injuries or remaining on benefits far longer than their recovery required.

These huge numbers grabbed the attention of the public and policyholders. The presumption in the press and in the state houses was that fraud was rampant and that most workers' compensation fraud was claimant fraud. Since that time, more than half of the states have passed legislation on workers' compensation fraud, with most of the laws directed primarily at claimants.

Thirty-three states currently have active workers' compensation insurance fraud units, any of them geared to fighting claimant fraud. In every state, some claimant fraud has been discovered; publicity about these cases has created a deterrent for workers who might contemplate fraudulent claims. But it has also created an atmosphere that some describe as the unwarranted and anecdotal vilification of the work force.

In its extensive investigation of workers' compensation fraud, one survey concluded that the perception that workers are cashing in by faking or exaggerating injuries has created a climate of mistrust in which every person who is injured and files a claim can become the subject of suspicion by insurance adjusters, doctors and industry lawyers.

Perhaps most importantly, the fixation on claimant fraud has distracted policymakers, enforcement agencies, and the public from growing evidence of the real problem:

- millions of dollars in employer and provider fraud
Few experts believe that claimant fraud is a major cost driver in workers' compensation. But some estimates suggest that fraud accounted for 25% of all employers' workers' compensation costs and 10% of the claims.

According to surveys some insurance companies saw fraud as a way to explain why premiums were soaring, and politicians and the media jumped on the bandwagon. While some insurance companies claim one out of three workers lie about their injuries, the actual number of fraud cases sent to prosecutors is less than 1 out of 100, or less than 1%.

**Employer Fraud**

Premium collection is fundamental to the operation of workers' compensation, but amidst the often-sensational stories of cheating employees it is easy to lose sight of the other major element of fraud in the industry:

- premium evasion by employers

In late 1990s the NSW government conducted an amnesty on underpayment, which revealed a significant problem. The crackdown produced a $15 million improvement in compliance.

Investigations have found many companies who have no workers' compensation insurance whatsoever and many others who under-insure by false declaration of wage levels or by providing misleading information concerning their industry classification. Premium levels are generally calculated as a percentage of total wages and are also influenced by the type of industry an employer is competing in.

Surveys have revealed that the level of non-compliance with correct premium payment in the building industry is between 30%-60%. A lot of effort is being made around the country to combat financial difficulties by reducing workers' benefits, but if everybody paid the correct premium, there would be sufficient revenue to adopt a different approach. Workers have been fined for fraud, but little has been done against employers who are committing unprecedented corporate crime.

Premium fraud includes a number of schemes used by employers to reduce the workers' compensation insurance premiums by underreporting payroll, misclassifying employees' occupations and misrepresenting their claims experience. According to the National Council on Compensation, the most common frauds include:
Underreporting payroll. Employers reduce their premiums by not reporting parts of the workforce, paying workers off the books or creating a companion corporation to hide a portion of the employees.

Declaring independent contractors. Employers avoid premium payments for employees by classifying them as independent contractors even though they are legally employees.

Misclassifying workers. Employers intentionally misrepresent the work employees do to put them in less hazardous occupational categories and reduce their premiums.

Misrepresenting claims experience. Employers hide previous claims by classifying employees as independent contractors or leased employees or creating a new company on paper.

In addition to premium fraud, employers often fail to purchase workers' compensation insurance, despite state laws mandating that they do so. There are also reports of employers.

- instructing injured workers to seek treatment under group health insurance rather than workers' compensation
- discouraging workers from filing workers' compensation claims
- firing workers who file claims

The key to fighting workers' compensation fraud is for employers to focus on prompt rehabilitation and return to work.

Medical Provider Fraud

Workers' compensation fraud also occurs among medical providers. These forms of fraud evolve as the nature of medical care changes over time. Outright fraud occurs when providers bill for treatments that never occurred or were blatantly unnecessary. Some of the newer forms of medical provider fraud include kickbacks from specialists and other treatment providers to referring physicians, and provider up-coding, where provider charges exceed the scheduled amount. Providers also shift from the less expensive, all-inclusive patient report to supplemental reports, which add evaluations and incur separate charges.

Medical provider schemes include:
• creative billing - billing for services not performed
• self-referrals - medical providers who inappropriately refer a patient to a clinic or laboratory in which the provider has an interest
• upcoding - billing for a more expensive treatment than the one performed
• unbundling - performing a single service but billing it as a series of separate procedures
• product switching - a pharmacy or other provider bills for one type of product but dispenses a cheaper version, such as a generic drug

Newer forms of fraud and abuse occurring under managed care arrangements include:

• underutilization - doctors receiving a fixed fee per patient may not provide a sufficient level of treatment
• overutilization - unnecessary treatments or tests given to justify higher patient fees in a new contract year
• kickbacks - incentives for patient referrals
• internal fraud - providers collude with the medical plan or insurance company to defraud the employer through a number of schemes

**Insult Added to Injury**

Because of the assumption of widespread claimant fraud, injured workers who file a workers' compensation claim may be subjected to insulting questions and treated as malingerers and cheats. Under the auspices of "fraud prevention," they may face endless questioning and unnecessary medical examinations. They may be subjected to constant video surveillance by private investors hired to follow their every move. Their employer may refuse to provide light duty work, or take retaliatory actions against them when they return to work. If they look for another job, their application may be screened for prior workers' compensation claims.

Although some of these tactics are used in legitimate attempts to investigate questionable claims, they have also become part of a broad employer attempt to intimidate workers from filing workers' compensation claims. Under the pretext of controlling what has been falsely presented as rampant claimant fraud, injured workers are discouraged from exercising their legitimate rights to workers' compensation benefits.
Other Bodily Injury Fraud

Estimates tell us that about one-third of all bodily injury claims contain some type of fraud. Property insurance covers damage to, or theft of possessions, and liability or casualty insurance pays for a legal responsibility to other people for property damage or bodily injury losses.

Slip-And-Fall Claims

Fraud indicators in fraudulent slip-and-fall claims have usually been the same as those of other claims involving medical fraud. A popular slip-and-fall accident scheme that con artists have often used in stores is when at least one of the con artists was a “witness” to another con artist’s fall.

Commercial P&C Insurance Fraud

Commercial insurance is insurance against the failure of a business undertaking or commercial enterprise to return a given amount of business or profit, to the exclusion of credit guaranty and other specific branches of guaranty insurance. Thus, an undertaking by one furnishing materials for a voting contest might make the case that if sales were not increased by the contest so that a small percentage would equal the amount paid for the materials, he would pay the difference in cash. This could be considered a contract of commercial insurance, and not of suretyship or a guaranty.

Commercial property owners, both those operating a business on their property and those leasing property to another entity, may purchase policies that protect the building and associated structures. A property owner's policy will not protect tenants from loss. Business owners who lease their property may buy policies that protect the building's contents, such as machinery, furniture and stored or displayed merchandise.

Different types of commercial property insurance policies protect against different dangers, called "risks," "causes of loss" or "perils." Commercial property policies are not standardized in some states. Insurance companies are free to use their own policies, subject to approval by the particular state's Commissioner of Insurance. Policies must contain reasonable coverages and meet all requirements set out by law. Insurers' ability to offer different commercial policies allows them to tailor their products to fit the needs of particular businesses. The availability of multiple policies encourages a competitive market.

Commercial property policies available generally fall into three categories:
• **Basic form** -- covers common perils, such as damage caused by fire, lightning, windstorm, vehicles, aircraft and civil commotion.
• **Broad form** -- covers basic perils while adding others, such as water damage, collapse, glass breakage, weight of snow, ice or sleet, and sprinkler leakage.
• **Special form** -- covers any cause of loss except those specifically excluded, such as flood, earth movement, war, nuclear disaster, wear and tear, insects and vermin.

Many commercial property insurance consumers buy additional coverage.

• **Liability** policies protect against the cost of a lawsuit and possible judgment.
• **Business interruption** coverage reimburses the policyholder for business income lost when a covered cause of loss damages or destroys a building or its contents.
• **Extra expense** coverage pays the added amount an insured must spend after a loss to resume business operations as quickly as possible.

**Fraudulent Schemes Against Businesses**

Insurance fraud schemes often target businesses and professional people because the victims need insurance to stay in business and large commercial policies generate large premiums. Historically, these schemes have concentrated on types of business insurance that are particularly expensive or hard to find in legitimate insurance markets. At various times, these have included:

• Workers’ compensation.
• Medical malpractice insurance.
• Commercial general liability.
• Performance bonds for contractors.
• Automobile liability insurance for truckers.

By far the most common schemes involve unauthorized insurance -- the sale of policies by companies not licensed in a particular state. These often are offshore companies, chartered by Caribbean or Pacific island nations that cannot regulate them effectively. The companies may have impressive sounding names and authentic-looking policy forms.

Property and casualty lines, fictitious or unlicensed offshore companies have defrauded individuals by selling them bogus medical malpractice, commercial general liability, contractors' performance bonds and trucker's liability insurance. The big selling points
were cheap premiums and/or lax underwriting standards. Policyholders ran a tremendous risk that their claims -- or liability claims against them -- would not be paid.

**Signs of Fraudulent Claims**

Any indication that the business is having financial difficulties or has immediate need for funds is definitely a reason to suspect fraud in a claim or application for a claim. Other reasons could be deteriorated or outmoded facilities when the business is in bad location or deteriorating neighborhood or machinery, production equipment or inventory is obsolete or unmarketable.

Fraud occurs when a person knowingly or intentionally conceals, misrepresents, and makes a false statement to either deny or obtain workers' compensation benefits or insurance coverage, or otherwise profit from the deceit. The key to conviction is proving in court that the misrepresentation or concealment occurred knowingly or intentionally.

“Material misrepresentation," as it pertains to insurance contracts, as an untrue fact, which affects the risk undertaken by the insurer. Thus, the insured's misrepresentation must be shown to have caused a substantial increase in the risk insured against, and would have, if the misrepresentations were known by the insurer, caused a rejection of the application.

Some courts have concluded that an insurance applicant has a duty to act in good faith, and that an insurer is entitled to truthful responses so that it may determine whether the applicant meets its underwriting criteria. Nevertheless, a good faith mistake does not excuse a material misrepresentation on an insurance application and does not preclude an insurer from rescinding a policy under some states’ law.

Any omission or concealment that is injurious to another or that allows a person to take unconscionable advantage of another may constitute criminal fraud. In Anglo-American legal systems, this latter type of fraud may be treated as deceit, subject to action in civil rather than criminal law.

**The Law of the Agency**

The insurance industry is committed to reducing fraud by teaching claims professionals how to recognize suspicious claims and work with law enforcement and investigative services. Insurance companies have units trained to investigate fraud. The insurance industry estimates the size of insurance fraud to be about 10-15% of the premium dollar. This puts the yearly costs around $18 billion nationally. As fraud is reduced or
eliminated, claims costs can be lowered and those savings can be passed on to policyholders.

Legally, the salesman is considered to be the agent of the company for which he works. An agent may be defined as a person who represents and acts in behalf of another person in dealing with third persons. The person who is represented by the agent is called the principal. The agent is always subject to the control of the principal he represents.

In selling, the company is the principal, the salesman is the agent, and the customer is the third party. As the principal, the company has the legal right to enter into valid contracts. When the company hires the salesman, it empowers him to take the place of the company in its business transactions with third persons. The contract that results from the salesman’s actions as an agent is binding on the principal and the third party. The agent is the go-between who brings the contracting parties together.

The authorization of the salesman by the company may be either written or implied, but in either case the salesman binds the company by his acts. The company is responsible for what the agent does as long as the agent is acting within the limits of the power that the company has given him. When the salesman exceeds his authority, the third party may hold him personally liable for any injury that results.

Thus, in order to act as an agent of his company within the bounds of the law, the salesman must know what the limits of his authority are and he must stay within those limits. He should also know that he cannot delegate or assign his authority to another person without specific permission from the company.

**The Law of Sales**

Knowledge of the law of sales will help the salesman to determine when the transfer of ownership takes place. Because of the variety of business transactions involved in buying and selling, a special set of rules has been developed governing the transfer of ownership. These rules have been brought together in the Uniform Commercial Code, which has been adopted by forty-nine of the fifty states.

A sales contract is an agreement that has as its purpose the immediate transfer of ownership, whereas a contract to sell is an agreement in which the parties agree that transfer of ownership will take place some time in the future.

Sometimes, merchandise is lost, damaged, or destroyed. In such cases, it is necessary to know when ownership was transferred from seller to buyer in order to determine who is responsible for the loss. For example, suppose a person buys an oil painting and
says that he will return the next day with his car to pick it up. If that painting is damaged or destroyed before he picks it up, the buyer is responsible. However, if the buyer had said that he would buy the painting when he moved into his new apartment the following month, whatever happens to the painting until that time is the responsibility of the seller.

**The Law of Contracts**

The insurance agent is constantly negotiating contracts between his company and his customers. Every time he writes an order, he is engaged in the process of negotiating a contract. It is important, therefore, that he understands what constitutes a contract. When the insurance agent learns what elements are essential in any contract, he will be able to negotiate a valid contract, which will be enforceable in a court of law.